FEASIBILITY STUDY FOR ASSESSMENT OF CULTURALLY ADAPTED BEHAVIOURAL ACTIVATION FOR THE TREATMENT OF DEPRESSION

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INTELLECTUAL PROPERTY AND PUBLICATION STATEMENTS

The candidate confirms that the work submitted is her own, except where work which has formed part of jointly authored publications has been included. The contribution of the candidate and the other authors to this work has been explicitly indicated below. The candidate confirms that appropriate credit has been given within the thesis where reference has been made to the work of others.

The work in CHAPTER 3 of the thesis has appeared in publication as follows:

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I was responsible for development of the protocol for the systematic review, conducting the databases searches, screening all studies identified at each step, extracting data from the included studies and drafting the article.

The contribution of other authors was that G. Mir double screened 10% of all abstracts and the full text of seven included studies and conducted a double quality assessment for two papers. R. West double screened the full text of the eight remaining included studies and conducted a double quality assessment for two studies. He also checked data extracted from the RCT studies included in the meta-analysis. A. Cardno contributed to the development of each draft of the manuscript. All three co-authors are supervisors of the first author's PhD. All authors were involved in reviewing the progress of the study at each step and each draft of the manuscript.

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ABSTRACT

Background: There is evidence that culturally adapted psychotherapies (CAPs) are more effective for treating mental illnesses than standard therapies, but further research is needed to evaluate efficacy of CAPs focusing on the treatment of depression. Behavioural Activation (BA), an existing evidence-based treatment for depression, has been culturally adapted for depressed Muslims in the UK (BA-M; Mir et al., 2015). BA-M has the potential to be beneficial for the treatment of depression in Turkey, which is a Muslim majority country, but this has not yet been evaluated.

Aims: The primary aim of this thesis was to examine the feasibility of conducting a full Randomised Controlled Trial (RCT) of BA-M for depressed Muslim adults in Turkey. A secondary aim was to compare findings of the feasibility study in Turkey with those obtained from the UK pilot study.

Research design: Three studies were conducted: (1) a systematic review and meta-analysis of face-to-face CAPs; (2) a mixed methods parallel group feasibility study of BA-M compared to Cognitive Behavioural Therapy (CBT); and (3) a comparison study based on findings from the pilot study of Mir et al. (2015) with findings from the feasibility study.

Results: The meta-analysis found that CAPs result in a statistically significant reduction in depressive symptoms for depressed adults compared with control conditions with a standardised mean difference of 0.63 standard deviations.

Quantitative and qualitative findings from the feasibility study provided evidence about acceptability of BA-M among depressed clients and their therapists in Turkey and that the feasibility study was partially successful, thus an RCT of BA-M could be feasible if issues regarding clients' recruitment and data collection are addressed.

The comparison study found some similarities and differences between treatment acceptability and outcome of BA-M among Muslim clients and therapists in Turkey compared to those in the UK.

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ABBREVIATIONS

APA	American Psychiatric Association
BA	Behavioural Activation
BADS	Behavioural Activation Depression Scale
BAI	Beck Anxiety Inventory
BA-M	Behavioural Activation- Muslim
BARB	Behavioural Activation of Religious Behaviours
BDI	Beck Depression Inventory
BT	BA therapist
C	Client
CA-CBT	Culturally Adapted Cognitive Behavioural Therapy
CAPs	Culturally Adapted Psychotherapies
CBT	Cognitive Behavioural Therapy
CES-D	Centre for Epidemiologic Studies Depression Scale
CG	Control Group
CI	Confidence Interval
CMHC	Community Mental Health Centre
COBRA	Cost and Outcome of BehaviouRal Activation
CSC	Cochrane Scientific Committee

CSI	Client Satisfaction Inventory
CT	CBT Therapist
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECT	Electroconvulsive Therapy
EBPT	Evidence-Based Psychological Treatments
EPDS	Edinburgh Postnatal Depression Scale
GAD-7	Generealised Anxiety Disorder Assessment-7
GDS	Geriatric Depression Scale
HADS-D	Hospital Anxiety and Depression Scale- Depression Subscale
HAM-D	Hamilton Depression Rating Scale
HAP	Healthy Activity Programme
IAPT	Increased Accessed to Psychological Treatments
ICD	International Classification of Diseases
IG	Intervention Group
IPT	Interpersonal Therapy
M	Mean
mhGAP	mental health Gap Action Programme
MI	Medical Intervention
MRC	Medical Research Council

MSc	Master of Science
NHS	National Health Services
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health and Care Research
PhD	Doctor of Philosophy
PHO	Physical Health Outcome
PHQ-9	Patient Health Questionnaire-9
pp	Participants
QOL	Quality of Life
RCBT	Religiously integrated CBT
RCT	Randomised Controlled Trial
RRS	Ruminative Response Scale
SCID	Structured Clinical Interview for DSM
SCL-90-R	Symptom Checklist 90 Revised
SD	Standard Deviation
SE	Standard Error
SMD	Standardised Mean Difference
ST	Supportive Therapy
TAU	Treatment as Usual

TR	Turkey
UK	United Kingdom
US	United States
VA	Values Asssessment
WHO	World Health Organisation
WL	Waiting list
WSAS	Work and Social Adjustment Scale
[…]	Omission of words
“ ”	Participants’ own words
[ ]	E.A.’s words to clarify meaning or use different words instead of the participants’ words in order to anonymise the participants
---	Words omitted to preserve anonymization

CHAPTER 1
INTRODUCTION

1.1 BACKGROUND

Depression affects more than 300 million individuals worldwide. In Turkey, this number is more than 3.3 million, corresponding to a prevalence rate of 4.4%, which is close to the 4.5% prevalence rate in the UK (WHO, 2017). The Turkish Statistical Institute conducted interviews with 23,119 people in 2019, of whom 17,084 were aged 15 years and older. The findings showed that in the previous 12 months, depression was reported by 12.2% of females and 5.7% of males; in total 9% of those aged 15 and over (Turkish Statistical Institute, 2020). Thus, depression appears to be more common in women in Turkey. This is in line with the general literature because females are about twice as likely as males to report experience of depression throughout their lives (Kuehner, 2017, Abate, 2013, Andersen et al., 2011, Lim et al., 2018).

Depression can be the cause of substantial impairment in social and occupational functioning (DeRubeis et al., 2008), so it can have personal and public health consequences (Burcusa and Iacono, 2007). Effective interventions for depression increase economic productivity and decrease health expenses (Hollon et al., 2002). There are effective biological and psychological treatments (Ekers et al., 2011, Türkçapar, 2018) such as antidepressant medication (e.g., selective serotonin reuptake inhibitors and tricyclic antidepressants) (Cipriani et al., 2018, Arroll et al., 2005) and electroconvulsive therapy (ECT), which is used mainly for severe depression (Kerner and Prudic, 2014, UK ECT Review Group, 2003, Elias et al., 2018). In addition, effective evidence-based psychological treatments (EBPTs) for depression include Interpersonal Therapy (IPT), Cognitive Behavioural Therapy (CBT) and Behavioural Activation Therapy (BA) (Türkçapar, 2018, NICE 2009, WHO 2017, Ekers et al., 2014).

Psychotherapies are mainly based in Western culture (Bernal and Rodriguez, 2012, Naeem et al., 2015), although they may have been developed elsewhere and influenced by religious teachings (Al-Issa, 2000). When the effects of culture on the content and process of psychotherapy (Smith et al., 2011) are taken into account, the necessity for culturally adapted psychotherapies (CAPs) emerges because some aspects of therapies developed in a Western cultural context might not be

relevant to non-Western societies (Benish et al., 2011). A meta-analytic review on culturally adapted mental health interventions by Hall et al. (2016) reported that they produced better outcomes, specifically a reduction of symptoms, than the non-adapted version of the same intervention or no treatment. Findings from a systematic review by van Loon et al. (2013) and a meta-analysis (Chowdhary et al., 2014) also favoured the effectiveness of culturally adapted treatments for depression. Findings related to the effectiveness of such therapies encourage their use to obtain better results from mental health interventions.

CBT, then IPT and BA are the preferred psychotherapies for cultural adaptation to treat depression (see reviews by Kalibatseva and Leong, 2014, Chowdhary et al., 2014). For example, CBT has been culturally adapted for treatment of depressed Latin Americans by Dwight-Johnson et al. (2011), and African American women by Kohn et al. (2002) and Miranda et al. (2003a). For treatment of depressed Latin Americans, IPT (Beeber et al., 2010) and BA (Chavez-Korell et al., 2012) have also been culturally adapted. Although Acarturk et al. (2019) have developed a culturally adapted transdiagnostic CBT for treatment of depression and anxiety for Turkish adolescents, there is currently none specifically for depressed adults in Turkey.

Religion can form a critical component of culture (Tarakeshwar et al., 2003), and it can affect mental health either positively or negatively (Pargament et al., 2011, Park et al., 2017). There are some studies that show the importance of religion on mental health (Koenig, 2008, Koenig et al., 2001). For example, a systematic review and meta-analysis reported that faith adapted CBT was statistically significantly more beneficial than both control conditions and standard CBT for treatment of depression (Anderson et al., 2015). The authors, however, mentioned that before firm recommendations about the benefit of faith adapted treatment were made, larger-scale trials were required because only a few of the included studies were randomised controlled trials (RCTs), and they had some methodological limitations, according to the Cochrane risk of bias assessment tool.

Most people in Turkey identify themselves as Muslim (Diyanet İşleri Başkanlığı, 2014) but there are only a few studies that empirically investigate the application of faith and spiritually sensitive therapy in Turkey (Summermatter and Kaya, 2017). Considering the importance of religion on mental health, the potential need for a faith-sensitive treatment alternative emerges for depressed people in Turkey.

Religiously integrated CBT and BA-Muslim (BA-M) can be given as examples of faith sensitive treatments. Religiously integrated CBT (RCBT) has been developed for five main world religions (Christianity, Judaism, Islam, Buddhism, and Hinduism) for the treatment of clinically depressed patients (Koenig et al., 2015, Pearce and Koenig, 2013). An RCT of RCBT reported that it was slightly more efficacious in more religious people compared to conventional CBT (Koenig et al., 2015). The focus was not on Islam and there was just one Muslim patient in the RCT, so there is a need for more evidence about whether it has the potential to be beneficial and acceptable to Muslims. In addition, BA-M was developed to enhance BA therapy, specifically focusing on Muslim patients by taking account of Islam. Results of a pilot study by Mir et al. (2015) showed that most patients had a positive view about the intervention and believed that being distant from Islam was a source of depression and guilt. The benefits of the BA-M model for clients were recognised by most therapists. Thus, there is more evidence for the potential benefits and acceptability of BA-M to depressed Muslims compared to general RCBT. Although the pilot study provides evidence for acceptability of the BA-M intervention with minority Muslims in the UK, one of its limitations is that it did not investigate whether it is acceptable within other cultures. Its efficacy also needs to be investigated through a full randomised controlled trial. In addition, the prevalence of common mental health disorders is higher in minority groups and they are less likely to seek and access mental health services. Even when they do so, the dropout rates are higher when compared to the majority groups in the same country (Bennett et al., 2014, Ward and Brown, 2015, Aguilera et al., 2017). Muslims are a minority group in the UK (Office for National Statistics, 2013), so there might be different outcomes when it is used in a Muslim population which forms the majority.

As Muslims are the second largest religious community in the world (Lipka, 2017), it is important to further investigate a psychotherapy that focuses directly on treatment for Muslims with depression. Findings from a systematic review on interventions for treating depression in Muslim patients showed that the majority of included studies were commentary or based on a case study (Walpole et al., 2013). Thus, it is important to further investigate the BA-M model as a mental health intervention and explore its acceptability and adaptation under the umbrella of a feasibility study in other contexts particularly those in which Muslims form the majority.

Therefore, further research is important to culturally adapt BA-M to the Turkish context and to evaluate whether the intervention is acceptable and feasible in practice among a majority Muslim population - and potentially as effective as standard CBT.

1.2 AIMS, OBJECTIVES AND RESEARCH QUESTIONS OF THIS THESIS

1.2.1 Aims

The principal aims of the work reported in this thesis are

(1) To examine the feasibility of conducting a full RCT of BA-M for depressed Muslims in Turkey
(2) To evaluate the acceptability of BA-M
(3) To inform the development of a definitive RCT to evaluate clinical effectiveness of BA-M as a treatment for depression
(4) To compare findings in this study based in Turkey with those from a pilot study conducted in the UK.

1.2.2 Objectives

The objectives of the study are:

1. To conduct a systematic review of culturally adapted psychotherapies for the treatment of depressed adults.
2. To translate an existing BA-M Manual and client self-help booklet and validate these through a translation development group.
3. To conduct a mixed methods, parallel group feasbility study exploring the feasibility of carrying out an RCT of BA-M for depressed Muslims in Turkey.
4. To collect, analyse and synthesise data about the acceptability of BA-M by using qualitative and quantitative methods.
5. To compare the findings - mainly qualitative - from the current feasibility study in Turkey to the previous pilot study done in the UK by Mir et al. (2015).

The systematic review provides useful background information on which types of psychotherapy are preferred for cultural adaptation, and why, and which methods are used to culturally adapt a treatment for depressed adults. Fieldwork data helps determine the feasibility

of conducting an RCT of BA-M for depressed adults in Turkey and helps assess its acceptability. The comparison study helps contribute recommendations for further development of the original BA-M therapy.

1.2.3 Research questions:

The following research questions are addressed in the proposed feasibility study:

1. Can BA-M be adapted to Turkish culture?
2. Is BA-M acceptable to both therapists and clients in Turkey?
3. What are the barriers and facilitators to implementing the approach in practice?
4. Is it feasible to conduct a definitive trial of BA-M in Turkey? What is the required sample size? What other aspects of the trial design can be guided by this work?
5. Are there any differences between clients in BA-M and CBT groups in terms of recruitment, retention and outcome of the treatments?
6. Are there any similarities and differences between Muslim clients and therapists in the UK compared to the those in Turkey in terms of feasibility and acceptability of the treatment?

CHAPTER 2
CONCEPTUAL FRAMEWORK

The conceptual or theoretical framework refers to "the system of concepts, assumptions, expectations, beliefs, and theories that supports and informs your research" (Maxwell, 2013 p.39). A conceptual framework can be presented either graphically or in narrative form, and explains "the main things to be studied – the key factors, variables, or constructs – and the presumed interrelationships among them" (Miles et al., 2014 p.37). Developing a conceptual framework helps a researcher be explicit about what they think they are doing, explaining the underlying ideas that inform research. It also helps to be selective to decide which features or variables are most important, which relationships are most likely to be meaningful, and in turn, it informs data collection and analysis, at least at the beginning of a study (Miles et al., 2014, Robson, 2016). Maxwell (2013) considers a conceptual framework as a tentative theory of the phenomena that is under investigation. This theory, in addition to explaining the underlying ideas that inform the research, helps to assess and refine research aims, develop relevant research questions, and select appropriate study design and methods.

A conceptual framework functions like a map for the field being investigated. As the researcher's understanding of the field improves, the map becomes more differentiated and integrated accordingly. This improvement can lead to evaluating the conceptual framework developed at the outset of the study (Miles et al., 2014). Thus, the tentative theory can be changed or evolve as the study progresses.

This chapter explores the concepts of depression and the relationship between culture, mental health and psychotherapy which shaped the research questions of the current study. The concept of depression is introduced as are its clinical features, diagnosis and the international/cultural perspective, its aetiology, theories and treatments. Then, the concept of culture and mental health is introduced and defined, and its effects on mental health in general. Finally, religion and psychotherapy and the necessity for developing culturally adapted psychotherapies are discussed.

2.1 DEPRESSION

The epidemiology of depression is briefly outlined in the Introduction. This section explores clinical features and diagnosis of depression, the international and cultural perspective, aetiology, theoretical approaches and treatment. The reasons for this are to understand how a person could be diagnosed with depression and with which tools, what kind of symptoms they present, whether there are cultural differences in terms of symptom presentation, what possible issues could be faced regarding diagnosis and what factors may cause depression. Furthermore, as the study focuses on two specific treatments of depression, BA-M and CBT, it is important to investigate theories of depression to help understand how these mechanisms work.

2.1.1 Clinical features and diagnosis

According to the International Classification of Diseases (ICD), depressive disorders are mental health disorders that are characterised by depressed mood or loss of pleasure accompanied by other symptoms - including cognitive, behavioural and neurovegetative symptoms - that significantly affect an individual's ability to function (WHO: World Health Organization, 2018). Similarly, the National Institute for Clinical Excellence (NICE, 2009) states that depressive disorders are characterised by low mood and/or loss of pleasure in most activities and a range of associated cognitive, behavioural, emotional and physical symptoms. These depressive symptoms include difficulty in concentrating, change in sleep pattern, feelings of guilt, change in appetite, reduced energy or fatigue, hopelessness and lack of drive (Comer, 2014). In the Diagnostic and Statistical Manual of Mental Disorders -5th edition (DSM-5), major depressive disorder is characterised by the presence of either depressed mood or lack of pleasure or interest in nearly all activities for and during at least the same two weeks (APA: American Psychiatric Association, 2013).

The ICD, 10th revision (ICD-10) (WHO, 1992) and DSM-5 (APA, 2013) are the two main classification systems used for the diagnosis of mental health disorders, including depression (Stein et al., 2013, Malhi and Mann, 2018). A diagnosis under either system will be referred to as depression in this study. Although, after revision of the ICD-10, the 11th revision (ICD-11) has been introduced (WHO, 2018), the process of transformation from ICD-10 to ICD-11 mainly began on the 1st of January 2022 (Stein et al., 2020). Therefore in this study diagnostic criteria from ICD-10 are discussed instead of from ICD-11. There are similarities and differences between ICD-10 and DSM-5, and the details related to them are presented in Table 2.1.

Table 2.1 The diagnostic criteria for depression in DSM-5 and ICD-10

	DSM-5	ICD-10
Clinical significance	The symptoms are accompanied by either clinically significant distress/ impairment in social, occupational, or other important areas of functioning; or functioning requires markedly increased effort.	Some difficulty in continuing with ordinary work and social activities, but will probably not cease to function completely in mild depression; considerable difficulty in continuing with social, work or domestic activities in moderate depression; very unlikely to continue with social, work, or domestic activities, except to a very limited extent in severe depression.
Duration	The symptoms must be present for most of the day, nearly every day, for at least two consecutive weeks.	The symptoms for at least two weeks for all three types of severity should be present, but in severe depressive episode, if symptoms are particularly severe and of very rapid onset, it may be justified to make a diagnosis after less than two weeks.
Severity	Five (or more) of the following symptoms have been present: at least one of them is either (1) depressed mood or (2) loss of interest or pleasure: 1. Depressed mood 2. Markedly diminished interest or pleasure 3. Significant change in weight or appetite 4. Insomnia or hypersomnia 5. Psychomotor agitation or retardation 6. Fatigue or loss of energy 7. Feelings of worthlessness or excessive or inappropriate guilt 8. Diminished ability to think or concentrate, or indecisiveness, 9. Recurrent thoughts of death, recurrent suicidal ideation with recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide **Mild:** The intensity of the symptoms is distressing but manageable, and the symptoms result in minor impairment in social or occupational functioning. **Moderate:** The number of symptoms, intensity of symptoms, and/or functional impairment are between those specified for “mild” and “severe”. **Severe**: The number of symptoms is substantially in excess of that required to make the diagnosis, the intensity of the symptoms is seriously distressing and unmanageable, and the symptoms markedly interfere with social and occupational functioning.	Depressed mood, loss of interest and pleasure, and increased fatigability are usually referred as most typical symptoms. Other symptoms include: 1. Reduced concentration and attention 2. Reduced self-esteem and self-confidence 3. Ideas of guilt and unworthiness (even in a mild type of episode) 4. Bleak and pessimistic views of the future 5. Ideas of self-harm or suicide 6. Disturbed sleep 7. Diminished appetite **Mild:** At least two of the typical symptoms and plus at least two of the other symptoms have to be present. If four or more of the somatic symptoms are also present, it is diagnosed with somatic symptoms. **Moderate:** At least two of the most common symptoms and plus three (preferably four) of the other symptoms have to be present. If four of the somatic symptoms are present, it is diagnosed with somatic symptoms. **Severe:** All of the most typical symptoms and plus at least four of other symptoms, some of which should be of severe intensity, have to be present.

The presence of low mood and/or loss of pleasure or interest in most activities is central to a diagnosis of depression (DSM-5: APA, 2013, NICE, 2009). Both the number, type and severity of symptoms, and the degree of functional impairment determine the severity of depression (ICD-10: WHO, 1992, NICE, 2009). For the diagnosis of major depressive disorder, DSM-5 requires the presence of at least five out of nine depressive symptoms during the same two weeks and a change from previous functioning; one of these symptoms is either depressed mood or loss of interest or pleasure. On the other hand, for the diagnosis of depression, ICD-10 focuses more on mild/moderate/severe depressive disorders, with moderate also usually requiring at least five out of ten depressive symptoms for at least two weeks, with two of these symptoms being from low mood, loss of interest and/or pleasure or loss of energy. To be considered as depression, a symptom must either have newly occurred or must have clearly worsened compared with the person's normal functioning. The symptoms must be present for most of the day, nearly every day, during at least two consecutive weeks.

Clinical presentation of depression can vary (Parker, 2012). For example, although disturbance in sleep and change in appetite are common features in depressive episodes, their presentation can vary among people with depression. Although sleeping less than usual is more typical in depression, some depressed people might sleep more than usual (hypersomnia). Similarly, some people lose appetite and then start losing weight, whereas the appetite of some increases and then weight gain occurs (Stevens and Rodin, 2011). Thus, the presentation of depressive symptoms can vary.

The severity of depression is categorised into three groups in the DSM-5 and ICD-10: mild, moderate and severe depression. The severity of depression relates to the treatment/s usually given. The NICE (2009) guideline suggests low-intensity psychosocial treatments, such as computerised cognitive behavioural therapy and advises against persistent usage of antidepressant medication for mild depression because the risk-benefit ratio is poor. For moderate and severe depression, the NICE guideline suggests the combination of antidepressant medication and high-intensity psychological treatments, such as BA or CBT. Only psychotherapy would be offered to depressed clients in this study regardless of depression severity, but using antidepressants would not be an exclusion criterion and this would be recorded.

The course of depression is often episodic – with a distinct onset and offset – but it is variable. An episode of depression lasts 3-6 months with treatment, and most patients recover in 12 months (Malhi and Mann, 2018). The majority of adults or youngsters do recover, but recurrence is seen in a substantial proportion (Kovacs et al., 2016, Comer, 2014). Although about 50% of the individuals with a first episode of depression recover and do not experience another episode, 15% have no remission and 35% recover, but experience one or more future episodes of depression (Eaton et al., 2008). Thus, the course of depression is often episodic but for some depressed people, it can be chronic.

To assess depressive symptoms, some scales such as the Beck Depression Inventory (BDI), Hamilton Rating Scale for Depression (HAM-D) and Patient Health Questionnaire (PHQ-9); and semi-structured or structured interviews such as the Structured Clinical Interview for DSM-5 (SCID) and Composite International Diagnostic Interview are commonly used instruments (NICE, 2009). Depression rating instruments can be used to make a categorical diagnosis of depression, or to assess and monitor the quantitative level of symptoms as an indicator of severity. The PHQ-9 was used in this study to quantitatively assess symptoms of depression among the clients who took part (for details, see Section 4.5.5).

Boundaries in the diagnosis of depression are not clear-cut. For example, there is a lower boundary to distinguish pathological depression from normal mood change. Depression is defined by the number of depressive symptoms present, however, it is not clear or easy to be sure about when a symptom crosses the boundary of the threshold for severity and can be counted as present, even it is present every day for two consecutive weeks (Paykel, 2008). The DSM-5, for example, in the context of loss, leaves the decision to clinical judgement: “This decision inevitably requires the exercise of clinical judgment based on the individual’s history and the cultural norms for the expression of distress in the context of loss” (APA, 2013 p.161). How a clinician understands and interprets this notion determines their decision on diagnosis (Geraghty et al., 2019). In mental health research settings, rating instruments are used to enhance reliability of assessments (Stuart et al., 2014, Costantini et al., 2021), but validation remains complex as there are no simple objective measures beyond clinical features to validate against (Wing et al., 1967, Costantini et al., 2021).

Depression frequently is comorbid with anxiety disorders (Tiller, 2013), borderline personality disorders, substance-related disorders, obsessive-compulsive disorder, anorexia nervosa and bulimia nervosa (APA, 2013). Depression may also be comorbid with some chronic physical health disorders such as congestive heart failure, hypertension and diabetes (Ferenchick et al., 2019); and with neurological disorders such as migraine and epilepsy (Steffen et al., 2020). Depression becomes more persistent when it is comorbid with or secondary to another disease compared to when it is pure depression (Kessler et al., 1996). Thus, when depression co-occurs with a disorder, it is often harder to be treated.

Some symptoms of depression can be similar to symptoms of other conditions such as dysthymia, borderline personality disorders, grief (APA, 2013), schizophrenia and anaemia (Malhi and Mann, 2018). The comorbidity with and/or similarity between symptoms of depression and other disorders can make it harder to diagnose (Smith et al., 2013). Thus, it is important to ensure that symptoms cannot be explained by another clinical condition when determining a diagnosis (Malhi and Mann, 2018). In this study clients were required to have depression as their primary condition since BA-M was developed to treat depression. The details regarding eligibility criteria for clients presented in Section 4.5.3.

2.1.2 International and cultural perspectives

The concept of depression has been presented from a general perspective in the previous section. Similarities and differences across cultures in terms of diagnosis and clinical presentation of depression and help-seeking behaviour of depressed people need to be investigated. Whether a specific type of behaviour or symptoms are considered normal or abnormal and the extent to which they are tolerated vary across cultures, social environments and families. Thus, when an experience becomes pathological will vary. The decision that a given behaviour is abnormal and needs clinical intervention depends on cultural norms that are internalised by the person and enforced by those around them, including clinicians. Awareness of culture may prevent making mistakes in diagnosis (APA, 2013). This shows the importance of cultural factors in diagnosis and linking to treatment, prognostic considerations and clinical outcomes.

It is important to investigate how culture affects the presentation of depression in different ethno-cultural groups as it can affect diagnosis of depression, even though some symptoms are thought

to be constant across cultures (Kirmayer et al., 2017). A review of 138 qualitative studies on how depression is experienced around world, by Haroz et al. (2017), revealed that diagnostic features mentioned in the DSM-5 were present across different regions, genders and socio-cultural contexts. Depressed mood, loss of energy, loss of interest, sleep disturbance, increase or decrease in appetite or weight, suicidal thoughts and feeling worthless or guilt were commonly reported symptoms in the studies reviewed. Some of the symptoms, however, are found not to be constant across cultures. Those most frequently reported, and not part of the DSM-5 diagnostic criteria for depression, were anger, diffuse pain, crying and loneliness or social isolation (Haroz et al., 2017). These symptoms are only listed as associated features for depression in the DSM-5 (APA, 2013). The findings from Haroz et al. (2017) raised some issues regarding the cross-cultural use of the DSM-5 criteria for depression as, despite being mentioned frequently across studies, these are not diagnostic criteria for depression in the DSM-5. Another issue that arises from this is that some DSM-5 diagnostic criteria for depression, specifically problems with psychomotor agitation or slowing and concentration, are not frequently reported in the global literature. Thus, this raises the question of whether the DSM-5 criteria for depression is representative and has some limitations.

Depressed patients present both psychological and somatic symptoms. The clinical picture in primary care may be frequently dominated by somatic complaints (Tylee and Gandhi, 2005). According to a review by Bagayogo et al. (2013), the majority of included studies reported racial/ethnic variation regarding reporting somatic symptoms. For example, some studies found that reporting somatic symptoms was more common among Puerto Rican depressed patients compared to non-Latino Whites (Coelho et al., 1998) and among Malaysian Chinese compared to Australian Caucasians (Parker et al., 2001). The mentioned variations across cultural groups were associated with the severity of depression in some of the studies included in the aforementioned review. The authors, however, considered this as weak evidence as the studies did not primarily aim to assess whether differences in the severity of depression were explained by ethnic/racial variations in the level of somatic symptoms reporting. Furthermore, some of the studies did not show a similar pattern (Bagayogo et al., 2013). Another possible explanation for the cultural difference in symptom presentation might be that some of these studies are conducted with immigrants, meaning that language/acculturation could be a barrier for the participants to express their symptoms. For example, a study conducted in Germany with Vietnamese and German psychiatric outpatients found that Vietnamese patients endorsed higher levels of somatic

symptoms overall, but those with poor German skills showed a significantly higher focus on somatic symptoms (Dreher et al., 2017). Similarly, a study conducted in Australia with Chinese and Australian Caucasian patients reported that acculturation seemed to have diminished Chinese inclination to somatise depression (Parker et al., 2005). This indicates that language could create a barrier for immigrants when they report their emotional symptoms, which could cause or be linked to underutilisation of treatment, since the findings of a review showed a clear association between insufficient language proficiency and underutilisation of psychiatric services (Ai Ohtani et al., 2015).

A study of factor analysis of depression symptoms was recently conducted with 6,982 participants across five broad cultural groups by language and country of residence. It included Spanish speakers from Venezuela, Colombia and Peru; English speakers from India, Pakistan and Sri Lanka and from the UK, the United States and Canada; Russian speakers from the Russian Federation and Kazakhstan; and Chinese speakers from China and Hong Kong (Goodmann et al., 2021). Some similarities and differences were found between those cultural groups. For example, the overall factor structure of the Latin America and South Asia samples was very similar, except for the direction of loading for sleep variables (sleep loss for Latin America, oversleeping for South Asia) and double loading of sinfulness or guilt in Latin America. Low self-esteem and suicidality variables were loaded on to the same factor only among Latin American countries. For only the group of Russian speakers, affective symptoms were linked to only a single factor. On the other hand, only for the Western English speakers, cognitive symptoms were linked to a single factor. Chinese speakers were the only group for whom weight gain and loss were linked to two different factors: the weight loss was clustered with appetite change and insomnia, whereas weight gain was loaded with agitation and hypersomnia. These findings indicate that there might be some cultural differences in depressive symptom presentation among different cultural groups.

There are some other studies that propose that people in Asia have a tendency to complain more about somatic symptoms than people in Europe and White Americans in the USA (Qusar et al., 2019, Ryder et al., 2008), but this does not mean the latter do not report somatic symptoms. Somatic or physical symptoms are considered to be prominent features for depressed people from Asia and Turkey. In addition to that, depressed people from Turkey tend to report cognitive symptoms similar to Western people (Yaluğ et al., 2012). Similar results were found in a study

that compared Turkish and German depressed patients living in Germany. Turkish patients presented higher somatic symptoms compared to German patients, but they did not differ in presenting other depressive symptoms (Diefenbacher and Heim, 1994). A study conducted in Bangladesh reported that patients could present somatic complaints, but after questioning on depression, they could be diagnosed with depression (Qusar et al., 2019). This may indicate that although the primary concern to seek help might be due to somatic symptoms, further questioning patients is more likely to lead to an accurate diagnosis. This shows the importance of evaluating depression rating instruments in the community where a study is conducted.

Because of the stigma associated with mental health disorders, such as depression, seeking mental health care might be difficult in some cultures, leading to the reporting of somatic symptoms, which may be considered as a more reasonable reason to seek help (Shafi and Shafi, 2014). When a patient presents with only somatic symptoms, the probability of diagnosing depression correctly reduces (Ferenchick et al., 2019), particularly at the initial clinic visit (Tylee and Gandhi, 2005). This might result in under-detected depression, which leads to not getting appropriate treatment (Ahmed and Bhugra, 2007, Tylee and Gandhi, 2005).

In a study with 707 participants on public attitudes to depression in urban Turkey, findings showed that the attitudes towards depression were very negative, and nearly half of the participants perceived depressed patients as dangerous; 64% claimed that they would not marry a depressed person; and 23% thought that depressed patients should not live freely in the community (Ozmen et al., 2004). Similarly, two surveys conducted in Germany – the first in 1990, with 3067 participants, and the second in 2011, with 2951 participants – found that around 15% would not want to have a neighbour with depression, about 33% would not introduce a depressed person to a friend, around 52-41% would reject having a depressed person married into the family, and around 60% would not want a depressed person to take care of their children (Angermeyer et al., 2013). These results clearly show the level of stigma towards depression, which is not specific to non-Western countries, and that stigma exists across different cultures (Seeman et al., 2016, Schomerus et al., 2012). Participants in the aforementioned study in Turkey who perceived depression as a somatic disease did not show an aversion to renting their houses or getting married to a depressed person (Ozmen et al., 2004). This lower level of stigma could explain why depressed people tend to prominently present somatic symptoms. This picture, however, might start to

change as depression is a common mental health disorder, meaning that a person is more likely to experience or know someone close to them who experiences depression (Utz et al., 2019), which might help to decrease stigma towards it, and subsequently increase help-seeking from professionals (Thornicroft, 2008, Wu et al., 2017).

Explanatory models (EMs) of depression might be another factor affecting symptom presentation and help-seeking behaviour of depressed clients. EMs are the beliefs that clients, families and professionals have about a specific illness episode (Kleinman, 1988, p.121). These can include beliefs regarding the causes, course, impact and treatment of depression (Kleinman, 1988). According to Kleinman (1988), a person's EMs might be shaped by popular culture and family EMs, both of which might be determined by factors such as ethnicity, social class, religion, education, previous experience in healthcare system; and by EMs of professionals. Professionals' EMs may be shaped by theoretical knowledge and clinical experience as well as by modern, indigenous or folk EMs –their personal EMs. Sometimes the personal EMs of a professional in a clinic may not overlap with their theoretical EMs.

People may sometimes simultaneously hold different EMs regarding an illness and have complex explanations about an illness. For example, a mixed-methods study on explanatory models of depression and preferred coping strategies among Somali refugees found that depressive symptoms were conceptualised as a problem related to overthinking (cognition) and sadness (emotion) but not to biological mechanisms. The study also found that the most preferred coping strategies were religious practice, family support and alternative treatment (e.g. physical exercise and spending more time in nature). The participants who were presented with a vignette including a depressed character explained the reason why the character felt like that, as possibly because of being a "bad" Muslim, Jinn possession or both. At the same time, they recognised that depression could be caused by stress and trauma (Markova and Sandal, 2016), in common with theoretical models of depression (see 2.1.3).

EMs of professionals and clients are considered to be central to the effectiveness of healthcare since EMs could affect symptom presentation and help-seeking behaviour. If a client seeks help,

discrepancy between a client's EMs and their practitioner's EMs might predict the treatment outcome (Kleinman, 1980). Thus understanding these EMs could help to provide better healthcare. According to Kleinman (1988), clients either do not present their EMs to professionals, or they present their EMs very briefly as they may be ashamed of revealing their beliefs in formal clinical settings, in view of this, encouraging clients to talk about their EMs is likely to be valuable. Clients may also avoid asking for professional help depending on whether they attribute the cause of their illness as physical, or non-physical as described by Ying (1990). If the clients explained the cause of depression as physical, then they were more likely to suggest professional help, whereas people who related it to psychological causes were more likely to seek non-professional help or rely on their own resources (Ying, 1990). Furthermore, a study conducted with Punjabi women in the UK found that these women believed that depression was not a medical condition, although they recognised symptoms of depression and identified various aetiological factors of depression. Their explanatory models determined their help-seeking from religious practitioners and by reading scriptures rather than asking for help of a health professional. As they saw depression as a part of life's ups and downs, they believed that doctors could not do anything about it (Bhugra et al., 1997 cited in, Bhugra, 2004). Thus, conceptualising depression as a non-medical condition might result in the underutilisation of mental health services. Since clients' EMs have an effect on their help-seeking behaviour and treatment outcome, exploring and constructively responding to clients' EMs are crucial for appropriate and collaborative formulation and management.

In conclusion, culture has an effect on the presentation of depressive symptoms and explanatory models of depression. Stigma towards mental health might contribute to not reporting other symptoms of depression and also reduce engagement with mental health services. This can cause under-detected or unrecognised depression, leading to not getting appropriate mental health treatment and consequent underutilisation of mental health services. In some cases, even if depression has been detected and treatment has been started, non-Western patients may still not be receiving appropriate or adequate treatment considering the presence of higher drop-out rates and disparities in retention (and engagement) in mental health services among minority groups compared to majority groups (Van Voorhees et al., 2007, Atdjian and Vega, 2005, Fortuna et al., 2010). Thus, it is important to address the relationship between culture and psychotherapy, which might affect seeking professional help, engaging with mental health services, premature

termination of treatment, and acceptability of treatment. This study aimed to address these issues by evaluating a culturally adapted therapy.

2.1.3 Aetiology of depression

The aetiology or causation of depression is considered to be multifactorial, as many risk factors are involved. These have been investigated from different perspectives focusing on biological, cognitive and social aspects of the disorder (Dobson and Dozois, 2008). Knowledge of the association between risk factors and onset of depression can help to understand who is at risk, whereas knowledge of the association between risk factors and recovery from depression can be used to guide treatment (Bottomley et al., 2010). It is sometimes considered that risk factors are more likely not to operate in isolation from one another but are correlated and may affect each other (Dobson and Dozois, 2008, Sullivan et al., 2000). For example, abuse in childhood may affect a child's view of themselves and personality, which may later influence their ability to engage in social situations and deal with stressful events, which may increase the risk of depression (Kendler et al., 2004).

Biological risk factors for depression include genetic risk and maternal infection (Dobson and Dozois, 2008) and anaemia (Vulser et al., 2016). Genetic factors have a moderate role in the aetiology of depression (Ebmeier et al., 2006). A meta-analysis of twin studies showed that the heritability of depression is 37%, with a minimum contribution of environmental effects common to siblings; and familial aggregation is found to be associated with recurrent depressive episodes (Sullivan et al., 2000).

There are some psychological risk factors for depression such as some personality traits, for example, neuroticism, negative cognitive schemas, beliefs and assumptions. Many studies showed that neuroticism is a premorbid risk factor for depression (Xia et al., 2011, see review by Christensen and Kessing, 2006). Many studies also reported that depressive cognitive schemas, such as mental representation of self that develops through childhood, is one of the predictors for the onset and maintenance of depression (Dozois and Beck, 2008, Friedmann et al., 2016, Garber et al., 1993). In some theoretical frameworks, depressive self-schemas are thought to develop in early childhood but remain latent until activated by difficult life events such as stressful events (Dozois and Beck, 2008, Beck et al., 1979). When this happens, negative automatic thoughts,

considered as one of the contributing factors to the onset of depression and one of its maintaining factors, occur (Dozois and Beck, 2008). It is also thought that when mental representation of possible futures – prospection – goes wrong, emotions, cognitions and behaviours are affected negatively and this is a factor that contributes to both onset and maintenance of depression (Roepke and Seligman, 2016). These factors have important links with CBT and related therapies (see Section 2.1.4).

Stressful life events, such as financial problems, serious housing problems and job loss, appear to be another risk factor for depression and there is some evidence of a causal relationship between the two (Kendler et al., 1999). Some studies showed that, on average, depressed clients had more stressful life events in the month prior to the start of their depression than other people in the same time period (Comer, 2014). Furthermore, according to a study by Kendler et al. (1999), the risk of developing depression rose more than fivefold in a month when a stressful life event occurred. Subsequently, working with clients' emotional, behavioural and cognitive responses to adverse life events is often an aspect of psychological therapies (see 2.1.5).

Racism and perceived discrimination can also be risk factors for depression (Molina and James, 2016, Fernando, 1984). A study, which aimed to explore the relationship between risk of common mental disorders (anxiety or depression) and indicators of racism among ethnic minority groups in England, reported some independent statistically significant association between risk of common mental disorder and experience of verbal abuse, physical assault, workplace discrimination and perceiving British employers to be racist. Those experiencing verbal or physical abuse were twice as likely to suffer from a common mental disorder compared to those reporting no harassment (Karlsen and Nazroo, 2002). Similarly, another study reported that experience of interpersonal racism and perceiving racism in the wider society are risk factors for depression among ethnic minority groups in the UK (Karlsen et al., 2005). Considering that Muslims (5% of the whole population) are a minority group in the UK (Office for National Statistics, 2018), the findings from the aforementioned studies suggest that racism is more likely to be a risk factor for depression among Muslims in the UK than in Turkey, as Muslims are not a minority there.

2.1.4 Theories of depression

This section introduces psychological models of depression,[1] which are examined by focusing on cognitive and behavioural models of depression. The reason to focus on these is that both treatment methods used in this study, namely BA and CBT, are based on behavioural and cognitive models of depression, respectively.

2.1.4.1 Behavioural theories of depression

The behavioural theories of depression that were introduced by Lewinsohn (1974) and Ferster (1973) were dominant theories in behavioural literature for many years and were influenced by Skinner's writings on reinforcement (1953; cited in Kanter et al., 2008a). Indeed, the first attempt at a functional analysis of depression was made by Skinner (1953; cited in Lewinsohn, 1975) who defined depression as a decrease in behaviour and isolation as a consequence of the disruption of existing behavioural patterns that have been positively reinforced by the social environment. This conceptualisation of depression has been fundamental to behavioural approaches (Lewinsohn, 1975).

Thus, it is important to understand Skinner's work on reinforcement, which will subsequently help to understand behavioural theories of depression. The reason to focus on behavioural theories of depression is that BA and the behavioural dimension of CBT are based on them, so understanding the theory behind both could help to understand and interpret qualitative findings of the feasibility study.

Skinner's operant conditioning model of learning explains behaviour as a result of 'reinforcement contingencies', that is, depending on the type of consequences followed by a behaviour, people learn to repeat or avoid it (Kaiser et al., 2016). When a behaviour is strengthened by its consequences, these are called 'reinforcers' (Skinner, 1974). According to Skinner, occurrence of a behaviour is determined by four categories of contingencies: *positive reinforcement* (when a behaviour is followed by a positive consequence), negative reinforcement (a consequence of a behaviour that reduces or terminates a potentially damaging or unpleasant condition), *punishment*

[1] There are also biological models of depression which can be investigated based on genetic, biochemical, anatomical and immune system studies but these are not included in this thesis as the treatments used in this study are based on psychological theories of depression, so they were out of the scope of this thesis.

(the addition of an unpleasant stimulus following a behaviour), *frustrative non reward* (non-occurrence of an expected reward after a behaviour). Although reinforcers increase the possibility of reoccurrence of behaviours, punishments are designed to decrease the possibility of it. Thus, these four types of contingency are defined as essential and sufficient variables to describe the probability of an individual repeating a behaviour (Kaiser et al., 2016). The relationship between these four learning conditions is illustrated in Table 2.2.

Table 2.2 Determinants of Behaviours

Consequences	**Presented**	**Omitted**
Positive	Positive reinforcement	Frustrative non-reward
Negative	Punishment	Negative reinforcement

Skinner (1974) mentions the application of some conditions with depression. For example, when reinforcement is no longer present, the behaviour associated with that reinforcement undergoes 'extinction', so is rarely exhibited. This leads a person to suffer, for example, loss of confidence and sense of power, which subsequently cause depressed feelings. Thus, extinction of an *adaptive behaviour*, which enables an individual to adjust to the environment appropriately, can be a cause of depressed feelings. Additionally, excessive punishment can make a lack of positive reinforcement more critical and leave a person more prone to severe depression and giving up (Skinner, 1974).

A more detailed functional analysis of depression is provided by Ferster (1966), who defines an essential characteristic of a depressed person with that the person has a reduced frequency of many behaviours in which the person normally interacts – in other words positively reinforced. The reasons for reduced frequency of those behaviours might be related to: (1) presence of punishment or aversive stimuli, such as a dentist's waiting room includes many stimuli preceding a highly aversive event; (2) a pause in reinforcement (schedule of reinforcement) - an environment that requires a large amount of behaviour to produce a significant change in it - such as writing a novel; and (3) sudden environmental changes, for example, death of a partner. In addition to the reduction in the frequency of adaptive behaviours, Ferster (1973) conceptualised the most obvious characteristics of depression such as an increase in *avoidance* and *escape* activities, such as crying,

most of which are likely to be passive.

Ferster (1973) also claims that the inability to cope with, escape from or avoid aversive social situations characterises some of situations that lead to depression. A direct or indirect action may occur when a depressed person faces an aversive situation. Direct action can alter the aversive situation, whereas indirect action simply acknowledges the situation. For example, perhaps for religious or cultural reasons, an elder son may be expected to take responsibility for his parents and respond to their needs at all times. If this issue is overwhelming for him, he can either discuss this issue with his parents and try to find a solution – a *direct action*, or complain about his parents to a friend – an *indirect action*. In the case of direct action, behaviour is negatively reinforced (e.g. reading religious teachings about this responsibility and discussing the situation with the parents to solve the issue) and the repertoire is active. In the case of indirect actions (e.g. complaining to a friend), however, it extends avoidance behaviour and is passive because the possibility of changing the aversive situation is low. Ferster (1973) added three more possible causes of reduced frequency of positive reinforcement that can lead to depression: (1) having a distorted, incomplete and misleading view of the environment, (2) presence of some factors that block the cumulative development of a repertoire, and (3) performing angry or aggressive acts which tend to be punished.

As mentioned above, Lewinsohn's model of depression was also influenced by Skinner's writings on depression. Lewinsohn (1974) proposes three core assumptions regarding a depressed person: (1) a low rate of positive reinforcement that is response-contingent (meaning that reinforcement is dependent on an individual's actions) directly elicits some depressive behaviours, such as feeling tired, (2) reinforcements in the form of sympathy, concern and interest that are provided by the social environment, strengthen and maintain depressive behaviours. These reinforcements are usually provided by the close family members and friends. As these depressive behaviours are thought to be *aversive-unpleasant* by most people around the depressed person, the family and friends may avoid the depressed person which will cause a further reduction in her/his positive reinforcement and emphasize her/his depression. (3) The total number of response-contingent positive reinforcements experienced by a person is assumed to be a result of three types of factors: (a) the number of potentially reinforcing events for an individual, which are considered to be dependent on individual differences influenced by biological (e.g. age and sex) and experiential

factors; (b) the availability of reinforcement in the environment; and (c) an individual's instrumental behaviour, for example, the degree to which they have the skills and produce behaviours that will generate reinforcement from their environment. Lewinsohn's assumptions regarding the relationship between depression and low rates of positive reinforcement emphasize the maintenance of depressive behaviours by the social environment and lack of social skills as antecedents of a low rate of positive reinforcement.

Depression is predicted when the probability of a person's behaviour followed by positive reinforcement is low, and when the probability of reinforcement being present without *emitting* – presenting or generating – the behaviour is high (e.g. after working for many years, when a person's salary depended on working, a retired person will receive payment without working anymore). The probability of emitting behaviour is reduced under both circumstances. Severity of depression depends on the rate of positive reinforcement. Improvement in depressive symptoms is provided by an increase in positive reinforcement. Cognitive changes that are commonly seen as depressive symptoms, such as low self-esteem, pessimism and feelings of guilt, are considered to be secondary elaborations of unpleasant mood which is assumed to be a result of a low positive reinforcement rate. The role of hostility is also considered to be a secondary elaboration to the low rate of positive reinforcement (Lewinsohn, 1974, Lewinsohn, 1975). Figure 2.1 shows a schematic representation of Lewinsohn's Model of Depression.

In summary, the development and maintenance of depressive symptoms has been explained by behavioural theories as a result of reduced environmental reward, associated decreases in positively reinforced healthy behaviours, strengthening depressive or passive behaviours by reinforcing them, and punishing healthy behaviours (Ferster, 1973, Lewinsohn, 1974, Martell, 2001). Avoidance behaviours, which can be presented as cognitions and overt behaviours, are known to have a significant role in reward and positive reinforcement reductions that make individuals more susceptible to depression (Carvalho and Hopko, 2011, Ferster, 1973, Martell, 2001). There are a number of studies which support behavioural theories of depression. The results of some showed that reduced reward is associated with higher depressive symptoms (Proudfit, 2015, Bress et al., 2015) and depressed individuals have less reward compared to non-depressed individuals (Hopko et al., 2003a). Behavioural avoidance has been found to be associated with higher levels of reported depressive symptoms (Carvalho and Hopko, 2011, Ottenbreit and

Dobson, 2004, Holahan et al., 2005). Although there are some studies that support behavioural theories of depression, some might criticise them regarding the lack of attention to cognition regardless of their effect on mood (Ciesla and Roberts, 2007). Although behavioural therapists do not tend to focus on the content of a depressed client's thoughts, they focus on the function and process of the client's response to their own thoughts (Veale, 2008). This suggests that behavioural theories do not ignore cognition.

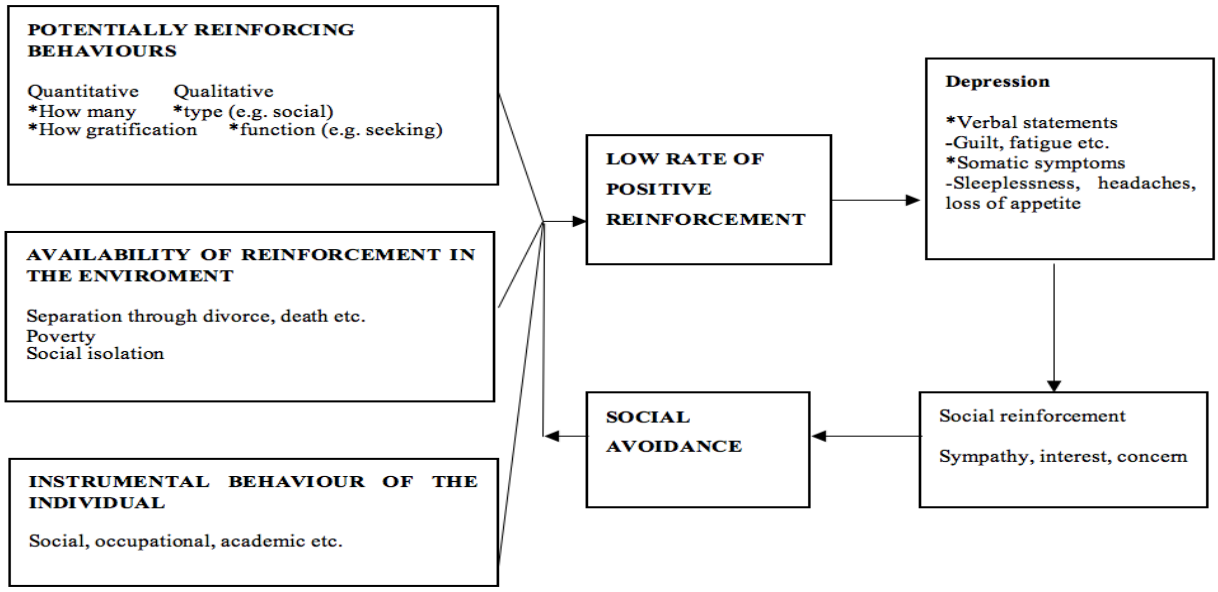


Figure 2.1 Lewinsohn's depression model adapted from Lewinsohn (1974)

2.1.4.2 Beck's theory of depression

Cognitive Behavioural Therapy (CBT) is based on both Beck's depression theory and the behavioural theories explained in the previous section. As CBT is used in the control group in the feasibility study, it is important to understand the mechanism behind the CBT in order to understand how the treatment works and the basis for therapists' and clients' views who took part in the study.

Systematic clinical observations and experimental testing by Aaron Beck led to the development of the cognitive model of depression (Beck et al., 1979). The cognitive model proposed three specific concepts to explain the psychological mechanisms of depression: "1- cognitive triad, 2- schemas, and 3- cognitive errors (faulty information processing)" (Beck et al., 1979 p.10).

A depressed person shows specific *cognitive distortions* including having a negative view of themselves, a negative interpretation of current experiences, and a negative appraisal of the future; these are called the *cognitive triad* (Beck, 1979). The depressed person see themselves as inadequate, deprived or diseased and, consequently, worthless. The negative view of current experiences include interpretation of interactions with the environment as representing defeat or deprivation. As such they view the world as presenting obstacles which are impossible to overcome for reaching their life goals. The negative appraisal of the future refers to anticipating that the current suffering or difficulties will last forever (Beck et al., 1979, Beck and Alford, 2009).

The second concept used to explain the psychological mechanisms of depression is *schema*. Although any situation is composed of many stimuli, to conceptualise it, an individual selectively reacts to specific stimuli and combines them in a pattern. The same situation can be conceptualised differently by different individuals, but each individual tends to be consistent in their responses to similar types of cases. These stable cognitive patterns determine how a particular set of situations is interpreted. The term 'schema' is used to refer these stable cognitive patterns. A schema may be inactive for a long time but then can be re-activated by a specific situation such as a stressful life event (Beck et al., 1979). Conceptualisation of specific situations is distorted in depressed patients to fit the dominant *dysfunctional/maladaptive* schemas. These overly active idiosyncratic schemas prevent the matching of an appropriate schema with a particular event. The depressed person is unable to activate other more appropriate schemas and loses most of their active control over their thinking processes. The dominant idiosyncratic schemas lead to a defective perception of reality and ultimately systemic errors in the thinking process so the person is less aware that their negative interpretations are incorrect. Being aware of these negative thoughts depends on the severity of the depression: in mild depression, a person might view the situation more objectively compared to severe depression when someone's thinking may be completely dominated by the idiosyncratic schema that it causes, such as *repetitive – automatic – negative thoughts* and difficulty in concentrating on external stimuli (Beck et al., 1979).

Faulty information processing – cognitive errors – is the third concept that is used to explain psychological mechanisms involved in depression. One of the common faults in the thinking process is *arbitrary inference* which refers to drawing negative conclusions based on little evidence. A woman waves to her friend, for example, he looks in a different direction and she

concludes he is avoiding looking at her. This can also be considered as *personalisation*, which is another type of faulty thinking process, for example, if she starts to think she is not lovable and that is why he ignored her. Similarly, a depressed person usually *overgeneralises* the significance of negative experiences and *minimizes* the positive ones. This may also include *selective abstraction* – focusing on a detail and ignoring the whole context – and *absolutistic, dichotomous thinking* – a tendency to place all experiences in one of two categories such as saint and sinner (Beck et al., 1979). Even when contradictory evidence is present, the faulty information processing of a depressed person maintain their beliefs in the validity of their negative concepts (Beck et al., 1979).

Beck (2008) expanded the cognitive model of depression and proposes that adverse early life experiences lead to the development of dysfunctional attitudes – schemas – embedded within cognitive structures. When these schemas are triggered by daily life events and re-activated, they produce negative thinking in the three forms – the cognitive triad – and mild depressive symptoms. The repeated activation of these negative schemas forms a depressive mode – a network of cognitive, affective, motivational, behavioural and physiological schema. The mode is impacted and becomes hyper-salient by accumulated adverse events or a significant negative event. This situation, demonstrated with increased negative interpretations and *rumination*, leads to faulty information processing. The cognitive regulation of emotionally meaningful evaluations is diminished and negative interpretations are constrained in reassessment. Clinical depression is the result of these processes. Beck and Bredemeier (2016) proposes a unified model of depression which states that genetic risk or protective factors and childhood trauma that contribute to stress reactivity and negative cognitive biases (alone or in combination), are expressed in structural and functional alterations of the brain. This can cause the development of the negative cognitive triad which, in turn, enhances the effect of negative life experiences or stressors by influencing the interpretation of their meaning by individuals. The course of depression is started when *loss of an investment in a vital resource* is perceived. Negative thoughts lead to consistent emotions such as feeling down and guilt; and to behavioural responses such as inactivity and staying in a bed for a long time. In addition to these emotional and behavioural responses, ‘sickness behaviours’, that is, decrease or increase in appetite and disturbed sleep are promoted by the activations in the immune and autonomic nervous system.

Beck's theory of depression has been supported by research. Some studies have shown evidence in support of the cognitive triad as a marker in depression (such as Braet et al., 2015, Pierce and Hoelterhoff, 2017). Many studies have also supported the view that depressed people have maladaptive or dysfunctional schemas and the severity of depression can be predicted by the number of these schemas (Renner et al., 2012, Calvete et al., 2015, Beck and Bredemeier, 2016). The claims related to faulty information processing have also received support from studies (Blake et al., 2016, Drapeau et al., 2019).

2.1.5 Treatment of depression

For the treatment of depression, the mental health Gap Action Programme (mhGAP) Intervention Guide – Version 2.0, developed by WHO, suggests psychosocial interventions including

> psychoeducation to the person and their carers, reducing stress and strengthening social supports, promoting functioning in daily activities and community life; and if available, considering referral for one of the following brief psychological treatments for depression: Interpersonal Therapy (IPT), CBT, BA and Problem Solving Counselling (p.26).

It also suggests considering pharmacological interventions i.e. antidepressants. After providing an intervention, regular follow-up is suggested using a standard protocol involving psychotherapy and medication, if necessary, to assess a client's improvement (WHO, 2016 p.30).

As mentioned in Section 1.1, there are effective biological and psychological treatments for depression (Ekers et al., 2011, Türkçapar, 2018). Since this thesis aims to assess the acceptability of BA-M which is religiously integrated form of BA, for the treatment of depressed adults in Turkey and the feasibility of an RCT of the treatment with a parallel group feasibility study by comparing it with the usual treatment, namely CBT, this section only focuses on these treatments, BA and CBT.

Behavioural Activation (BA) was initially conceptualised based on behavioural theories of depression (Hopko et al., 2003b, Ferster, 1973, Lewinsohn, 1974, Lewinsohn, 1975) as mentioned earlier in this chapter. BA assumes that adverse life events are critical causal factors in depression. In BA, both the events taking place in a patient's life and the patient's response to the events when they become depressed are considered. It is thought that many depressed clients' behaviours function as avoidance behaviour as they try to cope with unconditional responses to situations

marked by low levels of positive reinforcement or high levels of aversive control (Jacobson et al., 2001). Thus, the main goal of BA is to re-engage people with depression with stable and diverse sources of reinforcement from their environment, including engaging with pleasurable activities as well as difficult but positively meaningful behaviours that are consistent with their values (Kanter et al., 2012). This therapy considers cognitions as behaviour, so when a patient is ruminating, BA focuses on this behaviour and tries to activate alternative healthy behaviours (Kanter et al., 2012). It aims to activate patients in specific ways that will increase positively reinforced experiences in their lives. It considers that changing patients' current behaviours will help them to change their depressive feelings (Martell et al., 2013). It also helps in developing strategies about how to manage depression for future use (Rhodes et al., 2014).

On the other hand, CBT refers to a family of interventions that includes cognitive therapy which is mostly practiced among this family of interventions (Driessen and Hollon, 2010). Cognitive therapy for depression, which is based on Beck's cognitive theory of depression mentioned in Section 2.1.4.2, has been most influential and practiced theory within CBT (Westbrook et al., 2011). The main theoretical rationale behind it is that the way an individual conceptualises their world largely determines their affect – feeling and emotion – and behaviour and so "the therapeutic techniques are designed to identify, reality test and correct distorted conceptualisations and dysfunctional beliefs (schemas) underlying these cognitions" (Beck et al., 1979, p.4). Therefore, CBT utilises both cognitive and behavioural techniques. Cognitive techniques aim to identify and test the specific misconceptions and maladaptive cognitions of a patient. Behavioural techniques are used to change behaviour and elicit cognitions associated with specific behaviours, especially for severely depressed patients (Beck et al., 1979). The main goal of CBT is to help a patient to understand their current thinking and behaving mechanisms and to provide them with the tools for modifying their maladaptive cognitive and behavioural patterns (Fenn and Byrne, 2013, Beck and Alford, 2009). Changing maladaptive cognitions and behaviours that cause distressing emotions, in turn, is considered to help in changing emotions which are not easy to be changed directly (Bhat, 2017, Rupke et al., 2006).

Behavioural Activation (BA) focuses on changing behaviour first, whereas CBT focuses on changing negative thoughts first to alleviate symptoms of depression. Both approaches are short term structured therapies in which therapists need to have an active role and collaborate with

clients (Kanter et al., 2008a, Türkçapar, 2018). Both approaches can be delivered either in individual or group format, either face to face, over the phone or online (Mayor, 2019, Uphoff et al., 2020). Studies show that BA is as effective as CBT (such as Richards et al., 2016, Cuijpers et al., 2007, Dimidjian et al., 2006, Mazzucchelli et al., 2009). Although both treatments are effective, delivery of BA is less complex than CBT in which effectiveness depends on skills of therapists which is usually developed through intense, long-term and expensive training (Richards et al., 2016). This means that the access of depressed patients to CBT can be limited, especially in low- and middle-income countries such as Turkey, whereas BA can be delivered by non-professional mental health workers with less intense training, which means it can be more cost effective (Ekers et al., 2011). Furthermore, the number of BA therapists can be increased in less time so access to mental health treatment can be widened.

2.2 CULTURE, MENTAL HEALTH AND PSYCHOTHERAPY

Considering the potential influence of culture on people's perceptions, cognitions and behaviours (Kastanakis and Voyer, 2014), which may influence diagnosis and treatment of depression (see Section 2.1.2), it is important to understand the relationship between culture, mental health and psychotherapy. It is necessary to first understand what culture means, and what is meant by Western or non-Western culture in this study. There are numerous definitions of culture; for example, Baldwin et al. (2006) worked on 300 different definitions of culture. This shows that there is not a universally accepted definition. In this study, the definition of culture proposed by Marsella (2005) is used. He defines culture as "shared learned behaviour and meanings that are socially transferred in various life-activity settings for purposes of individual and collective adjustment and adaptation" (p.657). Cultures are represented externally (i.e. roles, social structures, institutions) and internally (i.e. beliefs, behaviours, values, expectations). Cultures form and build individuals' realities, which contribute to their perceptions, worldviews and motivations, and they construct these with their morals, ideas and preferences (Marsella, 2005). According to Marsella (2003), culture is the lens that has been used in defining, constructing and interpreting reality by individuals. This suggests that reality is, at least partly, defined and experienced in different ways by individuals from different cultural backgrounds. Thus, even experience of mental health disorders such as depression may differ across different cultures as these cannot be separated from cultural experiences (Marsella, 2003, Paniagua and Yamada, 2013).

In this thesis, the concept of Western and non-Western cultures (or societies) is frequently used. It is not easy to define the concept of Western or non-Western, as the "ideas of 'East' and 'West' have not been free of myth and fantasy, and even to this day they are not primarily ideas about place and geography" (Hall, 1992, p.276). These terms do not have a simple or single meaning and they represent complex ideas, but it is important to use a working definition in order to understand what 'Western' and 'non-Western' mean in this thesis without forgetting the limitations of any definition. Hall (1992) considered the concept of 'the West' as a historical construct rather than a geographical one. He referred to 'Western' as "a type of society that is developed, industrialised, urbanised, capitalist, secular, and modern" (p.277). He considered any society which shares these characteristics as Western, and does not exclude those that were colonised by European countries, despite these being considered as non-Western countries by Edward Said (1978). According to Said, the Orient (non-West) helps to define the West, as "the place of Europe's greatest and richest and oldest colonies, the source of its civilizations and languages, its cultural contestant, and one of its deepest and most recurring images of the other" (p.9). Considering aforementioned two definitions, 'Western' refers to a society that is developed, industrialised, urbanised, capitalist, secular, modern and not-colonised and the societies which do not fit in this definition are considered as non-Western in this thesis. This definition is used as a working definition in this thesis, thus, it cannot necessarily be applied across the board and there might be exceptions. For example, although Japan may be considered as a Western society based on this definition, Japan is considered as a non-Western society in this thesis.

Current clinical guidelines and standards of practice in mental health including psychotherapies are mainly based or depend on Western culture (Wing-Sue and Sue, 2015, Bernal and Rodriguez, 2012). A Western worldview, which emphasizes independence, individuality and self-reliance, assumes a culturally universal (etic) perspective (Carter, 2005), based on a belief that normality and abnormality can be considered as universal, so it is applicable to all societies and cultures (Helfrich, 1999). Thus, from an etic perspective, disorders such as depression are seen to exist in all cultures and require minimal change in their diagnosis and treatment across cultures (Wing-Sue and Sue, 2015). Psychotherapists sensitive to culture, however, consider normality and abnormality within a specific culture, from an *emic* perspective. Therefore, defining normality and abnormality based on Western cultural values might be biased and culture-dependent (Wing-Sue and Sue, 2015). The possible influence of culture on identity, behaviour and values is ignored in

favour of Western-culture, from an etic perspective (Sue, 2003). This neglect may cause *underutilization* of mental health services and *premature termination* of treatment by non-Western people (Carter, 2005) and can be an explanation for *mistrust* in mental health services among non-Western societies (Griner and Smith, 2006). Furthermore, incompatibility between EMs of a specific cultural group versus professional's EMs might be considered as another factor that contributes to underutilisation of mental health services (Benning and Chen, 2019). Cultural competence in evidence-based treatment has been proposed as a solution for the issues arising from ignorance of cultural values of minority or non-Western people (Bhugra and Mastrogianni, 2004, Schouler-Ocak et al., 2015, Castillo and Guo, 2011). Cultural competence refers to "a set of behaviours, attitudes and policies that come together in a system, agency, or among professionals; and enable that system, agency or those professionals to work effectively in cross-cultural situations" (Cross et al., 1989, p.13). Eliciting a patient's explanatory model of an illness is considered to be a crucial component of culturally competent health care by Kleinmen (Kleinman, 1988).

Cultural adaptation of treatments is an effort to deliver culturally competent healthcare (Huey Jr et al., 2014). In this thesis, cultural adaptation of a psychotherapy refers to "the systematic modification of an evidence-based treatment or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (Bernal et al., 2009, p.362).

Culturally adapted psychotherapies (CAPs), in addition to being more effective (see Section 1.1), can increase *acceptability* of a treatment (Ranslow, 2004) and so the absence of treatment that is culturally appropriate could be a barrier to seeking help (Augsberger et al., 2015). Culturally adapted treatments may help increase acceptability by addressing stigma towards mental health and treatments (Gureje et al., 2019, Oladeji et al., 2015, Ward and Brown, 2015). Indeed, some studies have reported that culturally adapted treatments show good evidence of accepability (Chowdhary et al., 2016, Leung et al., 2013, Ward and Brown, 2015). When considering underutilisation of mental health services, premature termination of treatment (Carter, 2005) and mistrust of mental health services among minority group clients (Griner and Smith, 2006), cultural adaptation of evidence based psychotherapies is an important step to increasing the acceptability of, satisfaction from, demand for, engagement with and positive outcomes from these

psychotherapies (Bernal and Scharron-Del-Rio, 2001), and to facilitate trust in mental health services (Griner and Smith, 2006). Thus, it can ultimately increase efficacy of the treatment (Chowdhary et al., 2014). Increasing these aspects of a psychotherapy might decrease premature termination and increase recruitment of non-Western patients and ultimately improve their mental health.

2.2.1 Religion, mental health and psychotherapy

Religion can form a critical component of culture (Tarakeshwar et al., 2003). It is necessary to provide a definition of religion and spirituality before examining their effect on mental health, in order to develop conceptual understandings. As with the concepts of culture and 'the West', defining religion and spirituality is not easy because there is much controversy and disagreement concerning their definitions (Koenig, 2012). Oman (2013) suggests that researchers who attempt to use a definition of religion and spirituality should focus on the most helpful one for their data rather than what the right definition is. Following Oman's (2013) suggestion, the definitions provided by Koenig et al. (2012) are used here. Religion:

> "[i]nvolves beliefs, practices, and rituals related to the transcendent, where the transcendent is God … or a Higher Power in Western religious traditions, or to Brahman, manifestations of Brahman, Buddha, Dao, or ultimate truth/reality in Eastern traditions. This often involves the mystical or supernatural. Religions usually have specific beliefs about life after death and rules about conduct within a social group. Religion is a multidimensional construct that includes beliefs, behaviours, rituals, and ceremonies that may be held or practiced in private or public settings, but are in some way derived from established traditions that developed over time within a community. Religion is also an organized system of beliefs, practices, and symbols designed (a) to facilitate closeness to the transcendent, and (b) to foster an understanding of one's relationship and responsibility to others in living together in a community" (p.45).

In addition,

> "Spirituality is distinguished from all other things – humanism, values, morals, and mental health – by its connection to that which is sacred, the transcendent. The transcendent is that which is outside of the self, and yet also within the self –… Spirituality is intimately connected to the supernatural, the mystical, and to organized religion, although also extends beyond organized religion (and begins before it). Spirituality includes both a search for the transcendent and the discovery of the transcendent and so involves travelling along the path that leads from non-consideration to questioning to either staunch non-belief or belief, and if belief, then ultimately to devotion and finally, surrender" (p.46).

Religion may be either a powerful resource for recovery or can be related to psychopathology (Koenig, 2008). The role of religion in coping (Pargament et al., 2005) and the relationship between mental health and religious coping styles has been widely investigated (Loewenthal et al., 2001). Religious coping can include either positive or negative styles of coping. Positive religious coping styles represent "a secure relationship with a transcendent force, a sense of spiritual connectedness with others, and a benevolent world view". Negative religious coping styles, on the other hand, represent "underlying spiritual tensions and struggles within oneself, with others, and with the divine" (Pargament et al., 2011, p.51). A meta-analysis of 147 studies by Smith et al. (2003) concluded that positive religious coping is related to less depressive symptoms compared to negative religious coping. Thus, positive religious coping is more associated with better wellbeing, whereas the negative one is more associated with less wellbeing (Park et al., 2017).

A recent systematic review reported that positive religious coping was less likely to predict lower rates of depression over time as only eight out of 28 studies reported that it predicted a statistically significant lower rate of depression, but only two studies reported that it predicted more statistically significant rates of depression. Religious factors that were grouped together (measures of religious attendance, motivation, and content of beliefs) were more likely to predict lower levels of depression over time in 47% of 17 studies. Religiosity predicted a reduction in depression over time in 49% of 138 studies. On the other hand, 59% of 22 studies reported that religious struggle predicted an increase in depression (Braam and Koenig, 2019). These results highlight the importance of religiosity, religious coping, attendance, motivation and religious struggle, and content of beliefs on mental health, however, the nature of the relationship is likely to be complex. The wide variation in follow-up was an issue in this review, suggesting a need for further research

in this area.

A review of research on religion, spirituality and mental health by Koenig, McCullough and Larson (2001) indicates that although a few studies found a connection between religious involvement, neurosis and mental illness, the majority support a statistically significant positive relationship between religious involvement and a wide range of mental health indicators. These findings have been largely supported by studies published since 2000 (Koenig, 2008, VanderWeele, 2017) and are also supported by positive outcomes from faith-sensitive interventions. For example, findings from a systematic review and meta-analysis by Anderson et al. (2015) revealed that faith adapted CBT may outperform both control conditions and standard CBT for treatment of depression. Another review reported that 19 out of 30 trials showed that religiously or spiritually sensitive treatments produced better outcomes for depression than either standard treatment or control groups (Koenig, 2012) and only two studies showed that standard treatments were superior to these treatments. These studies show the importance of religious involvement and faith sensitive treatments for mental health.

Furthermore, seeking help for mental health issues with religious healing methods (i.e. praying, baptism, reciting scriptures from Holy books) exists in different ethno-cultural groups, including Christians in Africa; Muslims, Christians or Hindus in India, and South Asian Muslims in the UK (Dein, 2020). A study by Younis et al. (2019), which included patients with mental illnesses in Iraq, reported that 294 participants (73%) mentioned visiting a faith healer before seeing a psychiatrist. Furthermore, a study that examined the prevalence of psychiatric disorders among people who visited a faith healer in Saudi Arabia found that 34% (N=112) had depressive disorders and 18% (N=60) had anxiety disorders (Alosaimi et al., 2014). A recent study by Akan (2020) reported that religion was a source of support for common mental health difficulties among Turkish-speaking people in the UK. These findings suggest that people use religious healing methods to deal with mental health issues and use religion as a source of support. These findings also suggest that seeking help from faith healers probably related to their explanatory models of mental illness.

CHAPTER 3
CULTURALLY ADAPTED PSYCHOTHERAPIES FOR DEPRESSED ADULTS

3.1 AIMS OF THE SYSTEMATIC LITERATURE REVIEW AND META-ANALYSIS

A number of systematic reviews have been conducted on culturally adapted treatments for mental illness (such as Hall et al., 2016, van Loon et al., 2013, Benish et al., 2011). Chowdhary et al. (2014) specifically targeted the treatment of depression, although some included studies did not have depression as their primary outcome (Afuwape et al., 2010, Patel et al., 2003, Patel et al., 2011). Other studies included used collaborative care or a stepped care programme from which it was not possible to assess efficacy of a psychological treatment alone.

This systematic review seeks to assess the efficacy of face-to-face culturally adapted psychological treatments alone compared with control conditions. A growing number of studies since Chowdhary et al.'s (2014) review suggests it is important to assess any advances in cultural adaptation and also to conduct a meta-analysis on culturally adapted evidence based psychological treatments (EBPTs) specifically for depression. Thus, the aims of the current review were to synthesize literature from a wide range of databases on culturally adapted face-to-face psychotherapies for depressed adults to identify: (a) which populations were targeted, (b) which adaptation approaches were preferred and reasons for these preferences, (c) the process of adaptation and (d) the efficacy of the culturally adapted psychotherapies.

3.2 METHODS

Cochrane and Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines were followed in this systematic review.

3.2.1 Protocol and registration

A protocol for the systematic review was registered through PROSPERO (registration number CRD42019116784).

3.2.2 Eligibility criteria

The PICOS framework was used to determine eligibility criteria (Pollock and Berge, 2017), which is presented in Table 3.1. Papers published since those considered by Chowdhary et al. (2014) were eligible for the review.

Table 3.1 Eligibility criteria

Population	***Intervention***	***Comparator***	***Outcome***	***Study design***
Depressed adults	Any culturally adapted/sensitive psychotherapy (talking therapy) to treat depression	No criteria to have a comparator group and all treatment methods as comparator can be included	Outcome is specified as efficacy	All study designs can be included except single case reports

3.2.3 Exclusion criteria

Papers in which the main focus was not depression were not included in the review. Studies discussing web or telephone-based psychotherapies were excluded as were studies related to adolescents as we focused on face-to-face psychotherapies for depressed adults. Single case reports were excluded due to a high risk of selection bias.

3.2.4 Information sources

Studies were identified by searching databases and reference lists of eligible studies. Following guidance on searching for studies on religion by Wright et al. (2014), this search was conducted in ArabPsyNet, CINAHL (1981- present), ProQuest Dissertations and Theses (1743- present), EMBASE (1996- present), Global Health (1973- present), Health Management Information Consortium (1983- present), Medline (1996- present), PsycINFO (2002- present), Sociological Abstracts (1952- present), and ULAKBILIM (1996- present) and YOKTEZ (1959-present) (the last two are commonly used databases in Turkey). No limits were applied to language for the database search. Where non-English studies were identified as eligible for full text screening authors were contacted for information on whether the studies could meet the inclusion criteria of this review.

3.2.5 Search strategy

Search terms were based on four concepts: culture, ethnicity, depression and psychotherapy. The search terms related to each concept were identified by the first author (E.A.) and an information specialist at the University of Leeds, building on search terms used for a previous study on cultural

adaptation by G.M. (Mir et al., 2015). Detailed search terms can be seen in Appendix A1. Appendix A2 includes search terms used for two databases separately as an example. Where possible, the following limitations for database searches were applied: publication after 2012 onwards and adult participants. The last search was done in 25th of August 2019.

3.2.6 Study selection

Records identified through databases were downloaded to an EndNote Library and then duplicate studies were removed by E.A. The PRISMA flow diagram below (Figure 3.1) illustrates which steps were followed for the study selection. After de-duplication, E.A. screened all studies at each step and 10% of the abstracts were double screened by G.M. The reviewers discussed any uncertainty or disagreement related to study eligibility and were able to resolve these without the need for a third reviewer. Each of the eligible studies were screened by two authors.

3.2.7 Data extraction process

The full texts of the identified studies were read in details to extract data. Data was extracted into two main tables: characteristics of studies and process of cultural adaptation of psychotherapies.

3.2.8 Risk of bias in individual studies

The quality of studies was assessed with tools appropriate for the study designs used in each study. The risk of bias assessment tool by Review Manager 5 (RevMan, 2014), which is produced by Cochrane Scientific Committee (CSC), was used for the quality assessment of RCTs. To assess the quality of non-randomized controlled studies, ROBINS-I, which is recommended by CSC, was used. Newcastle-Ottawa Scale (NOS) for cohort studies, which is identified as one of the best available tool for quality assessment of studies in systematic reviews by Deeks et al. (2003) and recommended by CSC (Cochrane handbook 13.5.2.3), was used with some modifications to assess the quality of uncontrolled studies. There is no unified tool to evaluate the quality of uncontrolled studies (Wang and Gu, 2018). For example, in a systematic review and a meta-analysis, Pavasini et al. (2017) used NOS to evaluate uncontrolled studies by removing two items: “Selection of the non-exposed cohort” and “Comparability of cohorts” which were not suitable to assess the quality of uncontrolled studies. The quality of uncontrolled studies was assessed by removing these two items from NOS in the current review as in Pavasini et al. (2017). All the studies were assessed with the identified tools by E.A. and four studies were double assessed by other authors

independently to reduce the level of subjectivity and also to ensure the tools were used in line with guidance. Disagreements were resolved by consensus between the reviewers. Appendix A3 represents results of the quality assessment of all included studies.

3.2.9 Synthesis of results

Narrative synthesis of the findings from the eligible studies was conducted by using thematic analysis (Braun and Clarke, 2006). Analysis was inductive at first and focused on preferred psychological approaches for cultural adaptation with reasons and which populations were targeted for the adaptation. Subsequent analysis was deductive and focused on the common elements in the process of cultural adaptation. This included predetermined themes, which were based on the Medical Research Council (MRC) framework for the development and evaluation of complex interventions (Craig et al., 2008). The framework recommends a phased development and evaluation process consisted of development, implementation, feasibility/piloting and evaluation. The development phase includes theoretical development and modelling and implementation includes formative research with key stakeholders. The process of adaptation was categorized under these phases.

Meta-analysis was performed using Review Manager 5 (2014). To deal with the different measures used in included studies standardized mean differences (SMDs) were used as appropriate. Studies were stratified in terms of different comparison/control groups and targeted population groups.

The I^2 test (Higgins and Thompson, 2002) was used to measure statistical heterogeneity across studies. If a substantial heterogeneity was observed, that is $I^2 > 50\%$, a random-effects model would be used for meta-analysis.

3.3 RESULTS

3.3.1 Study selection and characteristics

After adding additional records through hand searches and removing duplicates, 1381 potential studies were identified. The PRISMA flow diagram (Figure 3.1) shows results of the study selection from this starting point. Fourteen published studies were included in the review (Bennett et al., 2014, Chowdhary et al., 2016, Choy and Lou, 2016, Hwang et al., 2015, Leung et al., 2013, Naeem et al., 2015, Ward and Brown, 2015, Kanter et al., 2015, Jesse et al., 2015, Ebrahimi et al.,

2013, Armento et al., 2012, Aguilera et al., 2018, Gureje et al., 2019, Oladeji et al., 2015) and one unpublished PhD thesis (Roland, 2014).

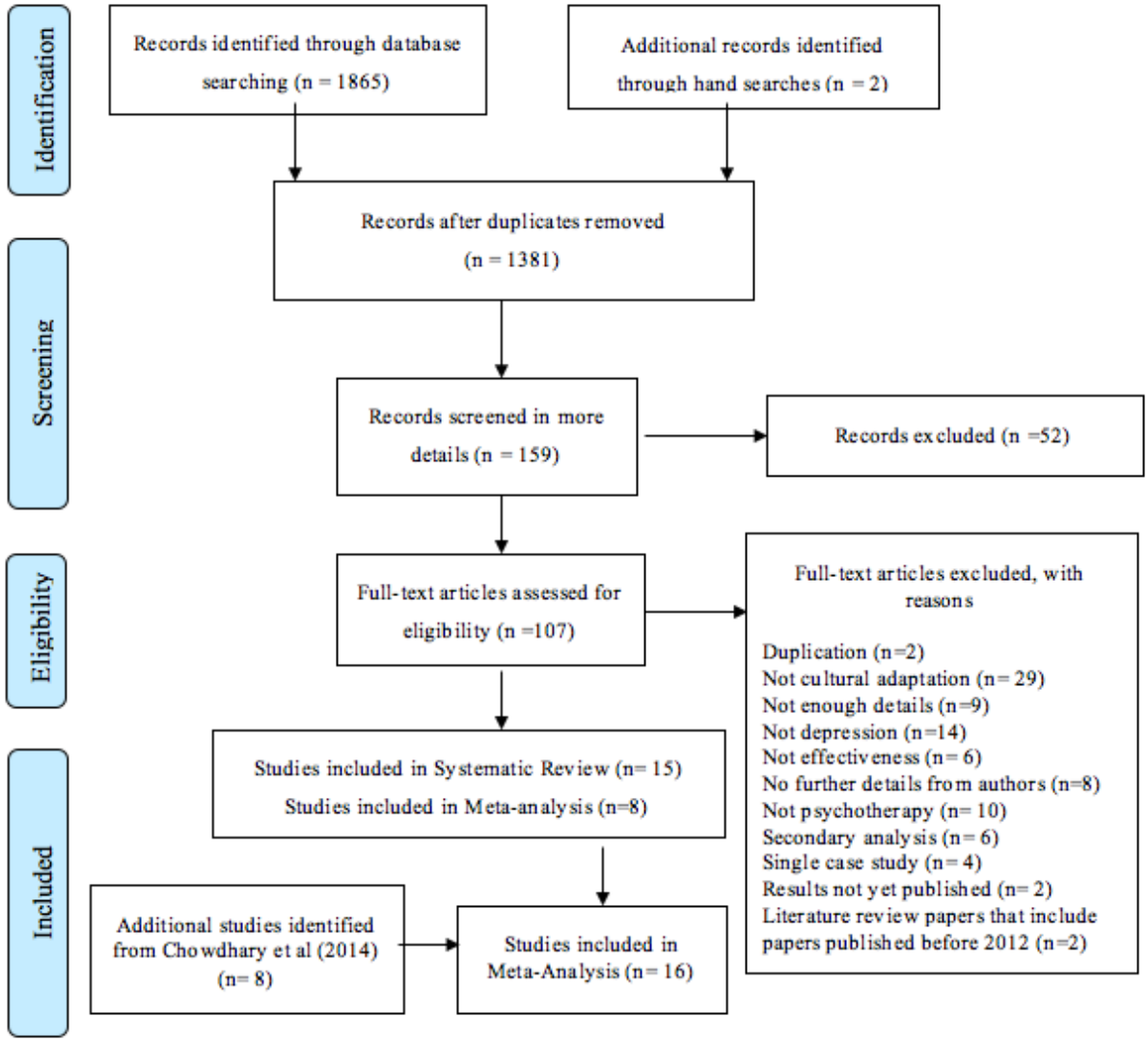


Figure 3.1 The PRISMA flow diagram

The characteristics of included studies are presented in Table 3.2.

Table 3.2 Characteristics of the studies

1. Aguilera et al. (2018) US					
Class of psychotherapy	*Treatment details*	*Treatment setting*	*Comparison group*	*Study design*	*Therapists qualification and training*
CBT	Group format, 16 weekly, hour and a half sessions	Safety-net hospital	None	One group pretest-posttest design	Four clinicians in total. The groups let by two therapists at a time: a licensed clinical psychologist and/ or a licensed clinical social worker with expertise in CBT and in treating low-income Latino/a patients
Population		*Outcome measure*		*Results*	
79 women, 17 men. All of them Latino/a and emigrated from a Latin American country		PHQ-9, at the beginning of most sessions Attendance rate Homework completion		Session attendance: Mean (M)=6.67 Homework completion rate was 23% (SD= 30%) Patients' level of depressive symptoms significantly decreased over the course of therapy (B = -.15, SE = .03, z =--4.84, p <.001).	
2. Armento et al. (2012) US					
Class of psychotherapy	*Treatment details*	*Treatment setting*	*Comparison group*	*Study design*	*Therapists qualification and training*
BA	Individual format, single session of Behavioural Activation of Religious Behaviour (BARB)		Supportive Therapy (ST): as BARB sessions lasted for an hour. Participants were strongly encouraged to discuss thoughts and feelings openly, and the therapist focused on summarization, reflection, and actively listening.	Random allocation	One advanced female doctoral student in clinical psychology trained in BARP and Behavioural Activation Treatment for Depression
Population		*Outcome measure*		*Results*	
50 students, 31 females and 19 males. 25 in control group (CG) and 25 in intervention group (IG). 2 atheist, 47 Christian and 1 Jewish. 88% Caucasian, 8% African American, 2% Latino and 2% African Indian or Alaskan Native		BDI-II Pre-post and 1 month follow-up		Mean (SD) from BDI-II scores at baseline: IG: 20.4 (9.7); CG: 18.5 (5.9) Post treatment: IG: 13.4 (9.0); CG: 16.2 (7.6) At 1-month follow-up: IG: 11.7 (8.2); CG: 14.8 (9.6) Two participants (pp) dropped out at follow-up, both in BARB (overall attrition = 4%)	
3. Bennett et al. (2014) New Zealand					
Class of psychotherapy	Treatment details	Treatment setting	Comparison group	Study design	Therapists qualification and training
CBT	Individual format: approximately 1 hour for each of 12 session	Community mental health service	None	One group pretest-posttest design	Psychiatrists and care managers
Population		*Outcome measure*		*Results*	
5 male and 11 female adults Maori		BDI-II At baseline, 1 month post-treatment and 6-month follow-up		BDI-II: baseline → post-treatment -3.414** BDI-II: baseline → 6-month follow-up -3.466** For these tests **p < 0.001 (Wilcoxon statistics). 2 pp dropped out at post-treatment test, and only one at follow-up test.	

4. Chowdhary et al. (2016) India

Class of psychotherapy	*Treatment details*	*Treatment setting*	*Comparison group*	*Study design*	*Therapists qualification and training*
Healthy Activity Programme (HAP): BA as the core psychological framework. with added emphasis on strategies such as problem-solving and activation of social networks	A. 9 month case series	Primary health centre	None	Clinical case series	4 mental health specialist, one experienced therapist and 19 lay counsellors
	B. Individual format, 6-8 session with weekly/fortnightly intervals over 5 months (modified HAP)	8 primary health centre	Enhanced Usual Care (screening results and WHO Mental Health Gap Action Programme (mhGAP) treatment guidelines to the primary health centre doctor)	Pilot RCT	HAP was delivered by eight counsellors

A

Population	*Outcome measure*	*Results*
271 patients (30 treated by specialists)	PHQ-9 In-depth interviews with 30 patients and 7 focus group discussions with counsellors	49% dropped out. Dose response reduction in PHQ-9 scores. Most interviewed patients (n = 19/30) agreed that they found the treatment to be useful and that the counsellor helped them to address their problems.

B

Population	*Outcome measure*	*Results*
20 Female and 11 Male in control group (CG): 18 female and 6 male in intervention group (IG)	BDI II at baseline and 2 months post-enrolment	BDI-II at two months M (SD) IG: 16.5 (14.4) CG: 22.8 (13.3). 6 (25%) participants in IG dropped out

5. Choy and Lou (2016) Hong Kong

Class of psychotherapy	*Treatment details*	*Treatment setting*	*Comparison group*	*Study design*	*Therapists qualification and training*
Instrumental Reminiscence Intervention-Hong Kong	Group format (7-8 patients); weekly; six 90-minute intervention sessions and two follow-up sessions (two weeks and 6 weeks after the sixth session)	Local elderly community centres	Wait List	RCT	8 hours training for therapists and observers. Social worker (as key therapist) and an observer who had training in either social work or psychology

Population	*Outcome measure*	*Results*
82 patients in IG; 68 patients in CG Chinese	Chinese version of GDS-15. Pre-post and 2 and 6 weeks after the treatment (as 2 follow-up tests). IG who attended four or more sessions were included for analysis.	Mean (SD) of GDS scores at pre-test: IG: 9.78 (1.53) (n=46); CG: 9.56 (1.54) (n=68) Post-test: IG: 6.79 (2.84) (n=39); CG: 9.60 (2.77) (n=42) 1st follow-up: IG: 7.30 (3.98) (n=40);CG: 8.58 (2.67) (n=31) 2nd follow-up: IG: 7.45 (3.29) (n=39); CG: 8.42 (3.18) (n=33)

6. Ebrahimi et al. (2013) Iran					
Class of psychotherapy	*Treatment details*	*Treatment setting*	*Comparison group*	*Study design*	*Therapists qualification and training*
Spiritual (Islamic approach) integrated psychotherapy (SIPT)	Individual format 8 weekly sessions of 45 minutes	No info	Waiting list (WL) CBT Medical Intervention (MI)	RCT	No info
Population		*Outcome measure*		*Results*	
SIPT=16, CBT=16, Medical intervention (MI)=15, Waiting list (WL)=15 Persian speaking		BDI-II in four stages: before the intervention (T1), 4 weeks after starting (T2), after ending the therapy (T3) and three months later (T4)		Mean (SD) of BDI-II scores at: T1, T2, T3, T4 MI: 30.2 (1.53), 2.93 (7.14), 15.2 (8.68), 19.13 (8.9) CBT: 29.06 (9.9), 17.37(6.97), 8.7 (3.84), 10.25 (4.61) SIPT: 28.35 (7.98), 16.75 (5.61), 7.3 (4.9), 8.13 (5.11) WL: 29.6 (8.37), 27.46 (10.16), 28.6 (8.3), 27.13 (8.13)	

7. Gureje et al. (2019) Nigeria					
Class of psychotherapy	*Treatment details*	*Treatment setting*	*Comparison group*	*Study design*	*Therapists qualification and training*
Problem Solving Therapy + BA – based stepped care management programme	Individual format, 12-22 sessions depend on individual's PHQ-9 scores, they also used medication with psychotherapy when PHQ-9 score is more than 15	Primary care clinics	Usual care enhanced with the WHO Mental Health Gap Action Programme intervention guide (mhGAP-IG) that includes either an unstructured psychotherapy or medication	Cluster- RCT	None physician, lay health workers. These providers received 6 days of training on problem-solving therapy and on use of the mhGAP-IG to identify and treat depression. Supervision through phone when needed.
Population		*Outcome measure*		*Results*	
Yoruba speaking IG= 631 patients CG= 547 patients		PHQ-9 at baseline (T1), 3 months (T2), 6 months (T3) and 12 months (T4)		Mean (SD) of PHQ-9 scores at T1, T2, T3 and T4 IG: 13.7 (2.6), 4.7 (4.5), 3.8 (4.1), 3.6 (4.2), 3.6 (4.2) CG: 13.5 (2.6), 4.8 (4.2), 4.3 (4.5), 3.9 (4.4), 3.5 (3.9)	

8. Hwang et al. (2015) US					
Class of psychotherapy	*Treatment details*	*Treatment setting*	*Comparison group*	*Study design*	*Therapists qualification and training*
Culturally adapted CBT (CA-CBT)	Individual format, 12 weekly sessions	Mental health clinics	CBT	RCT	Chinese-American therapists, 12 hours of training for both group followed by weekly group supervision
Population		*Outcome measure*		*Results*	
23 patients in CG; 27 patients in IG Chinese-American adults		Hamilton Depression Scale (HAM-D) at baseline, session 4,8 and 12th sessions		HAM-D scores. Mean at baseline, sessions 4, 8, and 12 IG: 26.4, 22.9, 19.3, 15.8. CG: 23.4, 21, 19.6, 17.7. Six patients in CG and two patients in IG dropped out	

9. Jesse et al. (2015) US					
Class of psychotherapy	*Treatment details*	*Treatment setting*	*Comparison group*	*Study design*	*Therapists qualification and training*
CBT	Group format, 2 hours once a week, 6 weeks	Local health department and affiliated regional perinatal centre prenatal care setting	TAU (prenatal care primarily and offered regularly scheduled child birth education classes)	RCT	Facilitators were Master's prepared licensed clinical social worker and other licensed mental health professionals (2 African-American and a Caucasian); resource moms (2 African-American)
Population		*Outcome measure*		*Results*	
146 African-American, Caucasian or Hispanic rural low-income pregnant women: 72 IG; 74 CG; 2 to 6 women in each group; 21 group; Mixed race and ethnicity; non-English speaking Hispanic women met separately		BD-II, At baseline (T1), post-treatment (T2) and one month follow-up (T3)		Mean (SD) BDI-II scores at T1, T2 and T3 *For low moderate risk group* IG: 12.25 (1.48), 7.25 (1.31) and 6.58(1.20) CG: 10.51(0.63), 9.93(0.72) and 9.00 (0.91) *For high risk group* IG: 23.48 (1.51), 16.93 (1.56) and 16.22(2.02). CG: 23.57(1.53), 19.69 (1.49) and 17.15 (1.77). 25 patients in IG and 2 in CG dropped out before intervention began. 5 patients in IG dropped out after receiving 1 or 2 sessions.	

10. Kanter et al. (2015) US					
Class of psychotherapy	*Treatment details*	*Treatment setting*	*Comparison group*	*Study design*	*Therapists qualification and training*
BA	Individual format, 12 sessions, generally scheduled weekly for 50 minutes	Community mental health clinic	TAU (12 sessions of generally scheduled weekly 50 minutes. Therapists provided their typical treatment for depression).	RCT	Eight bilingual mental health practitioners; random allocation 1:1 to each group; 16 hours training for IG; both group of therapists met with each other for weekly for one hour consultations to review study cases
Population		*Outcome measure*		*Results*	
21 Latinos in IG and 22 in CG; monolingual Spanish speakers		Spanish version of HAM-D and BDI-II at pre-post and before each session		IG performed well with respect to treatment engagement and retention. Follow-up tests revealed a significant decrease in HAM-D scores for IG clients who attended 9-12 sessions, t (8) = 5.97, p b .001, d = 1.99. For clients who only attended 0-4 sessions, the effect size favoured CG, but for clients who attended 5-8 and 9-12 sessions, effect sizes favoured IG, with large effects. Five IG clients and 10 CG clients did not provide post-treatment data.	

11. Leung et al. (2013) Hong Kong					
Class of psychotherapy	*Treatment details*	*Treatment setting*	*Comparison group*	*Study design*	*Therapists qualification and training*
CBT	Group format; six weekly sessions of 2h duration	Antenatal clinic	Only mentioned control group, no detail	Quasi-experimental design	Nurse; nothing about training
Population		*Outcome measure*		*Results*	
47 IG, 50 CG pregnant women who scored greater than 10 in EPDS.		Data were collected at recruitment as baseline (T1) and the within a week after the intervention (T2); Chinese version of EPDS was used.		Repeated measures analysis of covariance showed significant group differences favoured the IG on EPDS ($F1, 95 = 5.02$, $P = 0.02$). Post-intervention evaluation showed very positive feedback from IG	

12. Naeem et al. (2015) Pakistan					
Class of psychotherapy	*Treatment details*	*Treatment setting*	*Comparison group*	*Study design*	*Therapists qualification and training*
CBT + TAU	Individual format, 6 sessions + one additional session for the family		TAU (prescription of medication and regular hospital visits)	RCT	Psychology graduates with two years' experience in a mental health system; 5 days training in the use of manual; supervision at a weekly interval for 6 months before trial started
Population		*Outcome measure*		*Results*	
69 patients in IG, 68 patients in CG; Pakistani people		Primary outcome: Hospital Anxiety and Depression-Depression Subscale (HADS-D), at baseline (T1), at 3 months (T2) and 9 months after baseline (T3)		Mean (SD) of HADS-D at T1, T2 and T3 respectively for treatment group: 15.3 (3.4); 4.4 (3.8); 1.5 (2.0) for control group: 15.1 (3.9); 7.6 (3.6); 5.0 (4.0). 3 patients in IG and 5 patients in CG dropped out.	

13. Oladeji et al. (2015) Nigeria					
Class of psychotherapy	*Treatment details*	*Treatment setting*	*Comparison group*	*Study design*	*Therapists qualification and training*
Problem Solving Therapy + BA – based stepped care management programme	Individual format, 12-22 sessions depend on individual's PHQ-9 scores, they also used medication with psychotherapy when PHQ-9 score is more than 15	6 Primary health care centre	Usual care enhanced with the WHO Mental Health Gap Action Programme intervention guide (mhGAP-IG) that includes either an unstructured psychotherapy or medication	Cluster RCT	Primary health care workers. IG had 3+3 day training on intervention and also identification of depression. CG received 2 day training on identification and standard treatment of depression. A team of supervisors support the therapists during the course of treatment.
Population		*Outcome measure*		*Results*	
IG: 165 patients and CG: 69 patients who are fluent in Yoruba language		PHQ-9 at baseline (T1), at 3 months (T2) and 6 months (T3) follow-up		Mean (SD) at T1 and T3 IG: 11.3 (3.5), 4.1 (4.4) CG: 11.3 (3.5), 5.5 (5.2)	

14. Roland (2014) US					
Class of psychotherapy	*Treatment details*	*Treatment setting*	*Comparison group*	*Study design*	*Therapists qualification and training*
CBT	The format of treatment is not explicitly reported, 6 sessions	Mental health agency	CBT	Quasi-experimental design	A licensed clinical therapist
Population		*Outcome measure*		*Results*	
128 African-American women 65 women in IG 63 women in CG		BDI-II , pre-post test		Pre-post test BDI-II scores' Mean (SD) For IG: 39.81 (12.78); 17.36 (14.36) For CG: 56.19 (3.44); 54.32 (3.52)	

15. Ward and Brown (2015) US					
Class of psychotherapy	*Treatment details*	*Treatment setting*	*Comparison group*	*Study design*	*Therapists qualification and training*
CBT	Group format, over 12 week session and a 3 month booster session, lasts 2.5 hours Pilot 1 and Pilot 2	Local health clinics	None	One group pre-test and post-test design	Clinicians with 20 hours training on adapted therapy
Pilot 1					
Population		*Outcome measure*		*Results*	
18 women; African-American; 60+ years (2 groups)		CES-D; HAM-D; At baseline, week 6, 12 and at follow-up (week 24 or 3 months post-intervention) 1. Recruitment and retention tracking 2. Attendance Log 3.QOL 4. CSI 5. PHO		73% retained over the 6 months of the course. All women who completed study reported being very satisfied (M=90.1 and SD= 14.5). Depression scores on the CES-D decreased significantly from baseline (*M* = 24.1, *SD* =11.22) to week 6 (*M* =19.0, *SD* = 11.9) p < .019; baseline to week 12 (*M* =18.8, *SD* = 12.2), and from baseline to the 3-month follow-up (*M* = 17.5, *SD* = 11.36 *p* < 0.027	
Pilot 2					
Population		*Outcome measure*		*Results*	
40 African-American women and men		CES-D at baseline, week 6, 12 and at follow-up (week 24 or 3 months post-intervention)		87 % were retained. Depression symptoms decreased significantly from baseline (*M* = 26.9, SD = 9.6) to week 6 (*M* = 17.7, *SD* = 8.0) p < .000, with a mean difference of 9.0, indicating a significant change from moderate to mild depression. Also, significant decreases were evident from baseline (*M* = 26.9, *SD* = 9.6) to week 12 (*M* = 16.5, *SD* = 1.5), with a mean difference of 10.3, and the 3-month follow-up (*M* = 15.3, *SD* = 7.3) *p* < 0.00.	

Notes:

Treatment details include modality (individual/group), no. of sessions, frequency, duration.

US: United States, BA: Behavioural Activation, CG: Control group, IG: Intervention Group, BDI-II: Beck Depression Inventory-II, M: Mean, SD: Standard deviation, pp: participants, CBT: Cognitive Behavioural Therapy, RCT: randomized controlled trial, PHQ-9: Patient Health Questionnaire, GDS-15: Geriatric Depression Scale-15, HAM-D: Hamilton Depression Rating Scale, TAU: Treatment as Usual, EPDS: Edinburgh Post-natal Depression Scale, HADS-D: Hospital Anxiety and Depression Scale-Depression Subscale, CES-D: Centre for Epidemiologic Studies Depression Scale, CSI: Client Satisfaction Inventory, QOL: Quality of Life, PHO: Physical Health Outcome

Of the 15 studies included, ten were RCTs (Chowdhary et al., 2016, Choy and Lou, 2016, Hwang et al., 2015, Naeem et al., 2015, Kanter et al., 2015, Jesse et al., 2015, Ebrahimi et al., 2013, Armento et al., 2012, Gureje et al., 2019, Oladeji et al., 2015) and five non-RCTs (Bennett et al., 2014, Leung et al., 2013, Roland, 2014, Ward and Brown, 2015, Aguilera et al., 2018).

3.3.2 Populations targeted for cultural adaptation

Jesse et al. (2015) and Leung et al. (2013) culturally adapted psychotherapy for low income pregnant women (in the USA) and Chinese pregnant women (in Hong Kong) respectively. Choy

and Lou (2016) adapted treatment for Chinese people in Hong Kong whereas Hwang et al. (2015) adapted treatment for Chinese populations in the USA. Each group of people targeted for cultural adaptation in two different studies were African Americans (Roland, 2014, Ward and Brown, 2015), Latin Americans (Aguilera et al., 2018, Kanter et al., 2015), and also Yoruba speakers in Nigeria (Gureje et al., 2019, Oladeji et al., 2015). Each group of people targeted in just one study were Maori (Bennett et al., 2014), Indian (Chowdhary et al., 2016), Persian speaking (Ebrahimi et al., 2013) and Pakistani (Naeem et al., 2015). Armento et al. (2012) culturally adapted BA for diverse group of people, although the vast majority were Christian. Around half of the studies (7 out of 15) were conducted in the USA. The rest were conducted in New Zealand, Hong Kong, India, Iran, Nigeria and Pakistan. The results showed that although many studies were conducted in the USA, diverse groups of people were targeted to develop culturally adapted psychotherapies. Seven out of 15 studies involved minority groups, which is used to refer to a group that is different racially, politically, etc., from majority groups.

3.3.3 Preferred approaches for cultural adaptation with reasons

Behavioural Activation was selected in five studies (Chowdhary et al., 2016, Kanter et al., 2015, Armento et al., 2012, Gureje et al., 2019, Oladeji et al., 2015), while CBT was selected in eight studies (Bennett et al., 2014, Hwang et al., 2015, Leung et al., 2013, Naeem et al., 2015, Roland, 2014, Ward and Brown, 2015, Jesse et al., 2015, Aguilera et al., 2018) for cultural adaptation. Gureje et al. (2019) and Oladeji et al. (2015) also selected BA in addition to Problem Solving Therapy (PST) for cultural adaptation. One of the included studies was based on Instrumental Reminiscence Intervention (IRI) (Choy and Lou, 2016), and another study included cognitive, behavioural, and emotive-spiritual methods to develop a culturally adapted psychotherapy for the treatment of depression (Ebrahimi et al., 2013). Five studies used group-based psychotherapy (Choy and Lou, 2016, Leung et al., 2013, Ward and Brown, 2015, Jesse et al., 2015, Aguilera et al., 2018), whereas the other included studies used individual-based psychotherapy.

Although some studies (such as Hwang et al., 2015, Ward and Brown, 2015) did not justify why they chose a specific approach as a theoretical basis for cultural adaptation of the treatment that they developed, others provided some reasons for their preferences, even though these were not always explicitly justified. The reasons to select BA for cultural adaptation were mainly based on its effectiveness (Chowdhary et al., 2016), time limitations (Armento et al., 2012), its feasibility

of delivery by lay counsellors (Chowdhary et al., 2016), ease of training (Kanter et al., 2015), being present-focused (Kanter et al., 2015), being recommended in the literature (Kanter et al., 2015), and being recommended by an international expert group as the theoretical basis for the treatment, because BA was deemed to be the best fit, considering the culture and context (Chowdhary et al., 2016).

The reasons to prefer CBT for cultural adaptation were mainly based on its effectiveness (Bennett et al., 2014, Hwang et al., 2015, Leung et al., 2013, Naeem et al., 2015, Roland, 2014, Ebrahimi et al., 2013, Aguilera et al., 2018), and also recommendations from literature (Bennett et al., 2014), including that it can be delivered by a social worker and a paraprofessional health care provider for low-income and minority women, and might be easier to deliver than Interpersonal Psychotherapy (Jesse et al., 2015), and is recommended as a treatment option in National Treatment Guidelines in the US and UK (Naeem et al., 2015). Another reason cited by Bennett et al. (2014) to select CBT was that a large proportion of psychologists are trained in and prefer to use CBT, thus 'having clinicians *adapt* their current practice when working with Maori as a consequence of findings from this study was considered a more realistic and less disruptive prospect than having clinicians adopt alternative models of therapy'. Aguilera et al. (2018) mentioned rare availability of CBT in low income and public sector settings and even when CBT was available, it was usually not delivered in clinical trials.

IRI was chosen by Choy and Lou (2016) for two reasons: firstly, it was developed in the context of an integration of reminiscence and cognitive models of depression, which are well-established forms of psychotherapy; and secondly, it is a pragmatic approach that can help old people. PST was chosen by and Gureje et al. (2019), Oladeji et al. (2015) as it is effective, feasible and acceptable to patients, and feasible to be delivered by lay workers.

3.3.4 Process of cultural adaptation

Table 3.3 illustrates information related to the application of the Medical Research Council (MRC) framework for the development and evaluation of complex interventions (see, Section 3.2.9) in the included studies. Six studies (40%) systematically followed all four stages of the framework in the adaptation process (Chowdhary et al., 2016, Choy and Lou, 2016, Naeem et al., 2015, Jesse et al., 2015, Kanter et al., 2015, Gureje et al., 2019)..

Table 3.3 Process of cultural adaptation of psychological treatment (PT) for depressive disorders, based on Medical Research Council (MRC) Framework, for studies considering psychotherapy adaptation

Modelling/theoretical development	Formative research	Piloting
(Author, date), Method used for evaluation of efficacy		
(Aguilera et al., 2018), none		
Literature review. Therapist-client ethnic match, vocabulary of CBT simplified; attention to religious activities; recognising when passivity was helpful/harmful; recognising limitations of poverty and social context while scheduling activities	The cultural considerations recommended by researchers were applied to improve engagement in CBT with Latinos.	implementation study
(Bennett et al., 2014), within-subject design		
Culturally relevant and CBT literature in consultation with an advisory panel (AP), consisting of experienced consultant-level clinical psychologists of Māori (n=4) and non-Māori (n=3) descent	The advice of mental health consumers and elders with advanced cultural knowledge was sought.	None
(Chowdhary et al., 2016), pilot RCT		
Global and regional systematic review of effectiveness of psychological interventions for depression in primary care. Systematic review of explanatory models of depression in South Asia, and qualitative research of explanatory models of depression in study settings.	Distillation of strategies from empirically supported treatments, survey with mental health experts and lay counsellors, treatment development workshops with national and international experts. The clinical case series guided treatment modification.	Clinical case series
(Choy and Lou, 2016), longitudinal RCT		
A critical literature review about reminiscence intervention and CBT for depression was conducted. The intervention protocol was then modified and translated from the intervention manual developed by Watt and Cappeliez (1995; cited in Choy and Lou, 2016).	Professional advice was sought from two local experts on developing and conducting reminiscence therapy and CBT within the Chinese population. Learning from the experience of the pilot study, four major adaptations were made that contributed to a culturally sensitive IRI protocol with innovations.	Pilot study (n=5 participants)
(Ebrahimi et al., 2013), RCT		
The content and process of spirituality integrated psychotherapeutic intervention included theoretical model, intervention strategies and implementation guideline, which was extracted from religious (Islamic) sources in the first phase of the study.	Religious and psychological experts were interviewed in Iran and their viewpoints were collected until data saturation, followed by analysis and conceptualization. Religious sources, including written and electronic sources, were searched with regard to questions and goals and under the supervision of experts of religious sciences, considering the interview data.	None
(Gureje et al., 2019, Oladeji et al., 2015), RCT		
The Yoruba translations were done by panels of bilingual experts using standard protocols of iterative back translation. Adaptation of the interventions to the local language and cultural context were done by preserving their core elements. Local terminology was used. The label `mental disorder` in definition of depression was avoided to use for reducing stigma. More culturally appropriate tasks were used in the activity scheduling and PST.	The process of adaption involved an initial series of meetings and focus group discussions with health care providers experienced in working in primary care and with knowledge of the local culture, beliefs and practices, to discuss the chosen interventions, as well as in-depth interviews with patients. Insight gained from these interactions informed adaptation in terms of appropriate language and local terminologies that would be more acceptable in the cultural context	Pilot RCT study (see details in Table 2 under Oladeji et al., 2015)
(Hwang et al., 2015), RCT		
An integrative top-down and bottom-up approach called the Psychotherapy Adaptation and Modification Framework (PAMF) and the Formative Method for Adapting Psychotherapy (FMAP) were used to develop culturally adapted CBT. Two sets of 4-hour focus groups (14 total) were conducted with therapists at ethnic-focused community mental health clinics. Interviews were also conducted with Buddhist monks and nuns, spiritual and religious Taoist masters, and Traditional Chinese Medicine practitioners to understand Chinese notions of mental illness.	After the PI wrote the culturally adapted manual, another set of 4-hour therapist focus groups was conducted to further improve the manual.	None

Modelling/theoretical development	Formative research	Piloting
(Jesse et al., 2015), RCT		
Literature review, Beck's cognitive behavioural model, and Jesse's bio-psychosocial-spiritual theory provided the theoretical framework for the intervention.	Psycho-educational and pregnancy-specific information included in the manual was based on the first author's clinical experiences as a nurse-midwife providing care for rural, minority and low-income women. The research team developed and tested the Insight-Plus workbook, in a pilot with five African-American and Caucasian pregnant women at risk of depression at the local health department. Feedback from them helped to edit the workbook.	Pilot study with 17 women at risk of antepartum depression (Jesse et al., 2010)
(Kanter et al., 2015), RCT		
Literature review	Some experiences during treatment development suggested necessary alterations at the level of technique, such as a simplified treatment rationale, and less reliance on written homework assignments. Pilot case reports and other studies informed the evaluation of the current manual.	Case report (Santiago-Rivera et al., 2008), Case study (Kanter et al., 2008b), Open trial (Kanter et al., 2010b)
(Naeem et al., 2015), RCT		
Field observations, experience of therapy and clinical experience	Interviews with clinical psychologists (n=6) and depressed people (n=9). Focus group with university students (n=34).	Piloting in primary care settings
(Ward and Brown, 2015), None		
The ecological validity framework (Bernal et al., 1995) guided the adaptation.	They conducted a series of descriptive research studies examining-African Americans' beliefs about mental illness, perceptions of stigma, and experiences in counselling, and treatment preferences. They reviewed literature on African-American history and culture to identify an Afrocentric paradigm to incorporate into the OHDC.	Pilot 1: 18 African-American women. Pilot 2: 40 African-American women and men

BA, behavioural activation; CBT, cognitive behaviour therapy; IRI, Instrumental Reminiscence Intervention; OHDC, Oh Happy Day Class; PI, principal investigator; PST, problem solving therapy; RCT, randomized controlled trial.

*Only thirteen out of 16 studies included in this table because three studies did not explain the process of adaptation.

The other included studies either did not explain the treatment development process in sufficient detail or did not cover all the stages of the process. Some reasons for the adaptation were to increase the engagement of patients with treatment; the acceptability of a treatment/to reduce stigma; to maximise treatment gains; and to address the lack of qualified therapists.

The use of a modelling stage was reported in 12 (80%) studies. This comprised the choice of a psychotherapeutic approach, such as BA, commonly through empirical evidence collected from a literature review and via consultations with local advisors, such as experts in mental health. It also involved the use of a theoretical framework such as the Psychotherapy Adaptation and Modification Framework (Hwang et al., 2015) to guide the adaptation, the translation of a manual, the simplification of vocabulary within the manual, the selection of culturally appropriate tasks and the integration of religion/spirituality into treatment. The formative phase using qualitative or mixed methods to guide further refinements in the preliminary adapted version of the psychotherapy was presented in 12 (80%) studies. This involved mainly data gathered through consultation with mental health workers, focus group

discussions with key stakeholders, interviews with patients, and the results of previous pilot studies.

A piloting phase was reported in seven (46.6%) studies (Chowdhary et al., 2016, Choy and Lou, 2016, Naeem et al., 2015, Ward and Brown, 2015, Kanter et al., 2015, Jesse et al., 2015, Oladeji et al., 2015). Reports drew on qualitative and quantitative data through clinical case series and pilot studies. These data guided further refinements of the adapted treatments to increase acceptability and feasibility. The results of the piloting phase provided an initial assessment of the benefits and harms of the treatments. The evaluation phase was reported in 10 (62.5%) studies. This phase involved RCT and non-RCT studies, the results of which are presented in the next section.

3.3.5 Efficacy of the adapted psychotherapies

The depression score, the primary outcome, was measured most commonly by Beck Depression Inventory-II (BDI-II; n=7), Patient Health Questionnaire (PHQ-9, n=4), and Hamilton Depression Rating Scale (HAM-D; n=5); other scales are illustrated in Table 2 above. The duration of follow-up ranged from two weeks after the intervention to twelve months from baseline. All studies that explored the acceptability/feasibility of the culturally adapted treatment reported that the treatment was deemed to be acceptable/feasible (Chowdhary et al., 2016, Leung et al., 2013, Ward and Brown, 2015, Oladeji et al., 2015). All quantitative data results reported improvements in depression with culturally adapted psychotherapy. This benefit was either related to significantly greater improvements in favour of the treatment group in some studies (such as Choy and Lou, 2016, Armento et al., 2012), or significant overall improvements from baseline at post-treatment/ follow-up within the group in other studies (such as Bennett et al., 2014, Ward and Brown, 2015).

Some included studies did not report the change in depression score from baseline to the end of the treatment, thus the post-test scores from RCTs were used in the meta-analysis. The meta-analysis was restricted to RCTs, because of this use of post-treatment depression scores; it was assumed that the pre-treatment depression scores of patients would be similar across the treatment and control groups in RCT studies and therefore it was not necessary to control for pre-intervention scores. Seven studies were not included in the meta-analysis, since three studies did not have a control group (Bennett et al., 2014, Aguilera et al., 2018, Ward and Brown, 2015), and two were not RCTs (Leung et al., 2013, Roland, 2014). Although two other studies were RCTs (Gureje et al., 2019, Oladeji et al., 2015), these were not included as they

used a stepped care treatment in which it was not possible to understand the effect of culturally adapted treatment compared to control condition without considering the effects of other steps in the treatment settings such as usage of antidepressants.

Studies that were included in Chowdhary et al. (2014)'s meta-analysis were assessed in terms of eligibility for our meta-analysis. Eight out of 16 studies from their meta-analysis were assessed as eligible to be included into the current meta-analysis, resulting in a total of 16 studies with 2068 participants (Armento et al., 2012, Chowdhary et al., 2016, Choy and Lou, 2016, Ebrahimi et al., 2013, Hwang et al., 2015, Jesse et al., 2015, Kanter et al., 2015, Naeem et al., 2015, Bolton et al., 2003, Grote et al., 2009, Hamdan-Mansour et al., 2009, Miranda et al., 2003b, Naeem et al., 2011, Rahman et al., 2008, Wong, 2008, Beeber et al., 2010). A subgroup analysis was performed through stratification of studies in terms of four different control group conditions used: evidence based psychotherapy, antidepressants, treatment as usual/enhanced usual care and waiting list/no treatment. The pooled weighted SMD showed a statistically significant effect in favour of culturally adapted psychotherapies (CAPs) over the different kinds of control conditions [SMD= -0.63, 95% confidence interval (CI) -0.87 to -0.39], with a significant heterogeneity (Chi^2=82.53, df =15, p< 0.001, I^2= 82%) (Figure 3.2*)*. The test for subgroup differences did not show a statistically significant effect (p=0.13), meaning that the control condition used does not statistically significantly modify the effect of CAPs. There were, however, notable trends, with effect estimates ranging from -0.95 (95% CI -1.28 to -0.62) for waiting list/no treatment to -0.30 (95% CI -0.76 to 0.16) for evidence based psychotherapy. The number of studies and patients in each subgroup need to be considered when these results are interpreted.

Random effects were used because of the substantial heterogeneity (I^2>50%). These RCTs give consistent results with high heterogeneity, and all have the effect in the same direction: favouring culturally adapted therapy except (Miranda et al., 2003b) when medication was used in the control group.

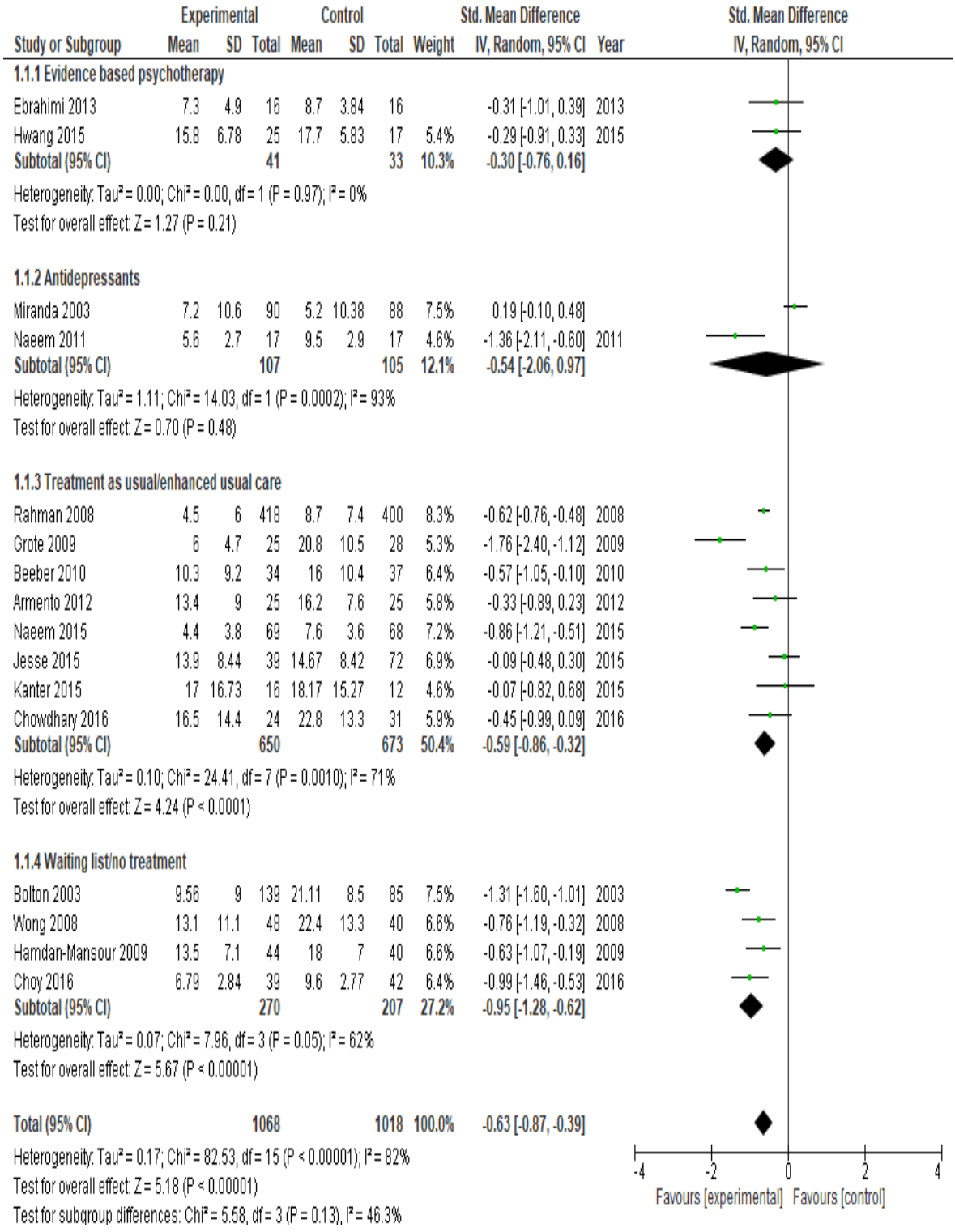


Figure 3.2 Effect of culturally adapted psychotherapies compared to evidence based psychotherapy, medication, treatment as usual or enhanced usual care, and waiting list or not treatment groups

When the studies included in the meta-analysis (apart from, Grote et al. (2009), Miranda et al. (2003b), Jesse et al. (2015), Armento et al. (2012), which did not target a specific cultural group as we know from the literature if a CAP targets a specific cultural group, it is four times more

effective than a CAP provided to groups consisting of clients from different cultural backgrounds (Griner and Smith, 2006)), were stratified by target population as either an ethnic minority or majority group, the test for subgroup differences showed a statistically significant subgroup effect (p= 0.04), meaning that the type of targeted population significantly modifies the effect of CAPs (Figure 3.3).

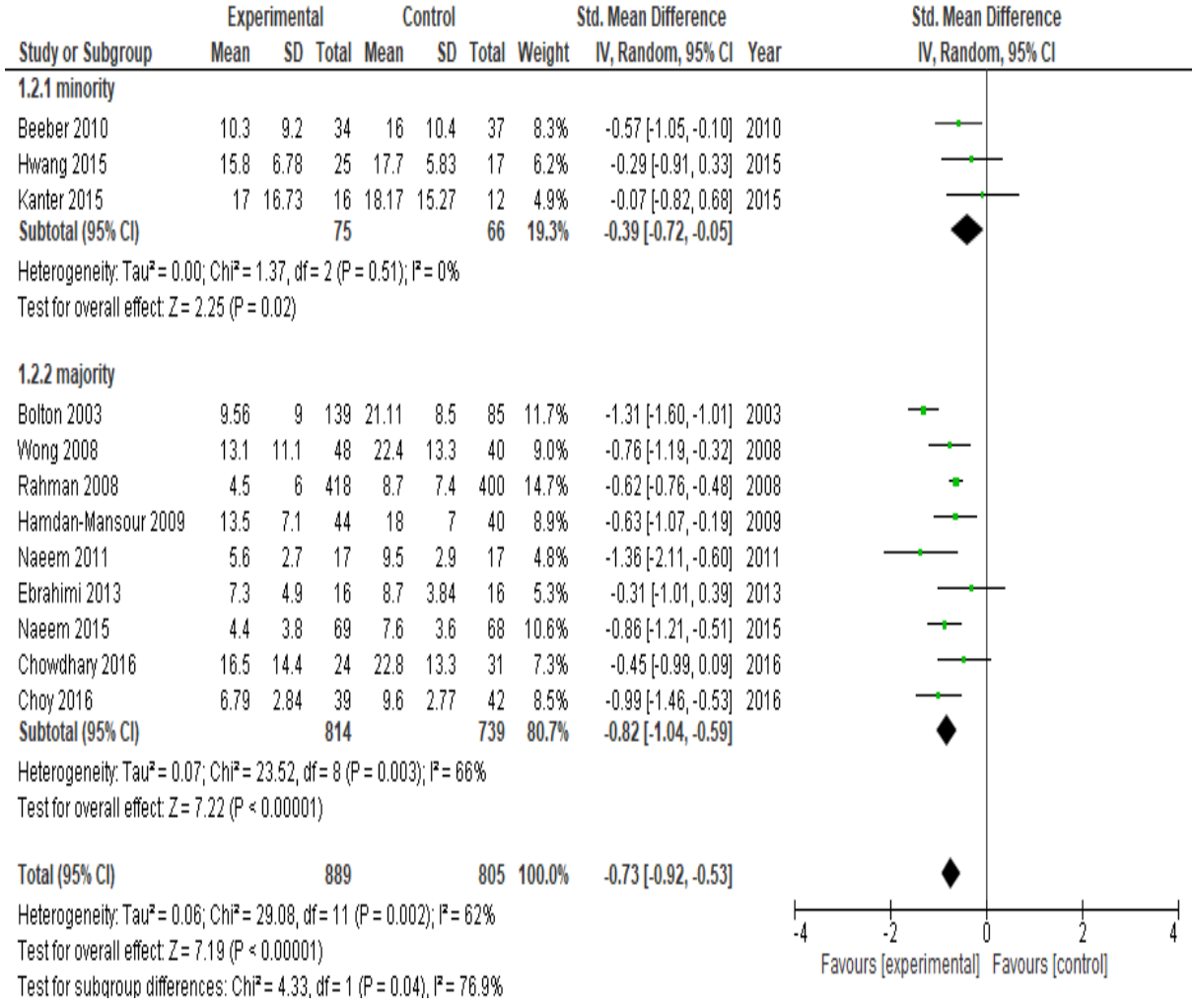


Figure 3.3 Minority versus majority ethnic groups

The treatment effect favours CAPs over different kind of control conditions for both minority and majority groups targeted. The treatment effect however is greater for majority ethnic groups (SMD= 0.82, 95% CI [-1.04 to -0.59], p< 0.0001 with a significant heterogeneity (Chi^2=23.52, df =8, p= 0.003, I^2= 66%) than minority groups (SMD= 0.39, 95% CI [-0.72 to -0.05], p= 0.002 without any significant heterogeneity (Chi^2=1.37, df =3, p< 0.51, I^2= 0%)). A smaller number of studies and patients contributed data to the minority groups (3 studies, 141 patients) than to the majority subgroups (9 studies, 1553 patients).

3.4 DISCUSSION AND CONCLUSION

The current study sought to systematically review literature on culturally adapted face-to-face psychotherapies for the treatment of depressed adults in a range of global contexts. Among studies published from January 2012 to August 2019, 15 studies were retrieved that were eligible for inclusion in this review. This suggests increased recent interest in cultural adaptation of psychotherapies for depressed adults from diverse cultural backgrounds, since a previous review covering the period 1981 - 2012 only identified 20 studies (Chowdhary et al., 2014). A recent meta-analysis of 78 studies confirms this increased interest in developing culturally adapted treatments (Hall et al., 2016).

Almost half of the studies (7/15) targeted minority groups who live in Western countries, and most of these studies were conducted in the US. The remaining studies, which were conducted in non-Western countries, targeted people from Pakistan, India, Hong Kong, Nigeria and Iran. Chowdhary et al. (2014)'s review results covered similar populations, although studies targeting people from Chile, the UK, Uganda and Jordan were included in that review, and studies targeting people from Iran and Nigeria were not.

Our review results also revealed that CBT was the most commonly selected approach for cultural adaptation, as found in other studies (Chowdhary et al. (2014);(Hall et al., 2016), however, Behavioural Activation was also a commonly chosen treatment for the adaptation. The reasons for these preferences were mainly based on their proven effectiveness, being recommended in the literature, and being expedient for time-limited investigations. These results align with existing mental health policy documents globally and in the UK. For example both CBT and BA are recommended as effective treatments for depression by WHO (2017), and NICE (2009). NICE guidelines for depression additionally recommend the delivery of IPT, which was not an approach adopted by studies included in the current review, although three studies included in Chowdhary et al.'s (2014) review did adapt IPT. The absence of IPT from global health policy is a possible explanation for this decline in adapted approaches for this therapy.

Twelve (80%) of the studies reviewed described the process of cultural adaptation, which appears to be heavily influenced by the Medical Research Council framework for development of complex interventions (Craig et al., 2008). Common approaches involved the selection of an evidence-based psychotherapy, consultations with mental health workers, focus group discussions with key stakeholders to inform the adaptation, assessment of the acceptability and

feasibility of the adaptation through qualitative and quantitative techniques, piloting studies for further refinements in the adaptation, and evaluation of implementation by RCTs. Furthermore, a formative research phase used in all these thirteen studies indicated a marked increase in use of the MRC framework from two-thirds of studies reporting this phase prior to 2014.

The feasibility or acceptability of the adapted treatments was reported in all the studies that aimed to assess this (Chowdhary et al., 2016, Leung et al., 2013, Ward and Brown, 2015). All the quantitative results that were reported showed improvements in depressive symptoms, and some studies (such as Choy and Lou, 2016, Armento et al., 2012) reported significantly greater improvements in favour of the adapted treatment compared to control condition. The results confirmed that CAPs are beneficial and acceptable.

The meta-analysis of 16 studies showed a statistically significant effect in favour of culturally adapted psychotherapies for the treatment of depressed adults over the different kinds of control conditions (SMD= -0.63). This result is consistent with previous studies: Chowdhary et al. (2014) reported SMD= -0.72 and Hall et al. (2016) reported g^2=0.67. These findings comprise further evidence for an increased range of people in favour of CAPs for the treatment of depressed adults.

When the studies were stratified by the types of control conditions, the subgroup analysis showed the largest effect size in the studies that compared CAPs with waiting list/ no treatment control groups (SMD= -0.95), with medium effect sizes in the studies when the comparison group was medication (SMD= -0.54) or enhanced usual care/treatment as usual (SMD= -0.59). It showed the smallest effect sizes when CAPs are compared with an evidence based psychotherapy (SMD= -0.30). It is not unexpected to find the largest effect size when comparing an intervention group with a waiting list/no treatment group as opposed to comparing it with other kind of control conditions constituting treatment as usual. The finding that study designs involving comparison with an evidence based psychotherapy resulted in smaller effects is similar with the results of the previous meta-analyses. There is some existing evidence that quicker results can be obtained from CAPs (Hook et al., 2010) and this is an area for potential further exploration across diverse populations.

[2] It refers to Hedge's g, which corrects for a slight bias in SMDs that is present when sample sizes < 20.

When included studies were stratified by the population targeted - as either an ethnic minority or majority group - the test for subgroup differences showed a statistically significant subgroup effect (p= 0.04), indicating that the type of targeted population significantly modifies the effect of CAPs. The treatment effect favours CAPs over different kind of control conditions for both minority and majority groups targeted. The treatment effect however is greater for majority ethnic groups (SMD= 0.82) than minority groups (SMD= 0.39). Although this result needs to be considered cautiously, as the number of studies and patients contributing data to minority groups are less than for studies of majority groups, it can be supported by a recent meta-analysis on culturally adapted healthcare interventions for depression in low socio-economic status populations (Rojas-García et al., 2015). Results from that study indicate that interventions adapted for minorities with low socio-economic status were significantly less effective. Thus, further investigation is needed to understand whether this finding can be generalised. Investigation of factors contributing to these differences might help to understand why efficacy of CAPs for minority groups are less than for majority groups. One potential explanation is that therapists delivering CAPs to minority ethnic clients are likely to have limited knowledge of their clients' cultural values and to work in contexts that involve discriminatory stereotyping, with consequences for therapist confidence and comfort in delivering CAPs (Mir et al 2015).

It is important to consider the limitations of this review when interpreting the results. The review is limited to studies published in English and seven non-English language studies were omitted from the review for this reason. The review is also limited by incomplete data of a core element for assessment of the risk of bias in two of the included studies (see Appendix A 3). Thus, the results of our meta-analysis should be considered cautiously. Although, it is important to explore the effect of CAPs compared to an evidence based psychotherapy for the treatment of depression, this issue cannot be explored in depth in this study as only two of the included studies used an evidenced based psychotherapy as a comparison group. This issue is consistent with the conclusion of a recent review of meta-analyses on culturally adapted mental health interventions which states that even though culturally adapted psychotherapies work better compared to treatment as usual, there were not enough data to claim that CAPs work better than an active treatment as the number of studies that were used an active treatment as comparison group were limited (Rathod et al., 2018). Thus, more studies are required to explore efficacy of CAPs compared directly to an evidence based psychotherapy. Although there was a statistically significant subgroup effect when the studies were stratified by the targeted population, only three studies were of minority groups so this result needs to be interpreted

cautiously. This suggests that it might be useful to investigate what can be done to improve efficacy of CAPs for minority groups.

In conclusion, this systematic review extends and updates the literature on culturally adapted face-to-face talking therapies for the treatment of depression globally. In addition to assessing efficacy, we explored the reasons behind selection of specific psychotherapies over others, thus offering a rationale for preferences. The results demonstrate that minority groups in Western countries were targeted for cultural adaptation by the same number of studies as those on majority populations in non-Western countries, so developing and testing CAPs for depression is a growing area in general. CBT and BA are commonly selected approaches for CAPs, mainly based on their effectiveness, and adaptation processes used have been systematic and potentially can be replicated. Our findings confirm that CAPs are generally more efficacious than control conditions. This suggests that psychotherapies should be culturally adapted to enable more extensive improvements in depression care and to help reduce its global health burden.

3.5 FURTHER DISCUSSION

Findings presented in this chapter showed that there were no included studies that targeted depressed Muslim adults in Turkey. The two databases, ULAKBILIM (1996- present) and YOKTEZ (1959-present), which are commonly used databases in Turkey, were searched in addition to the other databases (for details, see 3.2.4) and still no such studies were identified. Considering this finding, the efficacy of CAPs for the treatment of depression (see Section 3.3.5) and the effect of culture on mental health (see Section 2.2), the need to evaluate a CAP for the treatment of depressed adults in Turkey emerged. This need provides evidence regarding the importance of conducting the feasibility study.

As mentioned in Section 3.4, more studies are required to explore the efficacy of CAPs compared directly to evidence-based psychotherapy. This provided the reason to examine the feasibility of conducting a full RCT of BA-M compared to an evidence based treatment (i.e. CBT) in this thesis.

The meta-analysis results showed that the treatment effect was greater for majority ethnic groups than minority ethnic groups (see 3.3.5). Understanding the reasons for this difference could provide guidance on how to improve mental health treatments for minority groups. This provided the rationale to conduct a comparison study (see CHAPTER 7).

CHAPTER 4
METHODOLOGY

This chapter covers the philosophical worldview of the researcher regarding the research methods and the design used in the feasibility study (Study II). It starts with the general overview of the research paradigms and then explains the philosophical worldview (stance) of the researcher. Then, it gives short descriptions of three research approaches: qualitative, quantitative and mixed methods and justifies the reasons for choosing a mixed methods approach.

After justification of the research methodology used, this chapter addresses the details relating to the methods of the feasibility study (Study II), although a diagram of all three studies in this project is illustrated below (Figure 4.1). The methods used for Study I (the systematic literature review) and Study III (a comparison of perspectives from the UK and Turkey) are covered in CHAPTER 3 and CHAPTER 7, respectively.

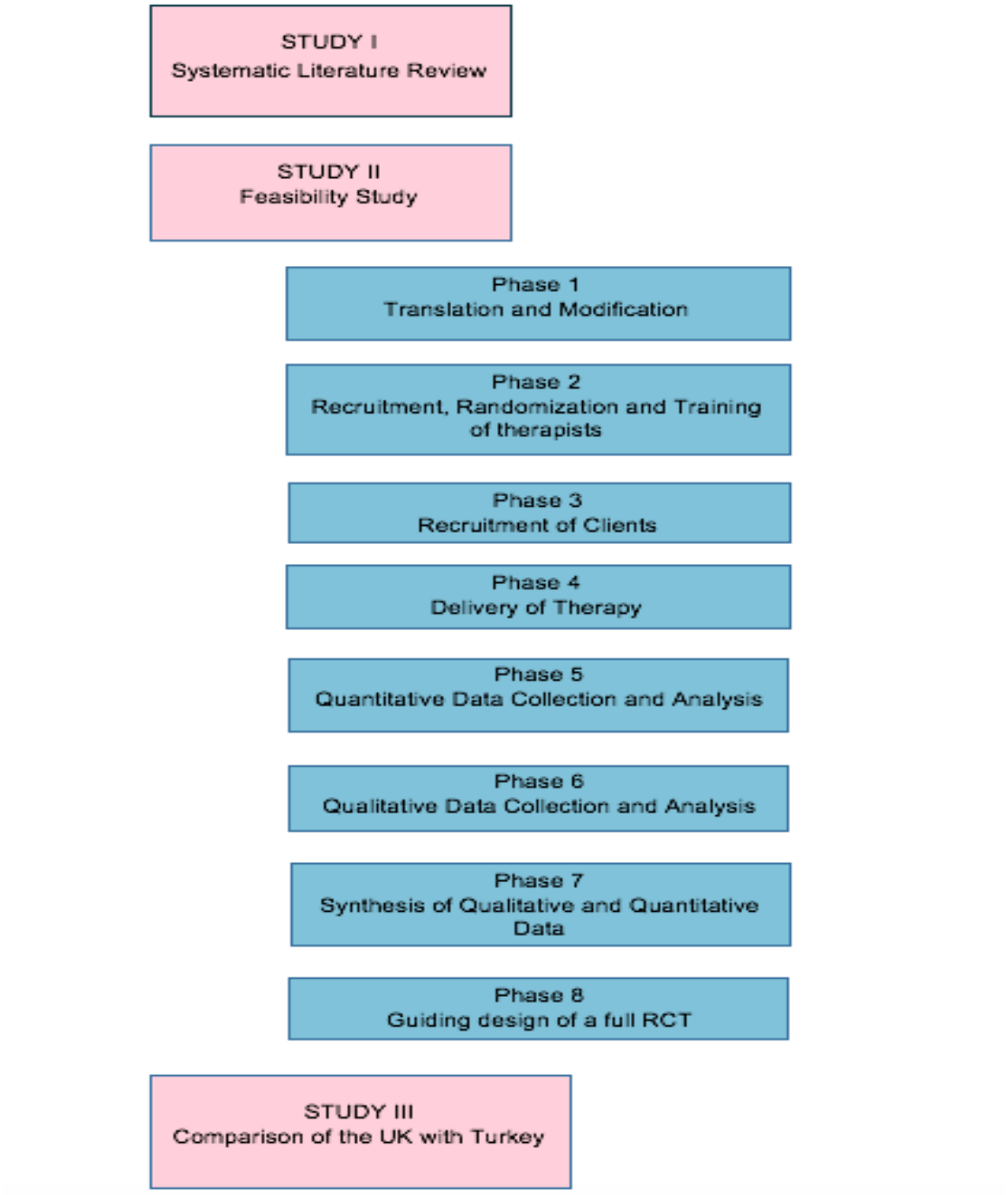


Figure 4.1 Study diagram

4.1 PHILOSOPHICAL WORLDVIEWS

The philosophical ideas of a researcher have an impact on the choice of research method and design. Although this impact usually remains hidden, it is important to mention in a research manuscript as it helps to understand why a qualitative, quantitative or mixed methods approach has been chosen to acquire and/or generate knowledge in a research study. Thus, an approach to research includes philosophical ideas, research designs and methods (Creswell, 2014).

Figure 4.2 illustrates a framework that shows the links between philosophical worldviews, designs and research methods which are involved in the generation of an approach to a research study. The figure might help to understand the effect of one's philosophical worldview on designs and research methods.

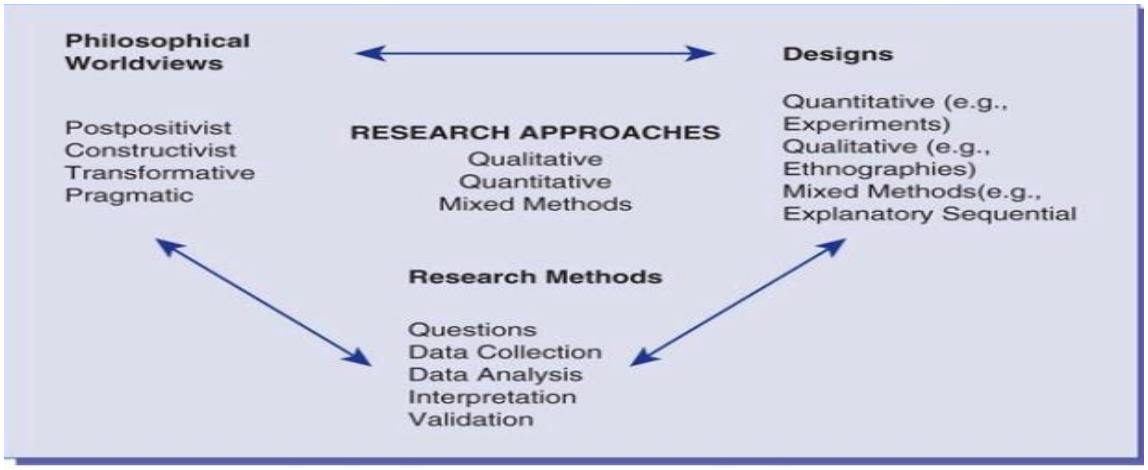


Figure 4.2 The links between philosophical worldviews, designs and research methods- adapted from Creswell 2014

The term *philosophical worldviews* - paradigms - refers to "a basic set of beliefs that guide actions" (Guba, 1990 cited in Creswell, 2014 p.35). These are beliefs about the nature of reality (ontology), how knowledge is acquired (epistemology), the role of values for learning the reality (axiology) and the process of research (methodology) (Creswell, 2014). Philosophies, such as postpositivism, constructivism, transformative and pragmatism, are often distinguished in terms of these beliefs (Guba, 1990 cited in Creswell, 2014). These different types of belief are examined in the context of four well-known philosophies: postpositivism, constructivism, transformative and pragmatism (Creswell, 2014), to help to illustrate these concepts.

According to Plano Clark and Ivankova (2016a), each philosophy differs in terms of ontological, epistemological and axiological beliefs. Postpositivism emphasises that there is only one reality, knowledge of the reality is acquired by being distant and observant of it, and the influence of a researcher's values should be largely controlled and removed from the research. Furthermore, since there are hidden variables and lack of absolutes in nature, we may not be able to fully understand what reality is and how to get to it. Postpositivism considers that nature can only be approximated (Lincoln et al., 2018) because measurements and observations are imperfect and biased by the social context and beliefs (Wahyuni, 2012). Postpositivism has been viewed as a philosophical stance especially for quantitative studies.

When it is used as a philosophical stance in mixed-methods studies, the quantitative part of it is often more dominant, and the qualitative data is quantified to be statistically analysed (Plano Clark and Ivankova, 2016a).

On the other hand, constructivism emphasises that there are multiple realities as knowledge of the reality is constructed by individuals and so the influence of the researcher is not expected to be separated from the research. It acknowledges that a researcher cannot be objective while doing research. Constructivism has been viewed as a philosophical stance especially for qualitative studies. When it is used in mixed-methods studies, qualitative data is more dominant and usually quantitative data is only analysed descriptively (Plano Clark and Ivankova, 2016a).

The transformative perspective also emphasises that there are multiple realities but it states that these realities are constructed through socio-political structures. Knowledge of realities can be obtained from individuals who experienced them, and the values of a researcher are indispensable since an interactive relationship between a researcher and participants in a study is required (Mertens, 2007). Thus, the influence of a researcher is acceptable and not expected to be controlled. When a transformative perspective is used as a philosophical stance in mixed-methods studies, researchers aim to advance social justice, so make a change for individuals who have been marginalized, and challenge socio-political structures via mixed methods within a theoretical framework.

Pragmatism emphasises that there are different viewpoints about reality. Knowledge of reality can be obtained through both individual constructs and empirical discovery. The researcher's influence is important as it shapes the research questions and conclusions. Knowledge is an instrument to make a change in the world (Plano Clark and Ivankova, 2016a, Cornish and Gillespie, 2009, Johnson and Gray, 2010). Thus, pragmatism is a kind of "middle philosophy" (Plano Clark and Ivankova, 2016a) within these philosophical worldviews. It does not limit the nature of reality, the way knowledge is acquired, or the subjective or objective stance that a researcher may adopt. However, it does emphasize the use of all methods that can help to obtain knowledge.

Pragmatism as a philosophical stance in mixed-methods studies, has been criticised for not taking into account the epistemological differences between quantitative (objectivist) and qualitative (subjectivist) approaches adequately (Plano Clark and Ivankova, 2016a). According to Morgan (2007), however, a pragmatist approach does not ignore the importance of

epistemology but it rejects privileging ontological issues and epistemology over methods. Pragmatism would consider research-related issues as a primary "line of action" on which methodologists should focus (Morgan, 2007).

Mixed methods design allows researchers the flexibility to use more than one worldview (Creswell and Plano Clark, 2017). These authors suggest using pragmatism as an umbrella worldview for a convergent parallel group study design since it involves data collection, analysis and synthesis of the data and results in parallel. Following this suggestion, pragmatism is the most closely matching philosophical worldview that aligns with the current study design – namely convergent parallel group design (see details, Section 4.3.1). Pragmatism guides this thesis overall, by consideration of the study designs employed that best fit with the research questions. As a result, post-positivism, constructivism and transformative emancipatory perspectives guide the aims of the study and the quantitative and qualitative methods used in this thesis.

4.2 RESEARCH APPROACHES

Research approaches refer to "plans and the procedures for research that span the steps from broad assumptions to detailed methods of data collection, analysis, and interpretation" (Creswell and Creswell, 2018; p.469). As mentioned above, three common approaches to research are: a) qualitative, b) quantitative and c) mixed methods (Williams, 2007), however, these approaches are not as distinct as they look. Even though quantitative and qualitative approaches represent opposite ends of a spectrum, they should not be thought as polar opposites or dichotomies, but rather as flexible and diverse categories (Creswell and Creswell, 2018, Tashakkori, 2009). Since a mixed methods study combines components of both qualitative and quantitative methodologies, it falls somewhere in the middle of this spectrum (Creswell and Creswell, 2018).

In this part, the three research approaches have been described and then the reasons for choosing a mixed methods approach have been justified. Different kinds of designs within mixed methods research are introduced to provide information related to the type of design used in the current study, namely convergent parallel group design.

4.2.1 Quantitative approaches

As mentioned earlier in this chapter, quantitative researchers are, in terms of philosophical worldviews, mostly post-positivists (Johnson and Gray, 2010). Quantitative researchers tend to test theories deductively, to eliminate bias - so try to be objective - to control for other variables that might affect the results of a study and to provide findings that can be generalized and replicated. They test theories by examining the relationship among variables. These variables need to provide measurable numeric data which can be analysed by using statistical procedures (Creswell, 2014, Meadows, 2003, Neuman, 2014). In a quantitative study, the topic and measures need to be specified or narrowed down before the start of data collection or conducting an experiment (Neuman, 2014). Experiments and surveys are examples of study designs (Creswell, 2014), and scales and questionnaires are examples of data collection methods in a quantitative study (Meadows, 2003, Quick and Hall, 2015). The aim in experimental designs is to test the effect of an intervention on an outcome by controlling for other variables that can impact the outcome, whereas this is not an aim in a survey study (Creswell, 2014). The current study is a feasibility study of an RCT of BA-M for treatment of depressed adults in Turkey, and is an experimental study design. The details related to the feasibility study design is described in Section 4.3.2. Furthermore, Section 4.5.5 describes what kind of quantitative data are collected, which measures were used and how the data were analysed.

4.2.2 Qualitative approaches

Phenomenological, narrative, grounded theory, ethnographic and case study research are examples of qualitative approaches to inquiry (Creswell, 2013). Constructivism has been viewed as a philosophical stance especially for qualitative studies (Plano Clark and Ivankova, 2016a). Qualitative studies are typically conducted in the natural world, focus on context, respect the humanity of the participants in the study and inform the research problems studied by addressing what a particular social or human problem means to individuals or groups (Creswell, 2013, Mason, 2002, Neuman, 2014). Qualitative studies do not have a rigid structure although they can follow a systematic procedure. Qualitative researchers consider the effect of their own biographies and social identities on the process of conducting a study, so they are reflexive. When they analyse data, they use complex reasoning that moves between induction – from data to theory – and deduction – from theory to data (Creswell, 2013, Mason, 2002, Neuman, 2014). In some qualitative studies, data can be used to generate theory and researchers need to be open for the unexpected as research questions might be changed based on factors

such as finding something new and exciting, or problems that may arise during the data collection and analysis process (Neuman, 2014).

In this study semi-structured interviews, commonly used in qualitative data collection , were conducted and the data were analysed by a framework analysis method (for details, see Section 4.5.6).

4.2.3 Mixed-methods approaches

Mixed methods research can be defined as "the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the purposes of breadth and depth of understanding and corroboration" (Johnson et al., 2007; p.123). It involves collecting quantitative and qualitative data and integrating these two forms of data to get a more complete picture in a study (Creswell, 2014). As mentioned above, quantitative approaches are limited in terms of depth and qualitative approaches are limited in terms of breadth in a study. Thus, both can answer different questions and be used collaboratively – in a mixed methods study – to gain breadth and depth within a single study. Breadth of understanding obtained through quantitative methods might provide depth of understanding and can be interpreted through qualitative methods (Neuman, 2014), such as if a quantitative study found that there was a statistically significant difference between clients in treatment A group compared to B regarding drop-out rate, qualitative interviews could be used to understand why there was a higher drop-out rate in the former, thus a more complete picture can be drawn. Both approaches can also be used together to 'act as a check' on another so validate each other, which is framed as triangulation in mixed methods studies. This validation process – through comparing findings from diverse methodologies – is believed to strengthen a researcher's confidence that the concept has been correctly measured. As each approach features potentially different error and bias, it is considered that one approach eliminates the weaknesses of the other one. Thus, when there is a congruence in the findings from both data sets, the researcher can be more confident in the results (Glogowska, 2011).

Health research is a complex area in which experimental designs – such as randomized controlled trials (RCTs) – might not be enough to improve health or healthcare systems considering potential issues faced when the results of RCTs, which are highly controlled studies, are applied in day to day life in practice (Palinkas, 2014). The Medical Research Council (MRC) framework for development of complex interventions suggests usage of both

quantitative and qualitative methods (Campbell et al., 2000, Craig et al., 2008), that is, mixed methods as qualitative methods can help quantitative methods by informing a quantitative study design, as previously mentioned. For example, perception of clinicians about frequency and content of potential measurements to use in an RCT can be explored via qualitative interviews before designing the RCT to decide which measurement to use and the frequency of it, providing depth of understanding of the results. The results of a quantitative study can be explained by a follow-up qualitative study, and applying its results in practice and so on (Palinkas, 2014). Quantitative methods can help qualitative methods by providing the opportunity to test the theory developed (Glogowska, 2011) and to examine whether it is possible to generalise results found through qualitative methods (Creswell, 2014). Thus, both methods comply with each other and a combination or mixed-methods approach is useful for development of complex interventions. In the current project, the quantitative part provides us the opportunity to answer questions related recruitment and retention rate, for example, and the qualitative part answers questions related factors such as the possible methods to increase the recruitment of clients and to keep therapists motivated in a study and so on. When both parts are integrated, so triangulated, it provides us information related to the acceptability of BA-M for depressed adults and whether it is feasible to conduct an RCT on BA-M for depressed adults in Turkey. Therefore, mixed methods have been chosen in this project to answer the research questions in the line with the MRC framework for development of complex interventions, as mentioned above.

4.3 STUDY DESIGN

After identification that a mixed methods approach best fits with the research aims, pragmatism underlines the philosophical foundation and the conceptual framework of the study; the next step is to identify the specific study design that best fits the research aims (Creswell and Plano Clark, 2017). This section firstly introduces different kinds of mixed methods study designs and justifies why a convergent mixed methods design, as it is described by Creswell and Plano Clark (2017), was adapted in this study. It then describes how the convergent mixed methods design was applied in the feasibility study and introduces feasibility study design.

4.3.1 Mixed methods design

The rationale for using a mixed methods approach was briefly introduced in the previous section. In this study, quantitative and qualitative methods help to examine the feasibility of evaluating BA-M in Turkey. Thus, both methods are used to address the study aims.

Creswell and Plano Clark (2017) state that every mixed methods study has its own unique design but still there are some key concepts to consider when applying mixed methods designs. There are different kinds of approaches such as a typology-based approach and interactive, system-based approach. The typology-based approach focuses on study methods used whereas the interactive approach focuses on the parts and process of a study. Creswell and Plano Clark (2017) recommend that researchers who are new to mixed methods research should use a typology-based approach to mixed methods design as a guideline. The researcher in this study was new to designing and conducting mixed methods studies so followed Creswell and Plano Clark (2017) recommendation and used a typology based approach to the study design.

Different authors have focused on different decisions and aspects of mixed methods designs so they developed different typologies focusing on, for example, timing of qualitative and quantitative data collection and analysis (e.g. sequential and concurrent), purpose of integrating methods (e.g. convergence or explanatory), and priority given to qualitative or quantitative methods in a study (Plano Clark and Ivankova, 2016b, Morse, 2009, Creswell and Plano Clark, 2017). These different typologies provide researchers with a variety of alternatives that are well established, promote a systematic approach to address study aims, and assist the researcher to predict and overcome challenging issues (Creswell and Plano Clark, 2017). Creswell and Plano Clark (2017) mention the typology of three core mixed methods research designs: explanatory sequential design, exploratory sequential design and convergent design. They think that researchers may apply either one or more type of core design in a study. Researchers might also use one of these core designs within larger frameworks such as intervention or experimental studies, which is called embedded experimental design.

In explanatory sequential design, first, quantitative data is collected and analysed, and then qualitative data is collected and analysed to explain or interpret the quantitative results. In exploratory sequential design, however, qualitative data is collected and analysed, and then quantitative data is collected and analysed to explore and generalise the qualitative findings. Convergent design, referred to also as concurrent or parallel group design or triangulation, is used when the researcher aims to compare or combine the results of qualitative and quantitative data analysis by integrating them. Both data sets are first analysed separately and then integrated. The basic aim in convergent design is to obtain a more comprehensive understanding of the issues, to validate one set of results with the other, or to assess whether participants respond in a similar manner when both data collection methods are used, by

comparing the results from the quantitative and qualitative parts of the study (Creswell, 2014, Creswell and Plano Clark, 2017, Kroll and Neri, 2009). This study used a convergent mixed methods design to obtain a more comprehensive understanding by merging and comparing – triangulating – quantitative results with qualitative results. Qualitative and quantitative data were collected and analysed separately and then the results from both data sets were triangulated and interpreted. The diagram below (Figure 4.3) illustrates the convergent mixed methods design used in this study.

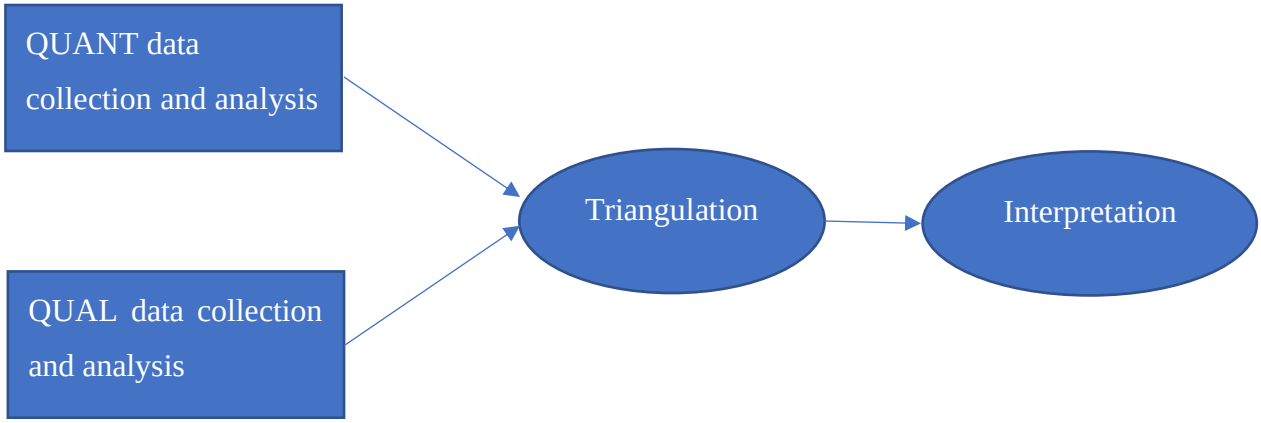


Figure 4.3 Diagram of Convergent Design adapted from Creswell and Plano Clark (2017)

There are some strengths and challenges in using convergent design (Creswell and Plano Clark, 2006). It provides researchers with complementary data on the same topic from different datasets (methods) and gives the opportunity to collect and analyse data within a shorter period of time as there is no need to wait for results from one data type (e.g. quantitative data) for collecting and analysing the other data type (e.g. qualitative data) (Creswell and Plano Clark, 2006, Plano Clark and Ivankova, 2016b). On the other hand, this design type might raise issues regarding the paradigms that guide the research as it involves integrating both data types obtained and results at one time (Creswell and Plano Clark, 2017). This challenge can be overcome by having pragmatism as the philosophical stance behind the research, as is the case in the current study. The assumptions of pragmatism are well fit for guiding the work of integrating qualitative and quantitative approaches into a wider understanding. Thus, instead of mixing different philosophical worldviews, it is recommended to use convergent design with pragmatism as it provides an umbrella worldview for a study (Creswell and Plano Clark, 2017), as mentioned earlier in this chapter. Another issue regarding convergent design might arise from inclusion of different samples and different sample sizes when converging the two data types (Creswell and Plano Clark, 2006). This should not be an issue in the current study since

the samples in the quantitative and qualitative strands of the study were from the same group of participants, and sample sizes in both datasets were similar. Another issue regarding this type of design could be that there is not an opportunity for the results of one approach to inform the methods of the other, as can be done in sequential designs (Creswell and Plano Clark, 2006). Despite this limitation, a convergent design was employed in the current study because of the practical issue that the qualitative interviews with therapists and clients had to take place before the quantitative analysis was completed.

4.3.2 The feasibility study design

The reasons to apply convergent design have been explained in the previous section. This section covers the application of convergence design within the feasibility study. It also introduces progression criteria that were determined before the feasibility study started.

A parallel group feasibility study of BA-M compared to CBT for depressed adults in Turkey was adopted in this study. Conducting feasibility studies prior to evaluating the effect of a complex intervention in a main study (e.g. RCT) is recommended by the MRC framework (Craig et al., 2008). RCTs are agreed to be the most reliable method of evaluating benefits and harms of a treatment, but trials are mostly conducted to evaluate the effects of pharmaceutical interventions. Specific challenges exist in defining, developing, documenting and reproducing complex interventions, such as a psychotherapies, that contain several interacting components (Campbell et al., 2000). Trials are often challenged by the issues, such as acceptability, treatment delivery, and recruitment and retention, which can be predicted by a previously conducted feasibility study (Campbell et al., 2000, Craig et al., 2008). Therefore, it is important to assess the feasibility of a definitive trial, before conducting a full one, as they are costly (Speich et al., 2018).

Essential objectives to conduct a feasibility study are to explore recruitment potential, the applicability/practicality of the study design; treatment acceptability, fidelity and participant adherence, and to collect sufficient data for sample calculation of the main study (Donald, 2018). Thus, feasibility studies estimate key factors that are required to design the main study, such as willingness of therapists to be randomised and to recruit clients, and whether primary data can be collected in a future trial (Arain et al., 2010). These key factors include intervention delivery, contextual factors and implementation (Donald, 2018). Feasibility studies in health sciences can also be used to examine whether an intervention is appropriate for further evaluation (Bowen et al., 2009).

Complex interventions are commonly referred to as interventions that consist of several interacting/interconnecting components (Campbell et al., 2000, Craig et al., 2008) and non-linear causal pathways (Petticrew, 2011). An intervention can be complex if it includes some dimensions of complexity. These dimensions emerge when an intervention has several interacting components, requires a number of behaviours (with varied difficulty) from those who deliver or receive it, targets a number of groups or organisational levels; has a number of outcomes and variability among these; and/or a degree of flexibility or tailoring of the intervention is permitted (Craig et al., 2008). Considering these dimensions BA-M can be described as a complex intervention.

Craig et al. (2008) emphasises that there is not a clear distinction between complex and simple interventions. Petticrew (2011) proposes that instead of defining an intervention as complex or simple based on its inherent characteristics, complexity and simplicity should be considered as pragmatic perspectives that are followed to describe and understand the intervention under investigation. It is suggested to refer it as intervention complexity rather than complex intervention as there is no simple intervention. Intervention complexity can be thought regarding three broad perspectives: how complex an intervention can be, how complex interactions can be revealed by the implication of the intervention in particular situations, and the broader context in which intervention is implemented (Thomas et al., 2019).

The first perspective refers to the definition of complex interventions mentioned in the previous paragraph as the inclusion of multiple components. BA-M incudes several components such as self-monitoring, activity scheduling, and value assessment (Mir et al., 2016). The second perspective focuses on interactions between the intervention and study participants in which the intervention context might be influenced by the characteristics of clients and therapists; and/or between components of the intervention (Thomas et al., 2019). The effect of BA-M might depend on, for example, the experience of therapists and engagement of clients with the therapy. The third perspective focuses on the broader context (like a system) where the intervention is implemented (Thomas et al., 2019). BA-M was developed for depressed Muslims in the UK (Mir et al., 2015) and in this study is adapted for Muslims in Turkey.

As BA-M was adapted for depressed adults in Turkey in this study, at the start there was no information on BA-M for depressed adults in the Turkish setting, including its acceptability, the willingness of clients and therapists to take part in the study, recruitment and retention rate for both therapists and clients, willingness to deliver and have BA-M as treatment, and the

effect size for sample size calculation. Thus, this study aimed to assess the feasibility of conducting an RCT of BA-M for depressed adults in Turkey, rather than being a pilot study that is a miniature of a main study to inform the main study design (Arain et al., 2010). The feasibility study had two groups of therapists who would be randomly assigned to deliver either BA-M (Turkey) or CBT, to Muslim clients with depression. It was not possible to randomly assign clients in this study, because randomising clients would mean the use of two approaches by the same therapist, which could lead to contamination. To prevent such contamination of therapy methods, randomisation would not be at the patient level, but at therapist level, and followed a cluster design. This means the unit of randomisation in the study was a cluster. An audit of sample sizes for feasibility trials undertaken in the UK revealed that for feasibility studies they range from 10 to 300 clients per arm (Billingham et al., 2013). Lancaster et al. (2004), suggested, as a general rule, sample sizes of 30 clients overall. This study follows Lancaster et al. (2004) recommendation and adjusts the sample size to 30 clients, placing 15 in each group. Considering the six-month timeframe, and necessity of delivering at least six sessions of therapy for each patient, the minimum number of clients that a therapist is likely to recruit and to follow in six months is three. Thus, recruitment of at least five therapists and 15 clients to take part in each group was targeted. Fifteen clients would receive BA-M (Turkey) treatment, while the other 15 would receive CBT treatment.

Progression criteria for conducting a definitive trial of BA-M, which draws on Avery et al. (2017) and Hallingberg et al. (2018), were specified before the feasibility study started. The progression criteria for a full RCT to be considered were:

1) to recruit at least (a) 10 therapists and (b) 30 clients within six months

2) to retain 60% of clients to completion of six sessions of BA-M

3) to ensure Patient Health Questionnaire (PHQ-9) is completed by at least 80% of clients at the baseline, 60% of the clients at six weeks, 50% of the clients at 12 weeks and 40% of the clients at 18 weeks. Filling PHQ-9 at 12 weeks and 18 weeks might be helpful as a follow-up for some clients.

The BA-M treatment manual recommends completion of at least six sessions of the therapy. After six sessions, if a therapist decided that a client did not need further treatment, it could be ended. Considering this, having criteria for completion of PHQ-9 at six-week intervals, which seemed to be practical, was set as a criterion (for the details regarding usage of PHQ-9, see Section 4.5.5). The period of treatment and follow up time for a definitive trial would be

determined by practical considerations of therapy in Turkey.

Potential efficacy of both treatments would be assessed as a secondary outcome of the study. However, as the study was not designed to investigate the efficacy of the treatments it is limited in this regard.

4.4 THE MENTAL HEALTH SYSTEM IN TURKEY

Before introducing the study procedure, it is important to understand the mental health system in Turkey as it will give information about the settings in which the feasibility study was conducted. Thus, this section introduces the mental health system in Turkey.

A community-based approach toward mental health services was adopted in Turkey after the Republic of Turkey National Mental Health Policy was published in 2006 (Haldun, 2016). The policy addresses issues such as integrating mental health services into general health and primary health care services, establishing community-based rehabilitation programs, and improving the quality of mental health services (Haldun, 2016, The Ministry of Health of Turkey, 2006). Following the Mental Health Policy, the decision to establish Community Mental Health Services (CMHSs) was made in 2009 and since then, 177 CMHs have been established. These services provide treatment for individuals with chronic mental illnesses such as schizophrenia and similar psychotic disorders and mood disorders due to their devastating effect on cognitive, managerial and social skills (Republic of Turkey Ministry of Health, 2021).

Although the policy aims to integrate mental health services into general health and primary health care services, mental health care is still mostly provided in secondary care in Turkey. This may lead people to seek help firstly from psychiatrists (Dereboy et al., 2017) who are either Adult Mental Health and Disease Specialists or Child and Adolescence Mental Health and Disease Specialists. According to the Ministry of Health in Turkey, psychiatrists are competent to diagnose mental illnesses. In a case in which there is no psychiatrist, other medical doctors can diagnose mental illnesses. After diagnosis with a mental illness, psychiatrists can prescribe a drug and/or can deliver any psychotherapy for which they have been trained. A psychiatrist can refer the patient to a clinical psychologist, or a client can see a clinical psychologist without being referred by a psychiatrist or a medical doctor. A clinical psychologist can deliver psychotherapy if they have enough training. Although clinical psychologists need to work collaboratively with psychiatrists for the treatment of a patient who is diagnosed with a mental illness, they do not need to work collaboratively with psychiatrists

to deliver psychotherapy to clients who are not diagnosed with a mental illness (Sağlık Bakanlığı, 2014). Thus, clinical psychologists do not have the authority to diagnose mental illnesses, and they need to work collaboratively with a psychiatrist when they see clients diagnosed with mental illnesses.

Mental health services are available in the public and private sectors in Turkey. In one study, 103 (42.9%) out of 240 participants admitted to a public hospital's psychiatry service reported that they had previously sought mental health help from professionals through either public or private services. Medication was recommended to most of those who had previously sought help (82%) at their first consultation, and psychotherapy was recommended only to five (5%) of them (Dereboy et al., 2017). Treatment of mental health problems in public services is likely to be based on medication in Turkey, which may be related to the shortage of time allocated for each appointment in public hospitals, clients' preference to use medication and the insufficient number of professionals who can deliver psychotherapy[3] (Dereboy et al., 2017). This shows that access to psychotherapy through public services might be limited in Turkey. The alternative to public services might be private services which are primarily self-pay (Ægisdóttir et al., 2019). Findings from interviews with 20 participants revealed that Turkey's high cost of private psychotherapy[4] was the main barrier for accessing psychotherapy in private settings (Cosan, 2015).

In the feasibility study, there was not an exlusion criterion for therapists regarding which treatment settings that they were working (for the details, see Section 4.5.2). Not having any restriction regarding treatment settings (public versus private) was because of that study focused on recruiting targeted number of therapists and because of need to explore which settings could be feasible for a full RCT of BA-M and what barriers and facilitators exist in these settings.

4.5 PROCEDURE

As mentioned in Section 4.3.1, a convergent parallel group design was applied within a parallel group feasibility study (the details of feasibility study design are explained in Section 4.3.2).

[3] Per 100 000 population in Turkey, the number of psychiatrists is 1.64, of psychologists is 2.54, of mental health nurses is 150.25 and of social workers is 1.64 (WHO, 2018b)

[4] The cost of therapists per session in the feasibility study ranged from 250TL to 450TL (which is equal to about £22 to £39).

At the preparation phase of the feasibility study, ethical approval was obtained from the University of Leeds, Faculty of Medicine and Health (MREC17-098); and from Istanbul Şehir University, Research Ethics Committee.

The feasibility study consisted of eight phases (see). In the preparation phase of the fieldwork – Phase 1 – translation and modification of the BA-M Manual (Mir et al., 2016) and the client self-help booklet (Shabbir et al., 2016) was written. In Phase 2, therapists were recruited and randomly assigned to either a BA-M or CBT group and then attended the relevant training. Phase 3 included recruitment of clients, their assessment in terms of the eligibility criteria for taking part in the study, and the consent process. The delivery of the therapy process was addressed in Phase 4. Phases 5-7 included the data collection and analysis process. The last one – Phase 8 – focused on informing the design of a full RCT of BA-M for the treatment of depressed adults in Turkey. Each phase is explained in details in this section.

4.5.1 Phase 1: Translation and modification

Phase 1 included the translation and modification of the BA-M Manual (hereinafter *the Manual*) and the client self-help booklet (hereinafter *the booklet*). Before the training of the therapists both documents needed to be translated and the cultural differences also needed to be taken into consideration.

A framework for translating an evidence-based intervention from English to Spanish has been developed by Maríñez-Lora et al. (2016) and was used as a guideline for the translation work. This Participatory and Iterative Process for Language Adaptation has 11 steps and is presented in Figure 4.4.

In the current translation work, not all the steps were followed due to time and resource constraints. The steps that have been followed in this study are: 1. Preparation, 2. Forward translation, 3. Review by a Translation Development Group (TDG), 4. Harmonising, 5. Review by an expert, and 6. Harmonising.

Step 1: Preparation

Preparation includes an investigation of developers and publishers; and whether there is a need for permission to translate. Permission from Ghazala Mir who is the project leader for the development of BA-M was obtained to translate the Manual and booklet. The translator – İrem Nur Kaya – is bilingual, had experience in psychology and in translation and a bachelor's

degree in Psychological Counselling. İrem was at the time, a master's student in the Department of Trauma and Disaster Mental Health. The language used for education in both departments is English even though they are located in Turkey. Prior to this, İrem had translated the book by Malik Bedri called the Dilemmas of Muslim Psychologists from English to Turkish *Müslüman Psikologların Çıkmazı* (Bedri, 2018). Eligibility criteria for the TDG were: a good level of English skills and at least one-year experience in clinical settings in mental health.

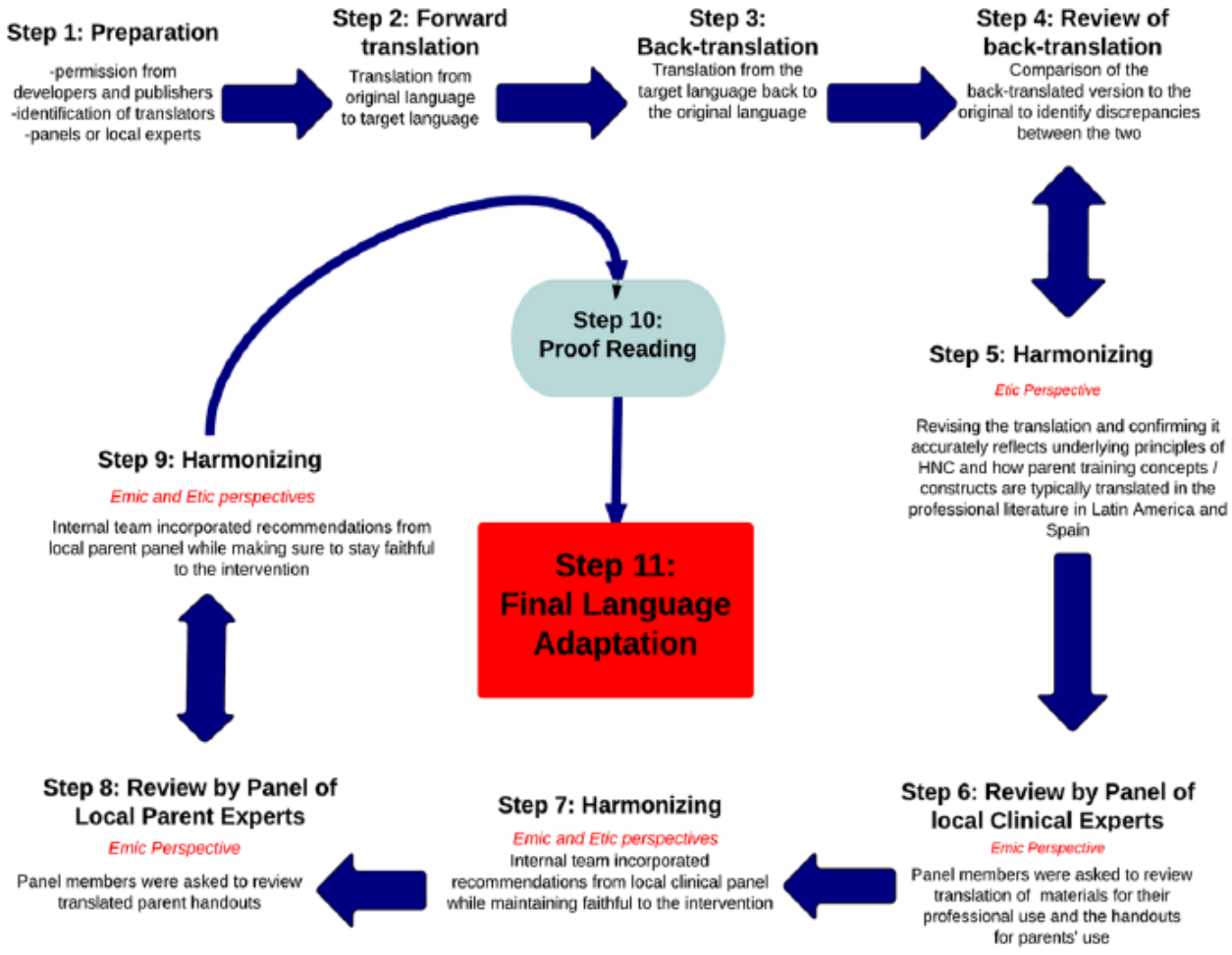


Figure 4.4 Participatory and iterative process framework for language adaptation by Maríñez-Lora et al. (2016).

Step 2: Forward Translating

Translation of the Manual and booklet from English to Turkish was done by Irem Nur Kaya, who was identified as an eligible interpreter, as mentioned above.

Step 3: Review by a Translation Development Group

Cultural appropriateness of the translated documents was discussed and modified with a TDG which involved two master's-level students in clinical psychology, a PhD student in

counselling psychology, two therapists (one had a PhD degree and one was doing an MSc) and a psychiatrist, six people in total, all of whom had a good level of English skills and at least one-year's experience in clinical settings. All of the participants gave consent for their involvement in the TDG and were provided with original and translated versions of the Manual and booklet three weeks before the TDG meeting and were asked to read and compare the documents. They were asked to make comments on their cultural appropriateness in Turkey and on how the Manual could be further developed to fit the Turkish context. The meeting was audio recorded to have reminders in case anything was missed which needed to be used for the modification of the translated documents. Thus, the recordings have only been used as reminders.

Step 4: Harmonising

The therapy resources were modified by using comments from the TDG meeting. The changes were made after subsequent discussion with Ghazala Mir on the feedback.

Step 5: Review by an expert

Dr Elif Çelebi, an experienced mental health practitioner who worked at Istanbul Şehir University and also runs her own private clinic, was asked to review the translated documents.

Step 6: Harmonising

After the review, Dr Çelebi did not ask for any modification and the documents were made ready for use by therapists during fieldwork. Section 6.1 presents what kind of modifications were made in both the Manual and booklet following this step and Section 8.1.3 presents suggested refinements for them based on the qualitative findings of the feasibility study.

4.5.2 Phase 2: Therapist recruitment, randomisation and training

An advertisement related to the study was distributed to therapists' and psychology research groups (via e-list and WhatsApp), mainly by Dr Elif Çelebi and Professor Hakan Türkçapar, who are well-known scholars in the field of psychology and psychiatry respectively. To take part in the study, therapists needed to have training and the theoretical background in at least CBT skills, one-year experience in clinical settings and a good level of English to understand the language during the training. Based on these prerequisites therapists were provided with an information sheet and asked to sign a consent form. Fourteen therapists gave consent to take part in the study.

Randomisation

Those who consented would be randomly allocated to either the CBT group or BA-M (Turkey) group. The two groups of therapists would deliver either BA-M (Turkey) or CBT exclusively to avoid contamination. It was intended to randomly allocate all the recruited therapists (for the details of randomisation, see 5.1). The reason for this intention was to examine whether it would be feasible to randomise therapists in a future trial and what could be potential barriers and facilitators for therapist randomisation.

Random allocation was done on 13th November 2018 by Robert West who is one of the supervisors of the researcher and does not have any interaction with any therapists who took part in the study. He made a random allocation of nine therapists by using Microsoft Excel random sequence number and then sorting them by special value. All therapists were informed by the researcher about their group allocation.

Therapists' training

The therapists who have been allocated to the BA-M group attended three days of BA-M training. Professor David Ekers, the leading UK expert on BA, Dr Ghazala Mir, who led the development of the BA-M approach and Gul Hussain, a mental health practitioner already delivering BA-M in Leeds, trained the therapists on BA-M at the beginning of December 2018. Due to resource constraints, simultaneous translation during the training could not be provided. This would have been preferable to make sure all training was fully understood as it was happening. A translator and the researcher, who is bilingual, were present during the training to provide translation when therapists needed it. To make the training more effective, all intervention group therapists had translated versions of the Manual and booklet during the training. The first one and half days of the training covered an introduction to the BA theoretical model, the evidence base for BA and depression, the rationale for BA techniques including self monitoring, homework assigment, homework review, functional analysis, activity scheduling, dealing with avoidance and rumination, and use of PHQ-9. It also covered what therapists were expected to do during the study. The other half of the training covered the background to the research project of BA-M in the UK, introduction of BA-M Manual, reflexive exercises, the Values Assessment tool, how to involve family in treatment and use the client booklet. It also covered scheduling activation assignments, using the client booklet, activity monitoring and community involvement/collaboration using case studies and role play. (The details of training

programme are presented in Appendix B).

Feedback from the therapists during the training was used to modify the study methods, i.e., using Symptom Checklist (SCL)-90R to identify eligible clients since it was already used by some of them in their usual practice, and collecting PHQ-9 at every session instead of only at the baseline, sixth session, week 12 and 18 of treatment.

Therapists in the CBT group were invited to attend half of the training which included just Behavioural Activation training i.e., not about the adapted version of BA (BA-M). The reason why attendance at half of the training was offered to the CBT group therapists was to motivate them to engage with the study. At the end of the study, the therapists in the BA-M group shared their experience of using BA-M with CBT group therapists in an arranged meeting to feedback their experience of using it.

4.5.3 Phase 3: Client recruitment

The requirement for being an eligible client to take part in this study was to be a depressed Muslim adult who a) does not have bipolar depression or b) is not psychotic or (c) does not have a primary disorder for which empirically supported treatments exist (e.g., PTSD, other anxiety disorders, and borderline personality disorder) unless it is felt that depression should be the immediate focus of treatment, or (d) does not have primary substance abuse or dependence.

As the Symptom Checklist-90 (Revised) Questionnaire (SCL-90-R) is an existing part of the therapists' practice, it was used to decide whether clients were eligible to take part in the study. The therapists helped clients to fill in the SCL-90-R, a 90 item self-report questionnaire that is widely used as a screening tool to identify a range of psychological symptoms (Schmitz et al., 1999, Derogatis and Savitz, 1999). Each of the items is rated based on a five-point Likert scale –ranging from 0 to 4. The questionnaire evaluates nine symptomatic dimensions including depression, somatisation, anxiety, phobic anxiety, hostility, paranoid ideation, psychotism, obsessive-compulsive disorder and interpersonal sensitivity (Schmitz et al., 1999). The Turkish version of SCL-90-R is available and found to be valid and reliable among university students in Turkey (Dağ, 1990). According to Dağ (1990), the results of test-retest reliability of SCL-90-R based on Pearson correlation coefficient for each dimension were: somatisation= 0.75, obsessive compulsive disorder= 0.87, depression= 0.87, anxiety= 0.73, hostility= 0.70, paranoid ideation= 0.73, phobic anxiety= 0.65, psychotism= 0.79, and interpersonal

sensitivity= 0.84. The Croanbach's alpha test for internal validity test was 0.97. In terms of validity, the correlation between depression dimension of SCL-90-R and BDI was 0.82 (Dağ, 1990).

The therapists had SCL-90-R on an Excel sheet with formulas to calculate mean score for each dimension which was developed by Arda Tuna (2004)[5]. The therapists provided the paper version of the SCL-90-R to potential clients and then the therapists filled the scores on to the Excel sheet in order to calculate mean score for each dimension. This was the routine practice for some of the therapists. In the training session, all therapists agreed to use SCL-90-R and considered mean score of 2 as cut-off point. If the mean score was 2 or above for any dimension except depression, the potential for comorbidity was considered.

The therapists decided whether a client was eligible for the study based on the results from SCL-90-R and clinical interview and also demographic questionnaire (for the details, see 4.5.5) at the assessment session. The demographic information was used to assess if clients identified themselves as Muslim, one of the eligibility criteria for the clients to take part in the study.

Once the therapists decided that clients were eligible to take part in the study, they informed them of the research and provided an information sheet. The therapists offered clients the choice to discuss their decision about taking part in the study with the researcher or the therapist. The therapists made it clear that the choice to participate or not would have no influence on the therapeutic relationship. If a client preferred to be referred to the researcher, the researcher would ask whether the client would like to be included in the study and would inform the therapists about the client's decision prior to their next session. If client preferred to discuss their decision about taking part with the therapist, at the next session (i.e., more than 24 hours later), the therapists would ask them whether they would like to be included in the study and take consent from those willing to take part. The therapists were trained on how not to cause coercion when they asked for consent. Since the consent form to take part in the feasibility study did not include consenting to take part in the interview, the researcher contacted the clients who had agreed to their contact details being shared with them in order to be asked about taking part in an interview after their treatment ended. The researcher then asked those clients for additional consent to take part in an interview.

[5] There is not further information regarding this Excel formula sheet, so it is not possible to cite it properly.

Initially, the feasibility study was planned to take six months, however, because of the low recruitment rate in the first six months the study was extended from six months to a year. In order to increase therapists' engagement and clients' recruitment during the course of the study, the therapists were offered a certificate of attendance to the study (for all) and one for the training (for BA-M only) at the end of study, and a therapist who recruited either a new client or has already recruited two clients in the study was acknowledged by presenting their names on the university webpage.

4.5.4 Phase 4: Delivery of the therapy process

As suggested in the BA-M Manual, it was intended for both interventions to contain a minimum of six face-to-face sessions of 50 minutes delivered in individual settings. The therapies were delivered in therapists' clinics. During the fieldwork, a room was provided in Marmara University, for two therapists who asked to have therapy sessions outside of their clinics. There was not an identified maximum number of sessions as it was a feasibility study, and exploring the average number of sessions needed by a client would help to inform the RCT design. The therapists in both groups were required to ask clients to fill in PHQ-9 at each session and if the treatment ended before at the 12th and 18th weeks after the start of the therapy (for the details about PHQ-9, see Section 4.5.5).

Culturally adapted Behavioural Activation (BA-M)

This culturally adapted BA (BA-M) is based on Behavioural Activation (for details on behavioural theories of depression see Section 2.1.4.1, and Behavioural Activation see Section 2.1.5). As explained in Section 1.1, BA-M was developed by Mir *et al.* (2015) to enhance BA therapy by taking account of religion, specifically focusing on Muslim clients. In this study, BA-M is delivered using the translated version of the therapy Manual (Mir et al., 2016) (for the details of translation and modifications of the Manual, see 4.5.1).

BA-M focuses on using behavioural techniques to schedule activities which are consistent with the clients' values and life goals. The BA-M Manual guides therapists on the delivery of the treatment, session by session. The first two sessions aim to include learning about the life story of a client and presenting the depression model of BA –the two circles model – by a therapist (the details regarding the model are presented in Section 6.3.1.1). The client is provided with an opportunity to involve a family member or friend to support the treatment process. From the third session to the end of the sessions, the therapist and the client work on reviewing and

scheduling activities which are consistent with the client's values and life goals. If the client chooses religion as a value and wants to work on it, the therapist introduces the client self-help booklet and then asks to them if they would like to use the booklet in the treatment process, though using the booklet is optional. Sessions included completion of PHQ-9 (for the details, see next section) and scheduling activities or homework. These activities would be based on getting the client active and enjoying aspects of their life. A step by step progress is suggested in the Manual, starting with assigning small – easier – homework by collaborating with the client and then step by step moving to the more difficult but achievable activities.

For more details on BA-M, the English Manual and the client booklet are available on the Leeds University School of Medicine website (n.d.). Currently English, Urdu and Arabic versions of the booklet are available on the aforementioned website, the Turkish version of the booklet and Manual will be added on the website soon.

Cognitive Behavioural Therapy (CBT)

As mentioned in Section 2.1.5, CBT is an evidence-based psychotherapy that is used for the treatment of depression. In CBT the mood of a person is seen as having a direct link with their pattern of behaviours, feelings and thoughts. The main goal of CBT is to help the client to with identification of their negative thoughts and then changing these thoughts with a healthier style of thinking that will lead to certain behaviours and moods. Therefore, changing negative thinking will help clients to change the behaviour patterns which are based on these negative thoughts (Bhat, 2017, Rupke et al., 2006). Changing negative thoughts and behaviours that cause distressing emotions will help to change emotions which are not easy to change directly.

The reasons to choose an evidence-based psychotherapy as a control group, namely CBT, where it is one a commonly used treatment in Turkey and comparison between two active treatments can provide more robust findings compared to having such as a wait-list as a control group (CITE). The therapists in the CBT group were asked to deliver CBT the way they normally delivered it; thus, the delivery of CBT was not based on a specified CBT manual. The only stipulation was on the number of sessions as they would need to have at least six with each client. Their feedback showed that they did usually have more than six sessions to treat a depressed patient. Thus, this requirement was not outside of their normal practice.

Supporting the therapists during the fieldwork process

The therapists in both groups were supported via regular Skype meetings. Support meetings were offered to BA-M and CBT group therapists monthly and bi-monthly respectively. The reason to offer CBT group therapists fewer support meetings was that they already had experience of delivering CBT, whereas BA-M group therapists did not have experience of delivering BA-M, thus they needed more support.

The therapists in the BA-M group had six Skype meetings in which they had peer supervision and also had a chance to ask questions to Ghazala Mir –the developer of BA-M and the main supervisor of this thesis, Gul Hussain – a clinician, or Alastair Cardno – a former clinician and the other supervisor. The researcher and Ghazala and either Alastair or Gul were present in all the meetings. The CBT group therapists had three support meetings in which the researcher and either David Ekers or Alastair Cardno were present. When translation from Turkish to English or from English to Turkish was required, the researcher acted as the translator for both groups. Having a bilingual person in the all meetings helped the therapists to express themselves better.

All the therapists had opportunity to contact the researcher directly via mobile phone or email whenever they needed.

4.5.5 Phase 5: Quantitative data collection and statistical analysis

The primary outcome of this part of the study was recruitment and retention rate of therapists and clients, and the clients' rate of completion of PHQ-9 at the baseline, sixth session, 12 and 18 weeks.

All participants were asked to fill in a demographic questionnaire. There were two demographic questionnaires: one for the therapists and one for the clients. The questionnaires included questions related to age, gender, religious view, perceived religiosity, employment status (only for clients), education level, work experience (only for therapists) and training received (only for therapists). Religiosity was measured based on answers given to the following question: "Please score how religious you feel you are", scores were from 1 to 5: 1 referred to not at all and 5 referred to too much.

Each client was asked to fill in PHQ-9 in each session. Even if the treatments of some clients were terminated before the 12th and 18th sessions, the clients would still be asked to fill it in at

12 and 18 weeks. The questionnaire includes nine items to assess depressive symptoms based on a Likert scale ranging from 0 (not at all) to 3 (nearly every day). The cut off points on PHQ-9 are 5, 10, 15 and 20, corresponding to mild, moderate, moderately severe and severe depression, respectively (Kroenke et al., 2001). This was chosen because it was used in the pilot study (Mir et al., 2015), and it is a commonly used scale with only nine items, which means it takes a short time to fill in (Hinz et al., 2016, Kroenke et al., 2001). It is also a reliable and valid measure of depression (Kroenke et al., 2001). Kroenke et al. (2001) reported that internal reliability of the PHQ-9 was high, with Cronbach's alpha of 0.86 and test-retest reliability was also high with correlation of 0.84. The authors assessed construct validity of PHQ-9 by comparing with the 20 item Short-form General Health Survey and the results showed that the PHQ-9 correlated with mental health (0.73), social functioning (0.52), general health perception (0.55), role functioning (0.43), bodily pain (0.33), and physical functioning (0.37). The Turkish version of PHQ-9 was also found to be reliable, with Cronbach's alpha of 0.84 (Sari et al., 2016)(for the Turkish version of PHQ-9, see Appendix C).

The Turkish version of the scale was used in the study. Filling in PHQ-9 provided information related to the feasibility of the scale for Turkish clients and it was not used as an assessment tool to decide which client was eligible for the study. As mentioned in Section 4.5.3, eligibility of clients was assessed by SCL-90-R, clinical interviews and a demographic questionnaire.

The therapists were provided with a worksheet which could be used to record the number and time of the sessions attended, PHQ-9 scores at each time, the price charged and the reason to end treatment for each client and whether BA-M clients had used the Booklet – and if so, for which sessions.

The potential efficacy of both treatments was assessed as a secondary outcome of the study as the was not designed to investigate the efficacy of the treatments so it is limited in this regard.

Statistical Analysis

The sociodemographic characteristic of the participants was summarised by using means and standard deviations for continuous data, and counts and proportions for categorical data. A chi squared test was used to assess whether clients and therapists in both groups statistically differ from each other in terms of sociodemographic characteristics. Feasibility was evaluated by calculation of recruitment and retention rate and completion of the PHQ-9 rate at specified times and then reporting their percentage. Section 5.1 presents findings regarding recruitment

and retention rate, Section 5.2 presents findings regarding characteristics of participants and Section 5.3 presents findings regarding sessions' attendance and PHQ-9 completion rate.

Independent samples t-tests were used to compare mean PHQ-9 scores of BA-M and CBT group clients at three different time points: baseline, sixth week, and last session. As PHQ-9 scores at the 12th and 18th weeks for most clients were missing, it was not possible to compare mean scores for both groups, so the t-test was not used for the 12th and 18th week (for more details and the findings regarding these tests, see Section 5.4.2). Independent samples t-tests were also used to examine whether there was a difference between BA-M and CBT clients regarding change in their depression scores at five different time periods: baseline to sixth session, baseline to last session, sixth session to last session, and baseline to 12th week (for more details and the findings regarding these tests, see Section 5.4.3).

After conducting several t-tests, the available data were examined by fitting a longitudinal mixed effects model (LMEM) which included different models to examine which one well fitted the data (see Table 5.6). This gave an indication (without a formal test) of anticipated efficacy (Mallinckrodt et al., 2008) which would help in the design of the subsequent definitive cluster RCT. The details of the models and findings regarding these models are presented in Section 5.4.4. One of the reasons to use a mixed effects model in addition to t-tests and as opposed to Analysis of Variance (ANOVA) was that these two methods assume that observations are independent of one another, but this assumption of independence cannot be met by studies that include features such as clients clustered in treatment groups and that rely on longitudinal recordings and involve repeated measurements over time of the same clients (Yu et al., 2021, Aarts et al., 2014), for example, PHQ-9 at every session. Since in the current study, PHQ-9 scores (at each session) were nested within the clients and the clients in turn were nested within the therapists, and PHQ-9 was completed by each client at each session – over time – meaning that observations were not independent of one another. In this case, PHQ-9 scores are organised as clusters of several measurements gathered from single units of analysis (clients), resulting in natural dependency and correlation between observations (Yu et al., 2021). Clients' baseline PHQ-9 scores could be related to their scores at the other time points and the level of improvement could be different for each client. Moreover, clients who were treated by the same therapist form a cluster and each therapist may affect treatment differently, for example, the level of therapists' experience and therapeutic relationship can affect treatment outcome. For example, a client who had a score of 22 on PHQ-9 at the baseline could continue

to have 22 at the next session and 18 at the third session but another client who had a score of 16 on PHQ-9, could have 12 at the second session and 10 at the third session. Clients treated by therapist A may have a better relationship with their therapists compared to clients treated by therapist B, which can have an effect on their treatment outcome. Thus, an analysis which can consider possible variations at the baseline scores and at the level of improvement or change in the PHQ-9 scores between clients, and cluster (therapist) effect would be a better method to use in this study. Since these variations could be taken into account by mixed-effects modelling (Cunnings and Finlayson, 2015), this was used to assess anticipated efficacy of treatments.

The other reason to use a mixed effects model instead of repeated measures of ANOVA was that they do not require a client with missing data to be removed from the model entirely, whereas in the repeated measures of ANOVA this is required (Ma et al., 2012). Considering that in longitudinal studies, missing data are practically unavoidable (Ma et al., 2012), deleting clients' data if there is missing data at some time points may mean having very few clients' data left for analysis, resulting in biased results (Ma et al., 2012). Since a mixed effects model takes into account all available data, it provides more efficient treatment effect estimates (Ma et al., 2012, Cunnings and Finlayson, 2015). Section 5.4.4 presents the details about models used and results of mixed effects models.

4.5.6 Phase 6: Qualitative data collection and analysis

Qualitative data includes field notes and semi-structured interviews with the therapists from both groups and the clients from the BA-M group. Field notes include data from e-mails, WhatsApp texts, phone calls and support meetings with the therapists. Field notes were used in the analysis where they were considered to be useful or necessary. The experience and views of the therapists and clients regarding the feasibility of an RCT and acceptability of BA-M have been explored through semi-structured interviews and field notes.

In semi-structured interviews, a topic guide is used to help a researcher to set an agenda regarding which topics to cover, but each interviewee's responses determine what kind of information is generated regarding those topics and their relative values (Green and Horogood, 2004). Semi-structured interviews were conducted in this study because they provide the researcher with an opportunity to ask open-ended questions she may want to cover and for various themes and subtopics to develop. The topic guides used in this study are modified versions of those used in the pilot study of BA-M (Mir et al., 2015), (Appendix D and E). An

alternative to individual semi-structured interviews could be focus group interviews, which are interviews conducted in group settings (Green and Horogood, 2004). Semi-structured interviews were considered to be more appropriate for the current study as it involves depressed clients and interviews included sensitive topics such as involving religion in treatment, reasons to take part in the study and clients' experience of the treatment. In this case, a focus group situation would be challenging in terms of providing full details of the study for consent, preserving confidentiality and anonymity, and due to possible risk of harm (Sim and Waterfield, 2019), and providing a comfortable environment in which sensitive issues could be freely discussed. In addition, obtaining appropriate consent might be difficult since it is considered as creating appropriate expectations in participants. As the researcher has minimal control over what participants may later share outside of the group, confidentiality and anonymity are potentially problematic. This problem becomes more serious if the group discussion fosters over-disclosure by some members. The discussion of sensitive subjects in a focus group may cause harm since the information shared may lead to such as discrimination, shame and stigmatisation (Sim and Waterfield, 2019).

The aim was to conduct semi-structured interviews with all therapists and eight BA-M group clients because of resource constraints; as well as interview at least one of each therapist's clients. After a client's treatment ended, their therapist asked whether they would be willing to take part in an interview with the researcher. If they said yes, the researcher contacted them and arranged a meeting to conduct the interview. Apart from two clients who were interviewed seven months after the study started, most were interviewed at the end of the fieldwork by the researcher. In total, seven therapists and eight clients from the BA-M group and three therapists from the CBT group were interviewed. Only one therapist from the CBT group did not take part in the interview as they were not available at the time that interviews were conducted.

Qualitative Data Analysis

The qualitative data were analysed by using framework analysis that sits within thematic analysis (Gale et al., 2013). It was developed in the 1980s (Ritchie and Spencer, 1994) and is now widely used in qualitative research (Ritchie et al., 2003) including healthcare research (Gale et al., 2013, Smith and Firth, 2011). It is a matrix based method for managing and synthesizing data (Ritchie et al., 2003). The reason to use framework analysis was that it is a highly structured method and provides detailed guidance on how to perform qualitative data analysis (Ritchie and Spencer, 1994, Ritchie et al., 2003). Moreover, in health research, it is

always required to be explicit about how the data is selected, organised, analysed and interpreted (Green and Horogood, 2004) and it provides this information as it is a highly structured and transparent method (Pope et al., 2000).

Other analysis techniques such as grounded theory were considered for analysing the qualitative data. Grounded theory was developed in the 1960s. Its analysis process includes data gathering, coding, comparing, categorizing, theoretical sampling, developing a core category, and generating a theory (Walker and Myrick, 2006). It is primarily an inductive process but it uses deductive methods within the data gathered (Green and Horogood, 2004). However, this would not be appropriate to analyse the qualitative data since the main aim of grounded theory is to generate a theory (Green and Horogood, 2004) and this study does not aim to do that.

Framework analysis does not align with a particular philosophical worldview (Smith and Firth, 2011) so it can be used in studies that align with pragmatism. It has often been conflated with deductive approaches as it is apparently systematic. Framework analysis, however, can be performed either deductively – themes relate to a predetermined theory or model – or inductively – themes emerge from the data itself, or combination of both depending on research questions because the tool is not dependent on either deductive or inductive thematic analysis (Gale et al., 2013). This gives the opportunity to explore a priori and emergent themes (Hind et al., 2010). Although theme identification in this study was primarily and mainly deductive, as a topic guide used in the interviews guided by existing theories that were mentioned in the section of the conceptual framework, it was also inductive as the study was open to any themes emerging from the data itself. Framework analysis with a step-by-step guidance is conducted considering the structured guidance, to make the analysis more manageable within a mixed methods study, and because of the importance of transparency in healthcare research. Both interviews with the clients and the therapists were analysed by using this framework analysis method. Then, QSR International's NVivo 12 qualitative data analysis software was used to store and code the data with the framework developed.

Procedures for Framework Analysis

Stage1: Transcription

All audio records of the interviews were transcribed verbatim. All transcripts were checked for accuracy by the research student (EA) listening to the audio records and then the transcriptions

were anonymised. The transcriptions of four interviews which were conducted with one CBT therapist, one BA-M therapist and two clients were translated from Turkish to English by a translator. The translation helped the supervisors to check the process of analysis. All transcriptions were uploaded to NVivo 12.

Stage 2: Familiarisation with the interviews

A researcher must become familiar with and gain an overview of the data collected before beginning the process of sifting and sorting it (Ritchie and Spencer, 1994). All interviews were conducted by the research student (EA), which increased the familiarity with the interviews. The transcriptions were repeatedly read by EA. The translated transcripts were also read by the main supervisor (GM). All the transcriptions were read, notes were taken on initial impressions and potentially important quotes were highlighted by EA.

Stage 3: Coding

This stage was used to label (code) the data. Coding was used to classify the data, which gives an opportunity to make a comparison with the rest of the data (Gale et al., 2013). After the familiarisation stage, the translated interviews were coded. Similar codes were grouped together to form a broader group or theme (Smith and Firth, 2011)

Stage 4: Development of a working analytical framework

After the initial coding, the research group met and discussed the codes applied to decide which to apply to the rest of the data (Gale et al., 2013). Two out of four translated transcripts were labelled (coded) by EA and GM independently. This was done before having a meeting to discuss codes and develop an initial framework. After the discussion an initial framework was developed.

The initial framework was applied to all the translated transcripts (for indexing) by EA and GM. A meeting was held to compare the indexed data: whether they assigned the same quotations to the same codes, and to discuss whether the initial framework needs to be further developed. After the discussion an agreed framework was developed. (See Table 4.1)

Table 4.1 The coding framework used in the qualitative analysis

1. **The acceptability of the study**
- 1.1 recruitment
  - 1.1.1 therapists
  - 1.1.2 clients
  - 1.1.3 obstacles or facilitators
  - 1.1.4 reasons to decline participation
    - 1.1.4.1 clients
    - 1.1.4.2 therapists
- 1.2 randomisation of the therapists
- 1.3 first feelings or expectations
- 1.4 information
- 1.5 motivation

2. Treatment as usual
- 2.1 CBT
- 2.2 combination of approaches

3. Therapists-client relationship
- 3.1 positive relationship
- 3.2 opportunity to describe experience
- 3.3 therapist understanding
- 3.4 similar or dissimilar background
  - 3.4.1 importance of religious background
- 3.5 openness to discuss religion

4. BA therapeutic tools
- 4.1 values assessment
  - 4.1.1 positive view
  - 4.1.2 negative view
  - 4.1.3 importance of therapists knowing values
    - 4.1.3.1 how important religion is
- 4.2 Two Circle Model
  - 4.2.1 positive views
  - 4.2.2 concern about the generalizability
- 4.3 Client Self-help Booklet
  - 4.3.1 whether its function explained
  - 4.3.2 timing to give the booklet
  - 4.3.3 experiences or views
    - 4.3.3.1 therapists
    - 4.3.3.2 clients
  - 4.3.4 relevance of the booklet
  - 4.3.5 acceptability of the client booklet
    - 4.3.5.1 concerns
  - 4.3.6 suggested improvements
- 4.4 Activity scheduling or homework
  - 4.4.1 appropriate (in-line with values)

4.4.2 what makes them easy or difficult

5. Comparison of Treatments
- 5.1 similarities
- 5.2 differences

6. The acceptability of BA-M
- 6.1 views on BA
  - 6.1.1 positive
  - 6.1.2 negative
- 6.10 suggested modifications for BA-M
- 6.2 change in views
- 6.3 focus on behaviour
- 6.4 instruction vs exploration
- 6.5 views or experience on involving a family member or close friend in therapy
  - 6.5.1 positive
  - 6.5.2 negative
- 6.6 feelings at the end of therapy
- 6.7 appropriate to use in Turkey
- 6.8 feelings towards number of sessions attended
  - 6.8.1 positive
  - 6.8.2 negative
  - 6.8.3 experience in rearranging sessions
- 6.9 Demand to continue to use the BA-M

7. The acceptability of training
- 7.1 language of delivery
- 7.2 appropriateness of examples

7.3 satisfaction with content

8.. The acceptability of attention to religion in therapy
- 8.1 positive views or experiences
- 8.2 negative views or experiences
- 8.3 concerns
- 8.4 change in the views after the study
- 8.5 perceived religiosity
- 8.6 the way religion used
  - 8.6.1 how raised during session

8.7 suggestions on how to use religious teachings in therapy

9. Feasibility of the study design
- 9.1 identification of eligible clients
- 9.2 usage of depression scales
  - 9.2.1 usual practice
  - 9.2.2 views on using or completing PHQ-9

9.3 views on the study process

10. Suggestions for future trial
- 10.1 how to increase recruitment and retention
- 10.2 therapist motivation
  - 10.2.1 reasons for low motivation
    - -performance anxiety

10.3 how to keep engaged

Stage 5: Indexing

Indexing is the systematic application of the agreed framework on the whole dataset (Ritchie and Spencer, 1994). The agreed framework was applied to the all transcripts by EA.

Stage 6: Charting

Charting refers to rearranging data according to appropriate themes by lifting them from their

original context (Ritchie and Spencer, 1994). It involves summarizing the data by codes or themes for each participant. It should include reference to quotations which are illustrative or interesting (Gale et al., 2013).

Stage 7: Interpreting the data

After charting all the data according to themes, key characteristics were identified and the data were interpreted as a whole. Broader themes were identified at this stage (for the themes developed see Figure 6.1 and Figure 6.2). The findings from the qualitative part of this study are presented in CHAPTER 6.

4.5.7 Phase 7: Mixed methods data synthesis procedure

As mentioned above, quantitative and qualitative data were analysed separately until the interpretation stage. Both strands contributed to answering the research questions based on acceptability of BA-M and feasibility of conducting a future RCT of BA-M for the treatment of depressed adults in Turkey. Quantitative and qualitative findings were integrated, and then the combined findings were interpreted. Integrating these findings helped to have a better understanding of the feasibility of a future RCT and acceptability of BA-M. This section presents the plan for integration and interpretation of the quantitative and qualitative findings.

Regarding acceptability of BA-M, quantitative findings provided information about the retention rate, whereas qualitative findings provided information about how clients felt about BA-M, how clients felt at the end of treatment and whether they were satisfied with the treatment. Integrating data helped to examine whether quantitative findings were convergent with the qualitative findings and to understand acceptability and potential efficacy of BA-M.

Regarding the feasibility of conducting an RCT of BA-M, (1) quantitative findings provided information about therapist randomisation process and retention rate, whereas qualitative findings provided information about how therapists felt about randomisation and why any dropped out. Integrating this data helped to understand whether it would be feasible to randomise therapists in a future trial and how feasibility of randomisation could be improved. (2) Quantitative findings provided information about whether progression criterion regarding recruitment rate was met, whereas qualitative findings provided information about whether recruitment practices worked in the field, whether therapists were willing to recruit clients, what factors were affecting recruitment and how recruitment could be improved in a future trial. Qualitative findings were used to explore factors that affected the recruitment rate, which

in turn, helped to assess whether it would be feasible to recruit therapists and clients in a future RCT. (3) Quantitative findings provided information about average number of sessions attended, whereas qualitative findings provided information about how clients felt about the number of sessions they attended. Integrating these findings helped to estimate how many sessions would be required in a future trial. (4) Quantitative findings provided information about PHQ-9 completion rate at every session and at 12 and 18 weeks, whereas qualitative findings provided information about how clients felt about filling PHQ-9 at every session, what clients and therapists thought about filling or asking to fill PHQ-9, what were the barriers and facilitators to complete PHQ-9. Integrating these findings help examine the feasibility of using PHQ-9, whether other measurements would be necessary, and how the data completion rate could be improved in a future trial.

4.5.8 Phase 8: Informing the design of a future RCT

Findings that could inform design of a future RCT of BA-M for depressed adults in Turkey are identified in Chapter 5, Chapter 6 and Chapter 7, and implications for a future study are discussed CHAPTER 8.

4.6 REFLEXIVITY

A researcher's reflexivity entails critical thinking about how their worldview, position, opinions and beliefs may shape their decisions regarding, e.g. research questions, methods and how to interpret data. Reflexivity is an ongoing process of explicitly disclosing potential factors that may have affected decision-making and interpretation during the research process, recognising that the researcher's position and biography connect with the perception of experiences in a research area (Finlay, 2002, Olaghere, 2022, Walker et al., 2013). Reflexivity was maintained in this thesis through an awareness of my role in the research processes and reflection on my assumptions and their impact on these processes. Being transparent about these could improve the study's usability, credibility and trustworthiness (De Loo and Lowe, 2011). The following paragraphs outline some of my beliefs and assumptions and my personal experiences related to this research area. I have also outlined some reflexive statements, which are boxed off, in other sections (see, Sections 6.2.8, 6.3.1.5, 6.3.2.1).

I observed the effect of secularism when I lived in Turkey, especially in terms of how it affected clinical practice and daily life. For example, I listened to the stories of my close friends, who I would describe as religious, who had psychotherapy in Turkey. These stories included how the

religious views of people were undermined in clinical practice. As a result, I became aware of some of the reasons why religious people would avoid psychotherapy. These included fear of being judged because of their religious views and also thinking that the reason for having some mental health issues was the result of weaknesses in faith. While I was influenced by these stories when I chose this research topic, I also examined what was happening in the field of psychology in Turkey more broadly and how psychology and religion were considered as alternatives to each other. The aim of this wider reading was to help me put the accounts I had heard from friends into wider context so as not to be overly influenced by them.

At the start of this research, I assumed that there might be a need for a culturally adapted psychotherapy (CAP) for the treatment of depression in Turkey. My initial literature review was in line with my assumption since I did not find any CAP for the treatment of depressed adults in Turkey. My assumption could have potentially shaped my initial literature review, e.g. by limiting my search to certain websites and search terms, but I then conducted a systematic review (SR) on CAPs for the treatment of depressed adults, which confirmed that my initial assumptions were correct. In order to minimise potential biases and assumptions regarding the need for a CAP in Turkey, the methods used for SR were mostly based on a previously conducted SR; in addition to the other databases, I searched two of the most commonly used Turkish databases and included words targeting people in Turkey and Turkish people in general and retrieved studies were partly double screened and reviewed by my supervisors (see 3.2). These procedures increased the validity and rigour of my study.

My assumptions could also have potentially affected the qualitative interviews and my interpretation of these. My body language could have showed what I expected to hear from the participants or I could unconsciously have worded questions in a way that reflected the answers I expected to hear. Using previously developed topic guides, conducting semi-structured interviews (see 4.5.6) and aiming to be aware of my assumptions while I was conducting the interviews were measures taken to help protect the interview data against my assumptions. Double coding interviews, using a previously developed coding framework, being open to emerging themes at the analyses stage of interviews and discussing the themes and my interpretations with my supervisors helped me to address and challenge my views throughout the study.

CHAPTER 5
FEASIBILITY STUDY: QUANTITATIVE FINDINGS

This chapter reports findings from the quantitative data collected during the feasibility study. It starts by reporting data on recruitment and retention of the participants in each group, then presents baseline characteristics of the participants, data on session attendance and PHQ-9 completion of clients and change in outcome measure for them.

Before the fieldwork some progression criteria were determined to give a guide to decide whether it would be feasible to conduct a full RCT of BA-M for depressed adults in Turkey (see Section 4.3.2). The progression criteria for a full RCT to be considered were:

1) to recruit at least (a) 10 therapists and (b) 30 clients within six months

2) to retain 60% of clients to completion of six sessions of BA-M therapy

3) PHQ-9 should be completed by at least 80% of clients at baseline, 60% at six weeks, 50% at 12 weeks and 40% at 18 weeks.

This chapter examines whether the progression criteria were met and if not, what were the possible reasons for that and whether some changes in the study could make a future trial feasible.

5.1 RECRUITMENT AND RETENTION

The recruitment period was two months (September–November 2018) for the therapists, and was extended to a year (January 2019–January 2020) for the clients because the therapists needed more time. Many therapists contacted the researcher via email to express their interest to take part in the study after announcement of the study on different platforms, i.e. social media and WhatsApp lists, by Dr Elif Çelebi and Prof Hakan Türkçapar. Those therapists who met the eligibility criteria (see 4.5.2) were provided with an information sheet and asked to take part in the study. Seventeen of them were eligible and 14 gave consent to take part in the study. The details of therapist recruitment and randomisation flow can be seen in Figure 5.1. Three therapists initially willing to take part in the study dropped out before random allocation and before giving consent, as one had family responsibilities and the other two would be away from the study site –Istanbul– for more than two months. One of them suggested taking part in the study by delivering treatment online, but delivery of online therapy was not considered appropriate because of possible different effects between it and face-to-face therapy.

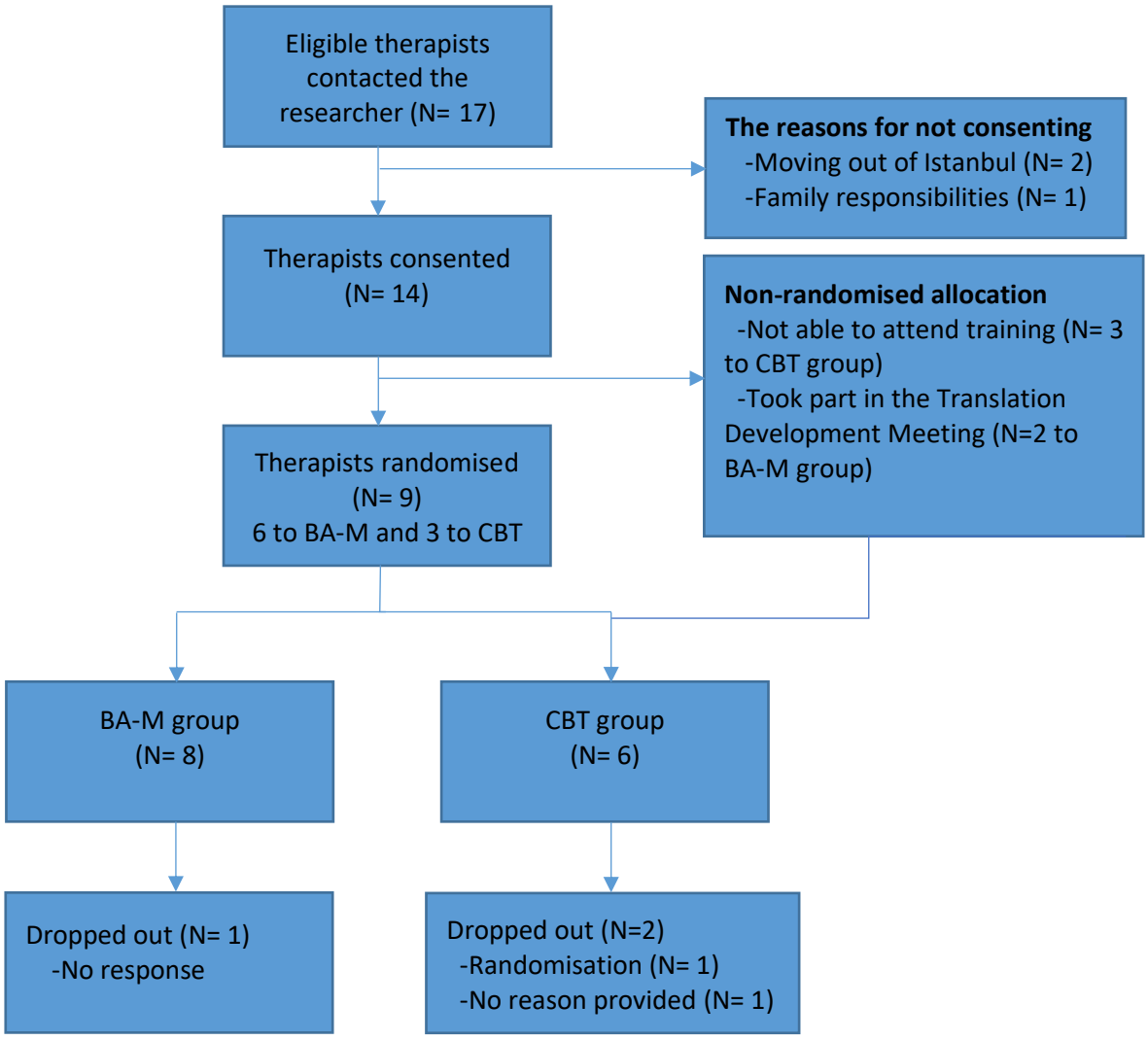


Figure 5.1 Flowchart of therapist recruitment and randomisation

It was intended to randomly allocate therapists. Only nine therapists out of 14, however, were randomly allocated. Three out of nine were randomly allocated to CBT and the rest were randomly allocated to the BA-M group. Five therapists were not randomly allocated since three of them chose to be in the CBT group because of not being able to attend the training for three days. The other two therapists were not randomly allocated because they had previously taken part in the TDG, meaning that they had read the Manual and client self-help booklet and so there was an issue of potential confounding affect if they were randomly allocated to CBT group. One of the therapists who was assigned to the CBT group dropped out, just after being informed about their group allocation. The feasibility of therapist randomisation is discussed in Section 8.2.2.

The number and details of therapists and clients recruited and then dropped out are presented in Table 5.1. One of the progression criteria (1) was to recruit at least ten therapists and 30

clients within six months. The recruitment of clients was initially planned to take six months as the therapists said they could each recruit three clients in six months. Although more than ten therapists were recruited, unfortunately, only ten clients had been recruited by the end of the first six months of the study. Therefore, the study period was extended for six more months – until January 2020 – to increase the number of clients recruited. As the recruitment target for clients was not reached in six months, in order to increase therapist engagement and client recruitment, the therapists' contribution to the study was acknowledged on the University of Leeds website if they had already recruited two clients or recruited a new one; and they were also informed they would have a certificate of participation at the end of the study. This, in turn, helped to increase client recruitment.

Table 5.1 The number of therapists and clients recruited and who dropped out (with percentages)

Group	Therapists			Clients		
	BA-M	**CBT**	**Total**	**BA-M**	**CBT**	**Total**
Recruited	8	6	14	14	8	22
Dropped out	1 (12.5%)	2 (33.3%)	3 (21.4%)	3 (21.4%)	2 (25%)	5 (22.7%)

Fourteen therapists and 23 clients were recruited. During the analysis stage, it became clear that one of the clients recruited to CBT group did not identify herself as Muslim. As one of the eligibility criteria for clients in the current study was being Muslim, that client was removed from the analyses. The rate of client recruitment per therapist was low as it was two clients per therapist, considering that 11 therapists remained in the study and 22 clients were recruited in total. About 79% of the therapists and 77% of the clients were retained during the course of the study. One therapist (12.5%) and three clients (21.4%) from the BA-M group, and two therapists (33.3%) and two clients (25%) from the CBT group dropped out of the study. One client from the BA-M group was classed as having 'dropped out', even though she continued to fill in PHQ-9 after ending the treatment, because she only attended four sessions and the requirement in the study was to attend at least six. Similarly, one CBT client was classed as having dropped out even though she felt well enough to stop treatment after attending five sessions. The other two BA-M clients dropped out without giving an explanation. The therapist of one client from the CBT group decided to continue their treatment with another approach. One BA-M therapist and one CBT therapist dropped out from the study without explanation

and a second CBT therapist dropped out because of objections to randomisation. The therapists who dropped out did not recruit any clients. The results of the analysis in this chapter is based on all the clients and only the remaining therapists.

The therapists approached 35[6] eligible clients, and 22 of them agreed to take part in the study, meaning that the recruitment rate for clients was 62.8%. Therapists were not asked to record the number of clients who were assessed in terms of eligibility. Thus, this number is not known.

Each therapist was required to recruit at least three clients. One CBT and three BA-M therapists recruited three clients, two BA-M and two CBT therapists recruited two clients, one BA-M and one CBT therapist recruited one client, and one BA-M and one CBT therapist (who dropped out) did not recruit any clients. The CBT therapist who recruited one client, initially recruited two clients but as mentioned above, one of the clients did not identify herself as Muslim, it was considered that she recruited only one client.

The progression criterion (1a) to recruit at least 10 therapists was met as 14 therapists were recruited. Some issues were challenging in recruiting eligible clients, so the progression criterion (1b) to recruit at least 30 clients was not met in the study as only 22 eligible clients were recruited. The potential reasons for these issues and how to overcome them in a future trial are presented in Section 6.2 by the qualitative findings and discussed in depth in Section 8.2.3.

5.2 CHARACTERISTICS OF THE PARTICIPANTS

Characteristics of the participants at baseline are presented in this section. All therapists' demographic characteristics were collected from the demographic questionnaire, with only three missing points which were the religious orientation of two therapists (one of them was from the BA-M group) and religiosity score of one therapist from the CBT group. Table 5.2 presents characteristics of the therapists in both groups. For group comparison p values, a Chi squared test (with continuity correction) was used for categorical variables and t-tests were used for continuous variables.

[6] It could be 34 as one of the therapists was not sure whether she had approached three or four potential clients.

Table 5.2 Characteristics of the therapists

	BA-M	CBT	p value
n	7	4	
Age (mean, SD)	36.00 (6.06)	36.00 (4.08)	1.000
Gender (n, %)			0.406
Female	4 (57.1)	4 (100)	
Male	3 (42.9)	0 (0.0)	
Ethnicity (n, %)			1.000
Kurdish/Other	1 (14.3)	1 (25)	
Turkish	6 (85.7)	3 (75)	
Religious Orientation (n, %)			1.000
Muslim	5 (83.3)	3 (100)	
No-religion	1 (16.7)	0 (0.0)	
Religiosity (n, %)			0.736
1	1 (14.3)	0 (0.0)	
3	1 (14.3)	0 (0.0)	
4	4 (57.1)	2 (66.7)	
5	1 (14.3)	1 (33.3)	
Education Level (n, %)			0.953
PhD	2 (28.6)	2 (50)	
Undergraduate/Master's	5 (71.4)	2 (50)	
Years of experience (n, %)			1.000
3 to 5	2 (28.6)	1 (25)	
5+	5 (71.4)	3 (75)	

n: number, SD: standard deviation

Most of the therapists were female, had an average age of 36 and were Turkish. All males were in the BA-M group. Most of the therapists identified themselves as Muslim except one non-believer in the BA-M group and two therapists did not report their religious orientation. Religiosity score of the most therapists were more than 3 (scoring this from 1 to 5 with 5 being the highest), indicating they felt quite religious. Most of them had an undergraduate or master's degree and had more than five years of experience in clinical psychology. There was little evidence of any imbalance between the therapists from the CBT and BA-M groups at the baseline, however, among the BA-M therapists, there were more males, Turkish, non-believer (though just one therapist) and lower education levels, although no measures were seen to be statistically significant at the 5% level.

All clients' demographic characteristics were collected from the demographic questionnaire, with only one missing score which was the religiosity score of one client from the CBT group. Table 5.3 presents baseline demographic characteristics and PHQ-9 scores of clients in both groups.

Table 5.3 Baseline Characteristics of the Clients

	BA-M	CBT	p value
n	14	8	
Age (mean, SD)	28.79 (7.62)	30 (8.35)	0.732
Gender (n, %)			0.445
Female	11 (78.6)	8 (100.0)	
Male	3 (21.4)	0 (0.0)	
Ethnicity (n, %)			1.000
Kurdish	2 (14.3)	1 (12.5)	
Turkish	12 (85.7)	7 (87.5)	
Muslim (n, %)			
Yes	14 (100)	8 (100)	
Religiosity (n, %)			0.330
Missing	0 (0.0)	1 (12.5)	
2	1 (7.1)	1 (12.5)	
3	6 (42.9)	1 (12.5)	
4	6 (42.9)	3 (37.5)	
5	1 (7.1)	2 (25.0)	
Education level (n, %)			1.000
High	10 (71.4)	5 (62.5)	
Low/medium	4 (28.6)	3 (37.5)	
Medication used (n, %)			1.000
No	13 (92.9)	7 (87.5)	
Yes	1 (7.1)	1 (12.5)	
Occupation (n, %)			1.000
Employed/student	10 (71.4)	5 (62.5)	
Unemployed/housewife	4 (28.6)	3 (37.5)	
BaselinePHQ-9 (mean, SD)	16.69 (4.75)	15.12 (3.64)	0.435

n: number, SD: standard deviation, high education: undergraduate degree or above, Low/medium education: primary or high school.

Most of the clients were female and Turkish. There were males (n=3) only in the BA-M group. The clients from both groups had an average age of 28 and 30, respectively. All clients identified themselves as Muslim, which was an eligibility criterion for clients. Similar to the therapists most of the clients chose 3 or more on the religiosity question. Most had a high education level – the proportion was higher in BA-M group – and did not use any antidepressant medication. Most of them were either students or employed, the proportion was higher in the BA-M group. The mean PHQ-9 score at baseline for the BA-M group was 16.69 (*SD*= 4.75), which was similar to the CBT group (*M*=15.12, *SD*= 3.64). There was little evidence of any imbalance between the clients from the CBT and BA-M groups at baseline, since no measures were seen to be statistically significant at the 5% level.

In order to assess whether there was evidence of any imbalance between the clients who used the booklet versus those who did not, in terms of baseline characteristics, the data related to baseline characteristics of the clients in the BA-M group was stratified by the usage of the booklet (see Table 5.4).

Table 5.4 Characteristics of BA-M clients who used the booklet versus those who did not

	Used	Not used	p value
n	5	9	
Age (mean, SD)	30.00 (10.70)	28.11 (5.97)	0.675
Gender (n, %)			1.000
Female	4 (80.0)	7 (77.8)	
Male	1 (20.0)	2 (22.2)	
Ethnicity (n, %)			1.000
Kurdish	1 (20.0)	1 (11.1)	
Turkish	4 (80.0)	8 (88.9)	
Muslim (n, %)	5 (100.0)	9 (100.0)	NA
Religiosity (n, %)			0.207
2	1 (20.0)	0 (0.0)	
3	1 (20.0)	5 (55.6)	
4	2 (40.0)	4 (44.4)	
5	1 (20.0)	0 (0.0)	
Education level (n, %)			1.000
High	4 (80.0)	6 (66.7)	
Low/medium	1 (20.0)	3 (33.3)	
Medication used (n, %)			1.000
No	5 (100.0)	8 (88.9)	
Yes	0 (0.0)	1 (11.1)	
Occupation (n, %)			0.930
Employed/student	3 (60.0)	7 (77.8)	
Unemployed/housewife	2 (40.0)	2 (22.2)	
Dropped out (n, %)			1.000
No	4 (80.0)	7 (77.8)	
Yes	1 (20.0)	2 (22.2)	
BaselinePHQ-9 (mean, SD)	13.80 (1.48)	18.50 (5.26)	0.081

n: number, SD: standard deviation

As seen in Table 5.4, although there was a trend towards a higher level of education and lower baseline PHQ-9 score in those who used the booklet, there was little evidence of any imbalance between the clients who did and did not use the booklet at baseline since no measures were seen to be statistically significant at the 5% level.

5.3 SESSION ATTENDANCE AND PHQ-9 COMPLETION

The minimum number of sessions was identified as six for both groups and there was not a criterion for the maximum number of sessions as it was aimed to determine how many sessions

on average would be sufficient per client in a future trial. The therapists were required to collect PHQ-9 at each session but progression criteria for the feasibility study was based on completion of PHQ-9 at baseline, the sixth session and 12th and 18th week even if treatment terminated before these weeks; PHQ-9 scores at these time points and the number of sessions attended by each client are presented in Table 5.5.

Table 5.5 PHQ-9 scores at baseline, sixth session, 12th week and 18th week, and number of sessions attended by each client

Group and ID	Baseline	Sixth session	12th week	18th week	Last session	Total number of sessions
BA-1	19	8	missing	missing	5	9
BA-2	24	10	missing	missing	5	9
BA-3	21	10	missing	missing	2	10
BA-4	missing	5	missing	missing	5	6
BA-5	22	17	4	19	3	10
BA-6	7	6	missing	missing	4	8
BA-7	14	3	1	18	4	18
BA-8	13	4	2	1	4	7
BA-9	16	missing	missing	missing	12	2*
BA-10	18	11	6	10	5	10
BA-11	14	missing	6	1	14	4*
BA-12	16	12	7	7	2	13
BA-13	21	23	21	missing	21	13
BA-14	12	missing	missing	missing	10	2*
CBT-1	15	9	missing	missing	4	10
CBT-2	16	16	missing	missing	16	6
CBT-3	12	missing	missing	missing	5	5*
CBT-4	15	11	14	missing	7	13
CBT-5	17	5	8	missing	8	14
CBT-6	16	11	10	missing	5	11
CBT-7	20	9	missing	missing	6	8
CBT-8	8	missing	missing	missing	5	2*
Percentage of data gathered (Total)	95.45%	77.27%	45.45%	27.27%	100%	
BA-M	92%	78%	50%	42%		
CBT	100%	75%	37.5%	0%		

*shows which clients dropped out (yellow row from the BA-M and orange row from CBT group)

Note 1: As presented in Table 5.5, two clients –BA 6 and CBT 8 – had PHQ-9 scores which are lower than the depression threshold of 10. They should not be considered as not meeting the eligibility criterion for being depressed since eligibility was assessed based on SCL-90-R and clinical interviews, and were not based on PHQ-9 scores.

Note 2: As presented in Table 5.5, BA-11 was categorised as dropped out since she attended only four sessions although she continued to complete PHQ-9 at week 12 and 18. CBT-3 was also categorised as dropped-out since she attended only five sessions although she recovered from depression. This was because of having a criterion of attending at least six sessions. The PHQ-9 scores of both clients were kept in the quantitative analysis since they did not ask to withdraw from the study.

As presented in Table 5.5, 11 (78.5%) out of 14 clients from the BA-M group and six (75%) out of eight clients from the CBT group completed at least six sessions. This means that the progression criterion (2) to retain 60% of clients to completion of six sessions of BA-M was met. The average and median number of sessions attended was 8.6 and 9 in both groups, respectively.

Another progression criterion (3) was that PHQ-9 should be completed by at least 80% of clients at baseline, 60% of the clients at six weeks, 50% of the clients at 12 weeks and 40% of clients at 18 weeks. As presented at the bottom of Table 5.5, this criterion was met for the baseline and six weeks, unfortunately, it was not met for 12 and 18 weeks. A possible reason for this issue may be that the treatment of some clients was ended at a time close to the end of study but before the 12th and 18th week of their treatment. Possible reasons for this issue are explored with the qualitative data and presented in the Discussion Chapter (see Section 8.2.5).

5.4 CHANGE IN DEPRESSION SCORES

Findings regarding the primary outcome – recruitment and retention rate and completion of PHQ-9 rate at four different time points are presented in the previous sections of this chapter. This section presents depression scores (measured by PHQ-9) and change in depression scores. It starts with two scatter plots to show depression scores by session. It, then, reports results from independent t-tests for three different time points, independent t-tests for change in depression score and multi-level analyses.

These analyses were conducted by considering the data as if it was from a definitive trial. The aim is to show how data can be analysed in a future trial. Potential efficacy of both treatments was assessed as a *secondary outcome* of the study. However, as the study was not designed to investigate the efficacy of the treatments, so it is limited in this regard.

PHQ-9 scores were recorded as follow-up data for most of the clients (N=17) at the 12th and 18th week and for four clients at the 18th week (see Table 5.5). Only for one client, PHQ-9 scores at the 18th week was post-treatment data, not follow-up data (for the details of the number of sessions attended by each client, see Table 5.5). This makes the analysis complicated so this issue needs to be considered when interpreting the results in this chapter.

5.4.1 Depression scores over time

A 'spaghetti' plot that was stratified by groups was produced to show changes and mean changes in PHQ-9 scores in both groups over time (see Figure 5.2). Each black line refers to the PHQ-9 score of a client over time and triangles show the mean change over time for each group. The plot only includes PHQ-9 scores for the sessions attended, thus it does not include follow-up data. This is because of that for some clients, 12 and 18 week was within their treatment period but for others these were follow-up data. In order to prevent any confusion because of that issue, only the data from sessions attended were used in the plot below.

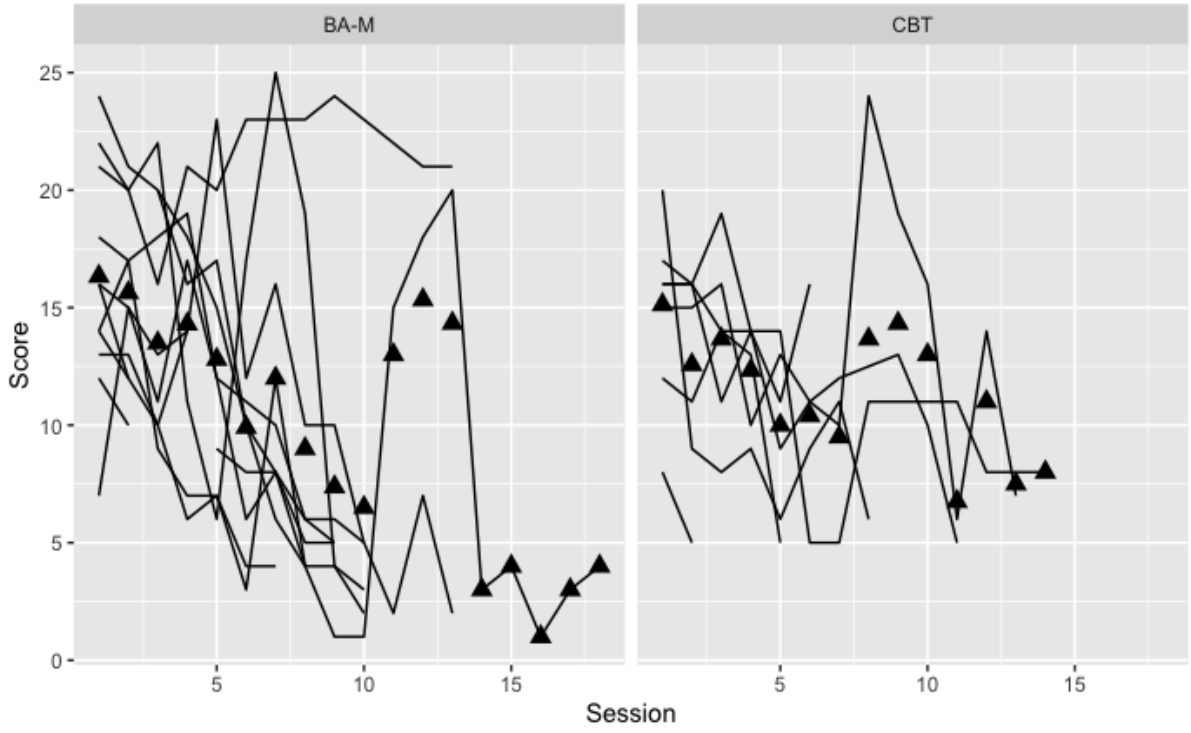


Figure 5.2 Change and mean change (triangles) in PHQ-9 scores for the clients in both groups by session

Figure 5.2 shows that PHQ-9 scores decreased with each session for both groups, and the relationship appears to be linear at least for the first eight sessions. The figure also shows that the availability of PHQ-9 scores of clients in both groups was high for the first eight sessions,

which is in line with average number of sessions attended, which was 8.6 (for the details, see 5.3).

5.4.2 Independent samples t-tests for three different time points

Independent samples t-tests were used to compare mean PHQ-9 scores of the BA-M and CBT group clients at three different time points: baseline, sixth week, and last session. As PHQ-9 scores at 12th week and 18th week for clients were missing, it was not possible to compare mean scores for both groups, so a t-test was not used for the 12th and 18th week.

5.4.2.1 Baseline

When a t-test was used to compare mean PHQ-9 scores at the baseline for BA-M and CBT group clients, the mean score for the BA-M group was 16.7(*SD*=4.75) whereas the mean PHQ-9 score for the CBT group was 15.1(*SD*=3.64). There was no extreme outlier in the data. As the p value of Levene's test was not significant (p=0.27), suggesting that there was not a significant difference between the variance of the two groups. Therefore, a student t-test was used as it assumes the equality of variance. A student two-samples t-test showed that the difference was not statistically significant, t(19) = 0.8, p=0.43, d=0.358 (see Figure 5.3); where, t(19) is shorthand notation for a student t-statistic that has 19 degrees of freedom. This means that there was not a statistically significant imbalance between clients at the baseline of the study.

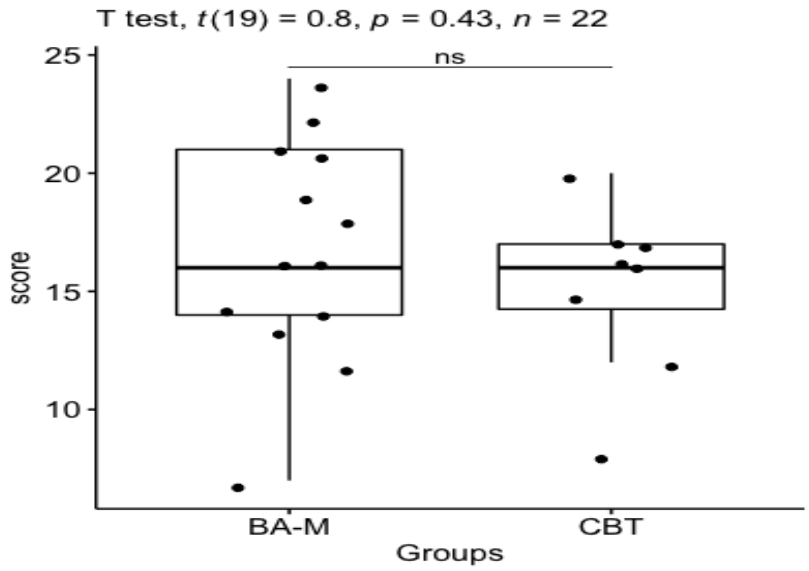


Figure 5.3 Result of t-test for baseline scores for both groups with a plot

Note: The middle horizontal lines in the boxplot show the median value for each group. The

maximum and minimum PHQ-9 scores, which were in line with usual observations are shown with upper and lower end of the vertical lines, respectively.

5.4.2.2 Sixth session

The PHQ-9 scores for the sixth session were available for 11 clients from the BA-M group and six clients from the CBT group. Thus, the t-test is based on the available data. When a t-test was used to compare mean PHQ-9 scores at the sixth session for both groups' clients, the mean score for the BA-M group was 9.91(*SD*=5.94) whereas that for the CBT group was 10.7 (*SD*=3.62). There was no extreme outlier. As the p value of Levene's test was not significant (p=0.29), suggesting that there was not a significant difference between the variance of the two groups. Therefore, a student t-test was used as it assumes the equality of variance. A student two-samples t-test showed that the difference was not statistically significant, t(15)= –0.28, p=0.78, d= –0.14 (see Figure 5.4), meaning that there was no statistically significant difference between mean scores of PHQ-9 for the clients of both groups at the sixth session.

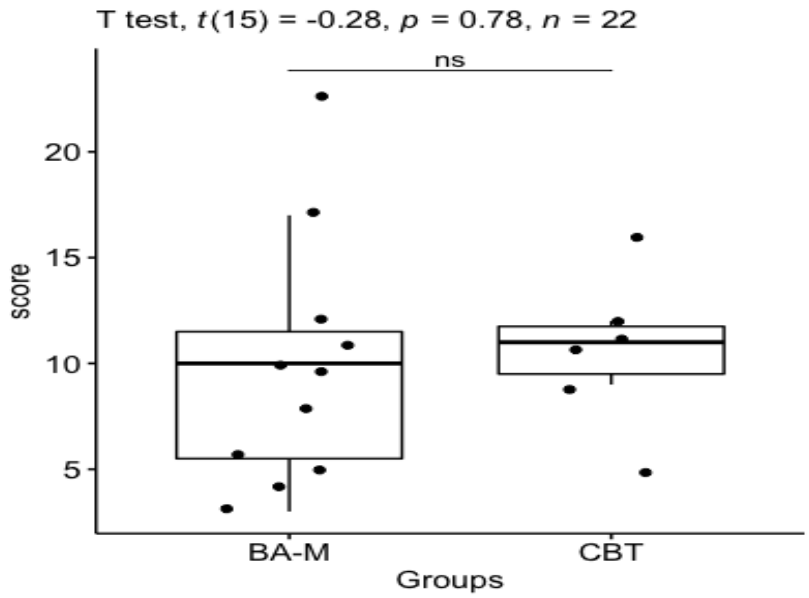


Figure 5.4 Student t-test for the sixth session

5.4.2.3 Last session

When a t-test was used to compare mean PHQ-9 scores at the last session for BA-M and CBT group clients, for the BA-M group it was 6.86 (*SD*=5.46), whereas for the CBT group it was 7.12 (*SD*=3.76). Outliers existed in both groups as can be seen in Figure 5.5.

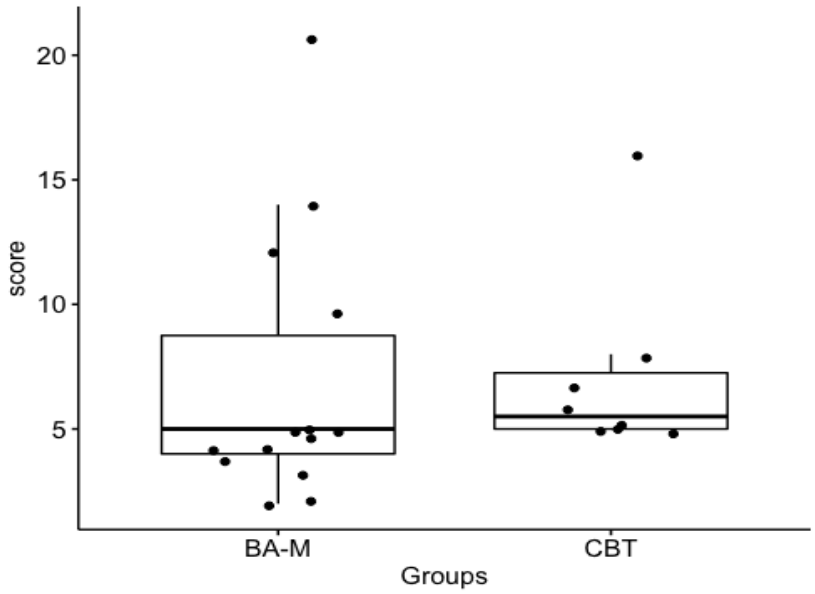


Figure 5.5 Boxplot of PHQ-9 scores for the last session for both groups

The data for the BA-M group was not normally distributed (see the data points that are mostly in the first quantile in Figure 5.5), the p value for Shapiro test was less than 0.001, so a Mann Witney U test, which is a non-parametric test, was used. The Mann-Whitney U test results in a two-sided test p-value = 0.19. This indicates that the null hypothesis, distributions are equal, should be accepted and there was not a significant difference in treatment efficacy. Descriptive statistics indicate that the median value for the BA-M group was 5 whereas it was 5.5 for the CBT group.

A t-test for PHQ-9 scores at the 12th and 18th week were not conducted since there was data available for only seven BA-M and three CBT group client at the 12th week, and was not available data for CBT clients at 18th week. .

5.4.3 Independent samples t-tests for change in PHQ-9 scores

Independent samples t-tests were used to examine whether there was a difference between BA-M and CBT clients regarding change in their depression scores at four different time periods: baseline to sixth session, baseline to last session, sixth to last session and baseline to 12th week. Since for some clients 12th week was before their last session and for others it was after their treatment ended, conducting a t-test to examine change in clients depression scores from post-treatment to 12th week or vice versa would not provide reliable results. Data from the 18th week was not analysed as there was no available data for CBT group clients at the 18th week.

5.4.3.1 Baseline to sixth session

When a t-test was used to compare mean change in PHQ-9 scores from baseline to sixth session for BA-M and CBT group clients, the mean change for the BA-M group (n=10) was –6.9(*SD*=5.36) whereas it was –6.17(*SD*=4.54) for the CBT group (n=6), minus referring decrease in PHQ-9 scores from baseline to sixth session. There was no outlier in data. As the p value of Levene's test was not significant (p=0.49), student t-test was used. A student two-samples t-test showed that the difference was not statistically significant, t(14)= –0.28, p =0.78, d = –0.14 (see Figure 5.6) although there was an improvement in PHQ-9 scores of clients from both groups.

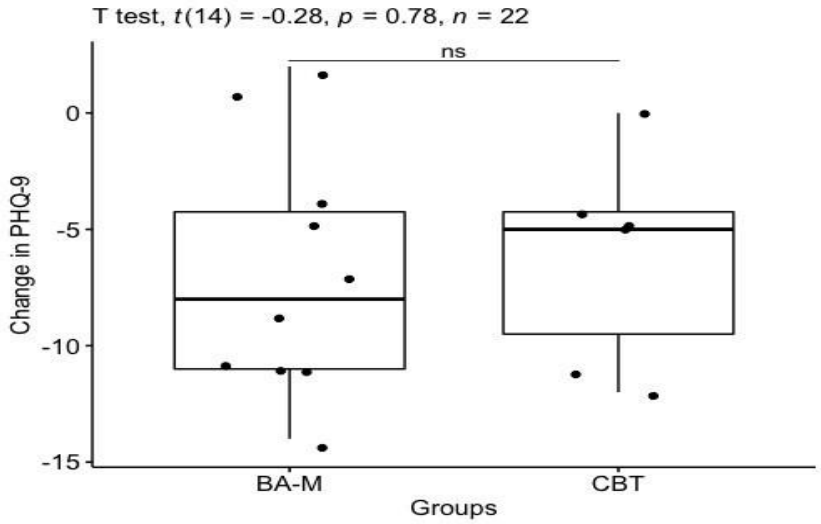


Figure 5.6 T-test for mean change in PHQ-9 scores from baseline to sixth session for both groups

5.4.3.2 Baseline to last session

When a t-test was used to compare mean change in PHQ-9 scores from baseline to post-treatment for BA-M and CBT group clients, the mean change for BA-M group (n=13) was –9.69 (*SD*=7.26), whereas it was –8 (*SD*=4.66) for CBT group (n=8), minus referring decrease in PHQ-9 scores. There was no outlier in data. As the p value of Levene's test was not significant (p=0.08), student t-test was used. A student two-samples t-test showed that the difference was not statistically significant, t(19)=–0.59, p=0.56, d=–0.26 (see Figure 5.7) although there was an improvement in PHQ-9 scores of clients from both groups. This means that although the change in depression score was larger by about 1.5 for BA-M group, the difference between two groups was not at a statistically significant level and depression of the clients in both groups improved from baseline to the end of treatment.

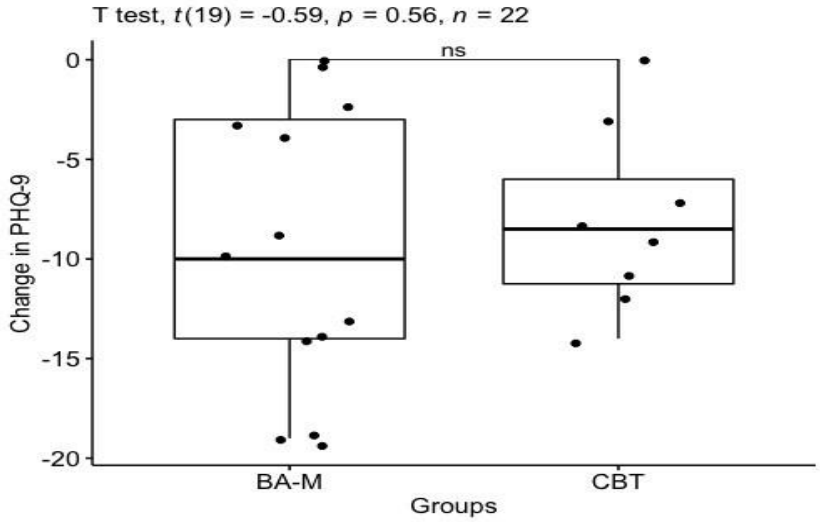


Figure 5.7 T-test for mean change in PHQ-9 scores from baseline to post treatment for both group

5.4.3.3 Sixth session to last session

When a t-test was used to compare mean change in PHQ-9 scores from sixth session to post-treatment for BA-M and CBT group clients, the mean change for BA-M group (n=11) was –4.46(*SD*=4.7) whereas it was –2.83(*SD*=3.76) for CBT group (n=6), minus referring decrease in PHQ-9 scores. There was no outlier in data. As the p value of Levene's test was not significant (p=0.59), student t-test was used. A student two-samples t-test showed that the difference was not statistically significant, t(15)=–0.72, p=0.48, d=–0.36 (see Figure 5.8) although there was an improvement in PHQ-9 scores of clients from both groups.

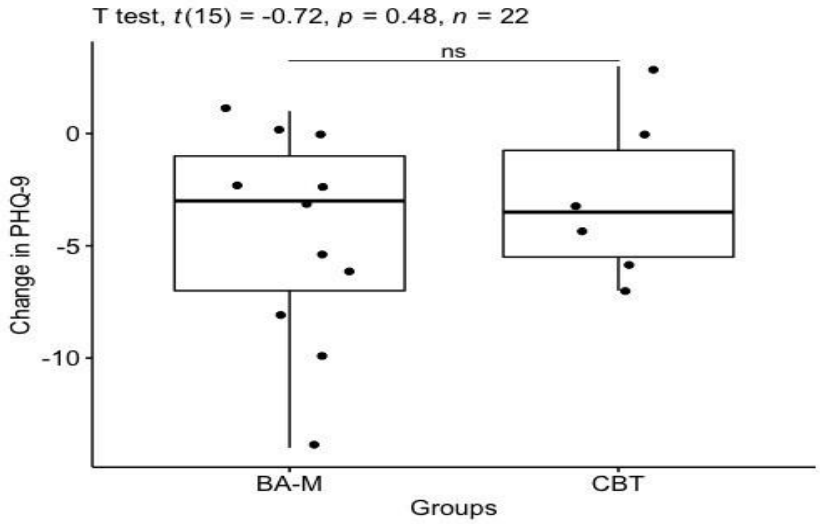


Figure 5.8 T-test for mean change in PHQ-9 scores from sixth session to post treatment for both group

5.4.3.4 Baseline to 12th week/session

When a t-test was used to compare mean change in PHQ-9 scores from the baseline to week 12 for BA-M and CBT group clients, the mean change for BA-M group (n=7) was −10.1(*SD*=5.52), whereas it was −5.33(SD=4.04) for CBT group (n=3), minus referring decrease in PHQ-9 scores. There was no outlier in data. As the p value of Levene's test was not significant (p= 0.68), a student t-test was used, which showed that the difference was not statistically significant, t(8)= −1.34, p=0.22, d= −0.92 (see Figure 5.9), although the mean change in PHQ-9 scores was about 4.6 point larger in the BA-M compared to the CBT group, the issue related to the number of clients in each group should be considered. There was an improvement in PHQ-9 scores of clients from both groups.

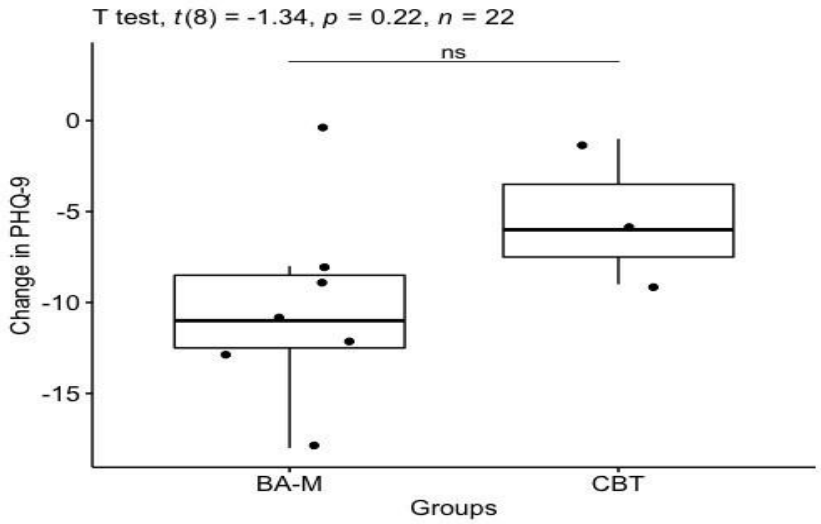


Figure 5.9 T-test for mean change in PHQ-9 scores from the baseline to twelve weeks for both groups

5.4.4 Multilevel analyses

After conducting several t-tests, multilevel modelling was used to analyse PHQ-9 scores with a 'lme4' package (Bates et al., 2015) in R Studio -Version 1.4.1106 (R Core Team, 2021) and restricted maximum likelihood (REML).

As illustrated in Figure 5.2, the data for most of the clients were available for the first eight sessions. Further, it was clear that during this time period the overall effect of treatment could be seen to be well represented by a straight line, which simplifies the analysis. Thus, it was decided to use the data for the first eight sessions from both groups for multilevel analyses.

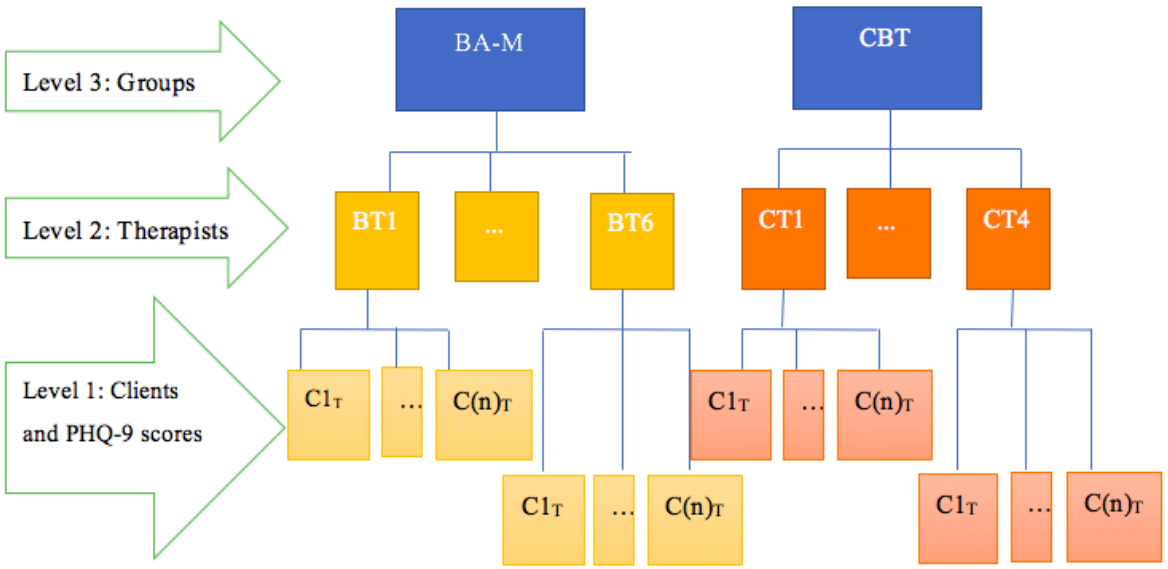
Different models were used to examine which model well fitted the data (see Table 5.6). It started with a 3-level random intercepts model. A multilevel diagram was drawn to present the

Table 5.6 Models with the formulas used in R Studio

Model	Formula
Model 1 (3-level random intercepts model)	Score ~ Group*Time + (1|Therapist/clients)
Model 2 (2-level random intercepts model)	Score ~ Group*Time + (1|clients)
Model 3 (2-level random intercepts and slopes model)	Score ~ Group*Time + (1 + Time| clients)

The part from the tilde mark to the first bracket shows fixed effect and inside the brackets shows the random effect(s) in the models

levels when a 3-level random intercepts model was used to analyse the data (see Figure 5.10). In all models, fixed effects included main effects of treatment groups, time (first eight sessions) and the group by time interaction; the dependent variable was the PHQ-9 score which was treated as a continuous variable.



(BT: therapist from the BA-M group, CT: therapist from the CBT group, C: client, n: number of clients recruited by each therapist, T: time from baseline to the eighth session)

Figure 5.10 Multilevel diagram for a 3-level hierarchical study of therapists nested in groups and clients nested in therapists in a flowchart format

The three-level random intercept model (Model 1) included the random intercept for PHQ-9 scores nested within the clients and the clients in turn nested within the therapists. Thus, the model accounts for the correlation of the measurements from the same clients and the correlation from the same therapists delivering the treatment. When the analysis was conducted

in R Studio, the results showed that there was a singularity issue. The variance attributed to the therapists was 0 (see Table 5.7), this means that there was not much difference from therapist to therapist. The reason to for a singularity issue is because of the closeness of the boundary in one of the parameters. The variance due to the therapists was seen to be low and so the therapist level was dropped from the analysis. For a definitive trial with more data, the therapist level might need to be reinstated (see Table 5.7). Therefore, a two-level random intercept model that did not include a therapist level was tried, to examine whether it fitted well with the data.

In a random intercept model, baseline differences in PHQ-9 scores are accounted for, but it assumes that the effect of treatment groups over time is going to be the same for all clients as each client is allowed to have their own intercepts but not slopes, as all the slopes have to be parallel to the average estimate.

However, this may not be a valid assumption because the effect of treatment can be different for each client. A random slope model can be used to overcome this issue. Thus, after the two-level random intercept model, a two-level random slope model (Model 3) was used as it allows each client to have a different intercept and a different slope for the effect of treatment over time.

The results from the three different models are presented in Table 5.7. The likelihood ratio test was performed to compare the three models in order to assess their fits. The results showed that this model provides a significantly improved fit over Model 1 and Model 2 ($X^2(2) = 11.03$, $p < 0.001$), indicating that a significant amount of the variance is coming from the random slopes. Similarly, scaled residuals (see Table 5.7) show that Model 3 provides an improved fit as its value is closer to zero so more symmetrical compared to the other two models. Furthermore, the intraclass correlation coefficient (ICC) value for Model 3 is bigger than for the other models, indicating that bigger proportion of total variance explained by random intercepts and slopes so Model 3. This suggests that Model 3 is more appropriate.

Table 5.7 Results of the three different mixed models used

	Model 1*		**Model 2***		**Model 3***	
Scaled Residuals (Median (min-max))	-0.14 (-2.7 – 3.26)		-0.13 (-2.7 – 3.26)		-0.08 (-3.22 – 2.86)	
Fixed Part	***Est. Coef. (SE)***	***95% CI***	***Est. Coef. (SE)***	***95% CI***	***Est. Coef. (SE)***	***95% CI***
(Intercept)	17.48 (1.31)	14.84 - 20	17.48 (1.31)	14.95 - 20	17.56 (1.29)	14.93 - 20
Group CBT	-2.73 (2.18)	-6.93 – 1.51	-2.73 (2.18)	-6.93 – 1.49	-2.76 (2.15)	-6.92 – 1.50
Time	-1.17 (0.19)	-1.54 – -0.80	-1.17 (0.19)	-1.54 - -0.80	-1.19 (0.28)	-1.76 – -0.62
Group CBT: Time	0.45 (0.33)	-0.20 – 1.11	0.45 (0.33)	-0.20 – 1.11	0.45 (0.48)	-0.48 – 1.41
Random part	***Est. SD***	***95% CI***	***Est. SD***	***95% CI***	***Est. SD***	***95% CI***
Clients			3.60	2.30 – 5.3	3.69	1.46 – 5.72
Clients: Therapists	3.6	2.30- 5.02				
Therapists	0.00	0 – 3.25				
Time|: Clients (slope)					0.75	0.34 – 1.15
Residuals	3.86	3.38 - 4.40	3.86	3.38 – 4.40	3.45	3.01 – 4.01
ICC	0.46 (clients: therapists), 0 (therapist)			0.46	0.52 (clients),	0.2 (slope)
AIC		785.46		783.47		776.43

Est.: Estimated; Coef.: Coefficient; SE: Standard error; CI: Confidence Interval; SD: Standard deviation; ICC: Intra-class correlation coefficient; AIC: Akaike Information Criterion

*The details about the models are presented in Table 5.6

As explained above, Model 3, the two-level random slopes model, fitted better compared to the other two models and so it is the final model in this study (see Figure 5.11). The results of the final model (see Table 5.7) showed that the estimated mean PHQ-9 score for the BA-M group was 17.56 whereas it was 14.08 (–2.73+17.56) for the CBT group at the baseline. The effect of time for the BA-M group was –1.19 and for the CBT group it was –0.74 (–1.19+0.45). This means that the PHQ-9 score of clients in the BA-M group decreased by just over one point at each session whereas this decrease was less than one point for the CBT group clients. This study did not aim to assess the efficacy of BA-M but a one point decrease on the PHQ-9 at each session may be considered as a good effect size because a client who has a score of 17 on PHQ-9 may have a score of 9 after having only eight sessions of BA-M which, on the PHQ-9, is the threshold for not being depressed.

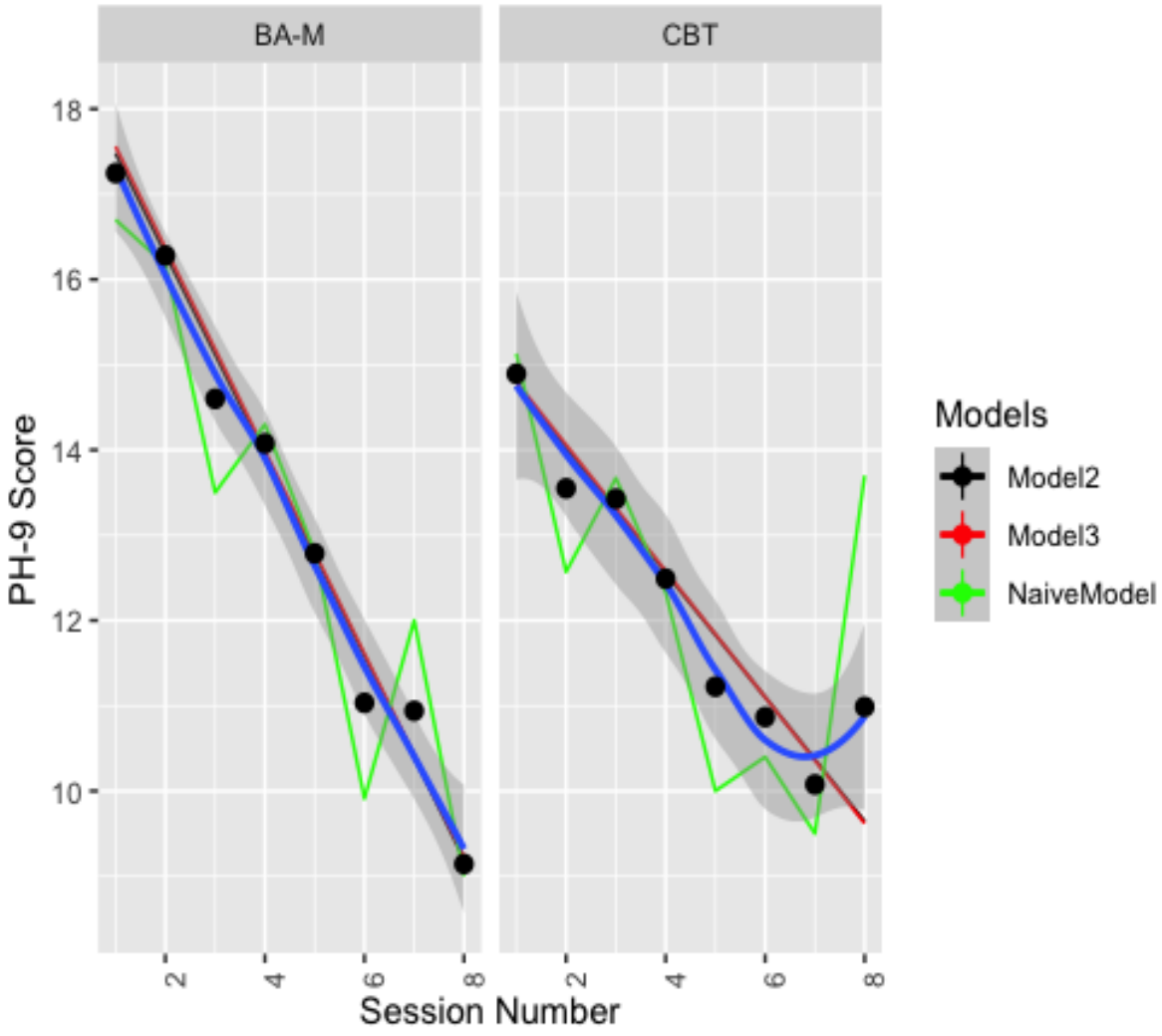


Figure 5.11 Comparison of model fit of Model 2 and Model 3 with a smooth through the plotted points for change on PHQ-9 over the time in both group

5.5 CHAPTER SUMMARY

This chapter presented quantitative results on the feasibility of conducting a full RCT of BA-M for depressed adults in Turkey. Fourteen therapists and 22 clients were recruited. Thus, the progression criterion 1(a) was met whereas progression criterion 1 (b) was not met. The possible reasons for low recruitment rate and how it could be increased in a future trial are explored with qualitative data and discussed within the broader literature (see Section 8.2.3).

One therapist (12.5%) and three clients (21.4%) from the BA-M group, and two therapists (33.3%) and two clients (25%) from the CBT group dropped out from the study. The progression criterion (2) was met as 78.5% of BA-M and 75% of CBT clients completed 6 or more sessions.

It was possible to randomly allocate some of the therapists (N=9) to either BA-M or CBT group. Reasons were explained why other therapists were not involved in the random allocation. In Section 6.2.2, feasibility of the therapist randomisation is explored qualitatively and evaluated in the Discussion Chapter.

The progression criterion (3) was met for baseline and six weeks, unfortunately, it was not met for 12 and 18 weeks. Possible reasons for this are that it might be hard to reach clients when their treatment ended as for most clients (N=17), 12 weeks was post treatment. Another possible reason might be that some of the clients' treatment ended just before the end of study deadline so before the 12^{th} and 18^{th} week after their treatment start and so data were not collected after that time.

A multilevel model for analysis of a future definitive trial is recommended. Steady improvement was seen in both group for first eight sessions but beyond that time ability to collect data was less, and the results became very variable and biased towards retained clients. Thus, the future trial should consider improving the data collection beyond that point by addressing the reasons for low rate of data collection (see Section 6.2.8 and 8.2.5). Overall, the results reported in this chapter show that the feasibility work showed partial success.

CHAPTER 6
FEASIBILITY STUDY: QUALITATIVE FINDINGS

This chapter reports findings from the manual validation process in Turkey, qualitative interviews with the BA-M therapists and clients and CBT therapists, and field notes, focusing on feasibility of the study and acceptability of BA-M for depressed adults in Turkey. Findings are presented under two main sections: Feasibility of an RCT and Acceptability of Treatment. A summary of suggestions for a future Randomised Controlled Trial of BA-M in Turkey is presented at the end of this Chapter.

Feasibility of study was explored via eight main themes identified comprising awareness of study or therapy, randomisation, motivational factors, capacity, confidence, eligibility criteria, recruitment support and assessment tools (see Figure 6.1 for details).

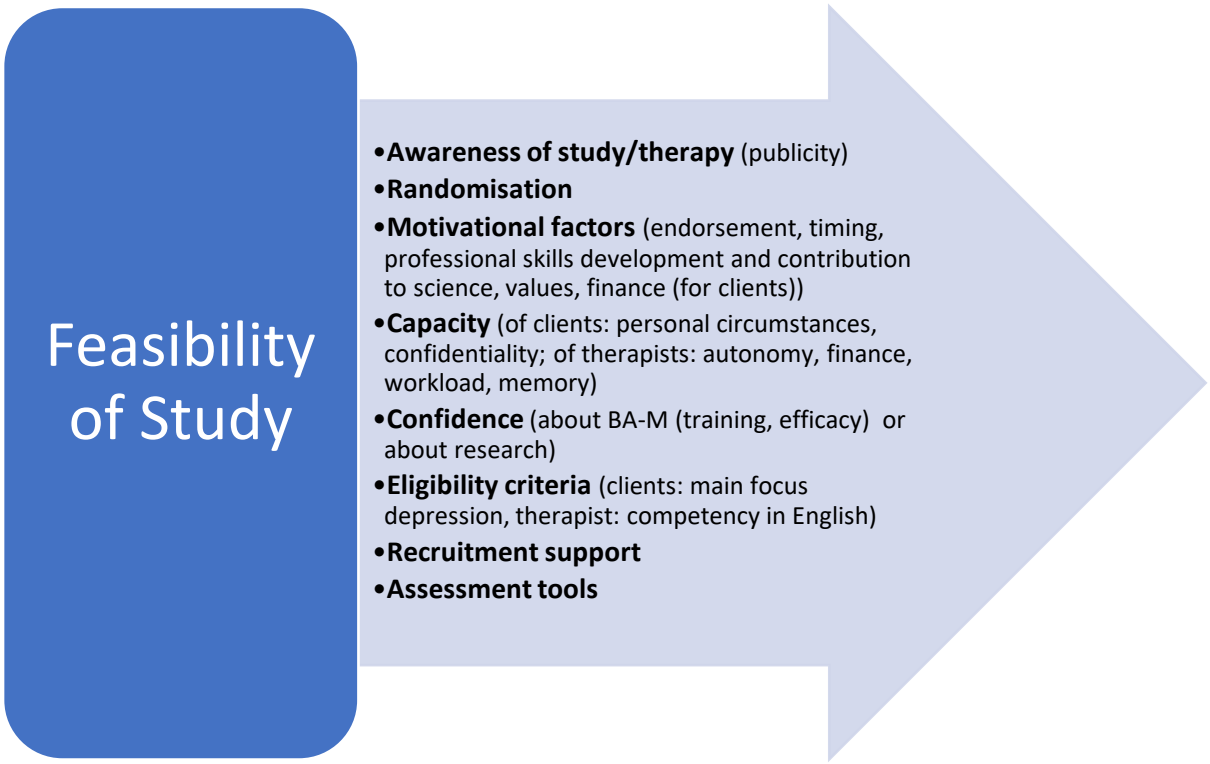


Figure 6.1 Themes identified for feasibility of study

Acceptability of treatment was explored via four main themes: perceived benefits, personal values, capacity and following an integrative approach (see Figure 6.2 for details).

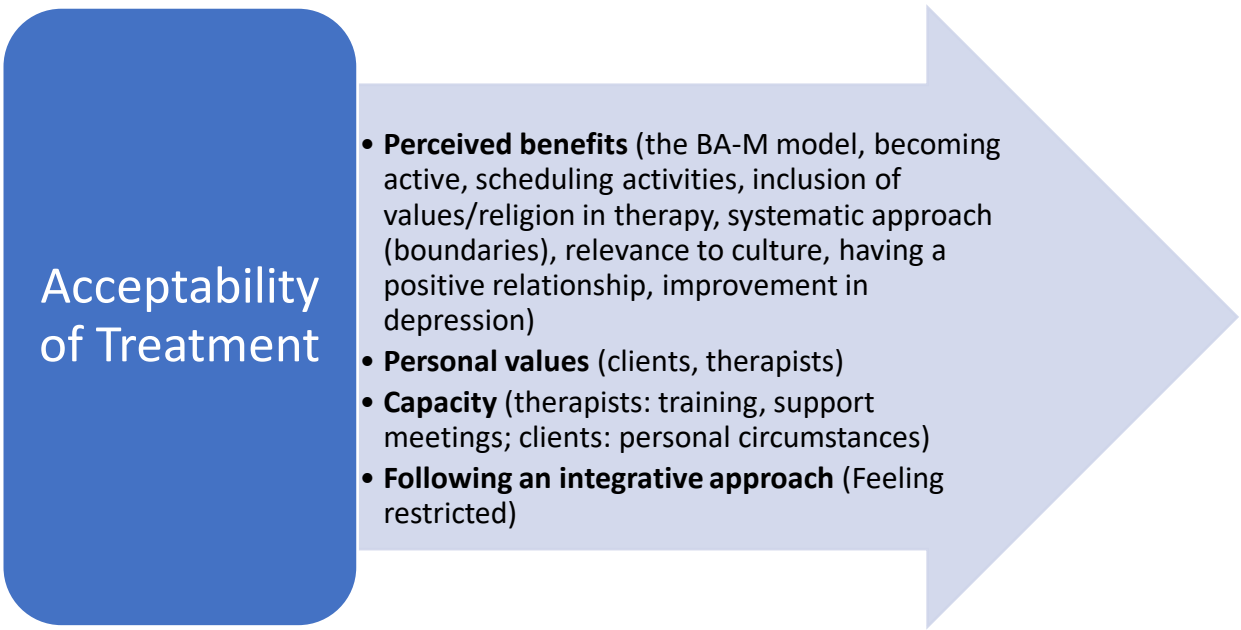


Figure 6.2 Themes identified for acceptability of treatment

6.1 THE MANUAL AND BOOKLET VALIDATION PROCESS

In order to explore feasibility of BA-M in Turkish context, the BA-M Manual and the client self-help booklet was translated and the translated version of both was discussed during the Translation Development Group (TDG) meeting (for the details about translation process and TDG meeting see Section 4.5.1 and 4.5.4). Thus, this section includes changes suggested during the Translation Development Group (TDG) meeting on how to adapt BA-M Manual (hereinafter the "*Manual*") and the client self-help booklet (hereinafter "*Booklet*") to culture of Turkey. Some statements were added and some have been deleted or replaced.

A section titled as 'Notes from the translation editor' was added to the Manual in order to explain that the Manual was originally developed for adult Muslims with depression in the UK and then translated in Turkish, and which steps were taken to adapt the Manual to culture of Turkey including TDG meeting and feasibility study. This page could help to understand why the Manual includes some examples from the UK. Summary of findings from the feasibility study on the acceptability of the booklet was added in the section on the booklet in the Manual which presents findings from the pilot study conducted in the UK. Information related to the percentage of Muslims who live in Turkey was added. In the booklet, after the statement of 'Think about what happens when you respond in this way', which is presented in the section of Dealing with difficult life events, translation of 'when you behave this way' is added in brackets to make the meaning of statement clearer to clients.

Clients were used instead of service users. In the Manual, there were statements related to the context in the UK. Those statements were presented in Turkish Manual either as an example or words replaced with another words that fits to the context in Turkey. For example, in the Manual stated that Pakistani key informants reported that derogatory terms such as 'pagal' (mad) or 'challa' (simpleton) could sometimes be used for people with depression and this statement started with "for example" in Turkish Manual since it was not possible to do a literature search to replace those words with Turkish derogatory terms during the TDG. Some words were replaced such as "limited ability in English" replaced with "limited ability in Turkish." Similarly, 'problems caused moving to the UK from a different country' was replaced with 'problems caused by migration' as it gives meaning of moving to another city or country. In the Manual there was an example of a follow-up letter following several non-attendance, this was edited as letters or emails as sending letter is not a common practice in Turkey.

The words that specifically used in Urdu were deleted such as 'taweez'. Section of difficult life events included dependence on khat, a culturally specific drug, is associated with depression in some African and Middle Eastern Muslim communities. As khat is not commonly used or known in Turkey, this statement was deleted. In the Manual, therapists were advised to discuss any concerns about whether prescribed medications were halal if a client had been prescribed medication and link to a helpful publication was provided about that issue. As there was not an alternative publication, this was deleted in the translated Manual. The section of the therapeutic relationship included a statement started with "I am not a Muslim …". This part of the statement was deleted as it thought that this would not be appropriate in Turkey.

Instead of Behavioural Activation Depression Scales- Short Form, full version of it included in Turkish Manual since there was not a translated version of the short form. GAD-7 omitted from Turkish Manual as it would not be used in the feasibility study.

The section of useful resources that contained a list of local organisations in Bradford and West Yorkshire to which clients could be referred was deleted as it would not be useful for clients who live in Turkey. The section also included websites and online resources which were not in Turkish, has been removed. Alternative websites which are in Turkish can be added before a future trial. An alternative Turkish website to the website related to du'as –calling on Allah- for different occasions or for general dhikr which was suggested in the original booklet have been provided in Turkish booklet.

One of the values focused in the Manual and the booklet is Citizenship values. There was a discussion about whether it was one of the values in Turkey and what it meant by citizenship values in TDG meeting. After the meeting, Ghazala was asked what citizenship values referred in the UK context: it could refer to volunteering, being active in politics and contributing to the community. As those could be value for some people in Turkey, it was decided to keep citizenship as one of the value areas in both the Manual and booklet.

As it mentioned above, there were only minor editions suggested for both the Manual and booklet. Any changes suggested for the booklet during the feasibility study is presented in Section 6.3.

6.2 FEASIBILITY OF A FUTURE RCT

This section presents findings related to the feasibility of a future randomised controlled trial (RCT) in Turkey. It aims to answer research questions regarding whether it is feasible to recruit therapists and clients, randomise therapists, the study design in its current form is feasible, it is feasible to run a definitive trial of BA-M in Turkey and what other aspects of the trial can be guided by the current research. Eight themes identified to determine the feasibility of a future study are presented in this section (see Figure 6.1).

6.2.1 Awareness of study or therapy

Awareness of the study on BA-M therapy through publicity was one of the factors that affected recruitment of participants. This section presents findings on how the participants became aware of the study or therapy.

Some therapists became aware of the study through publicity received via social or professional groups:

> "We have a professional psychology group, and the notice about it came to me through that" (HB, CT)

> "I heard [about the study] through a friend […] and I said that I wanted to take part" (GUD, BT)

Some clients were recruited by the therapists who publicised the study via their social circles or groups to find eligible clients:

> "We passed the word round. How did we find them? Well, two of them were found by people we know, they were referred to us by my [X]'s circle. The last client was […] a client that had being seen by [person] in a group to which I was providing supervision, yes, a client referred by [person]." (---, BT)

When the therapists were asked how to increase recruitment of clients in a future trial, publicising the study was one of the recommendations made:

> "A more extensive network could be established. Posts could be shared over that network, and if it is a specific population—for example—there is a great need in schools, if these networks could be established in universities, if one was proceeding on a target-specific basis directly addressing the departments, the professors, [clients] could easily be found." (HB, CT)

> "A public notice [could be published]" (UM, CT)

Clients also suggested publicising a study, advising the use of different platforms including social circles and social media to increase recruitment of clients in a future trial:

> "It might be more likely to be someone from your social circle, e.g. I have heard from my social circle. For example, I could tell a friend who is in difficult circumstances about it, or anyone, I could tell them. It could happen like that" (Ayşe, C)

> "I think a social media [account] could be set up and information [related to the study]could be published ." (Derya, C)

6.2.2 Randomisation

This section presents findings related to feelings of the therapists about randomisation. To investigate the feasibility of randomisation, therapists were asked how they felt about it, and how they would feel if they were allocated to the other group, and to what extent their motivation was affected by randomisation.

The majority of the therapists mentioned that they would prefer to be in BA-M group, as they would prefer to learn and apply a new treatment method. Although some mentioned that being assigned to CBT group would decrease their motivation, it would not cause them to drop out, as from the beginning they knew that there would be a random assignment. Random assignment was thought to be a fair and scientific way to conduct a study:

> "To be honest, it was fair, because if it had been biased […] I mean, of course, this idea of receiving new training was very attractive so obviously I wanted to be in this group [BA-M]… But if it had not been like that, we could have made no claims […] [my motivation] might have waned [if I had been allocated to CBT] […] No, there was no chance [of me dropping out]." (GUD, BT).

> "It seemed natural to me really […] I have seen that manipulative [non-random] selections did not manage scientific resources very well. It seemed logical and smart to me because I think that it will produce a much better quality result" (UDM, CT)

However, for some therapist, being assigned to CBT did not decrease their motivation, and indeed it was considered as a source of feeling confident:

> "If I had been allocated to the CBT I would have felt comfortable, because that would have been my area, and perhaps I would have had less to worry about in terms of performance." (ZM, BT)

> "It made me feel very good, because I received training in CBT, of course, and I use it in my therapies, that is to say, it is an important tool in my toolbox. It always felt good to me to use this technique and consequently, I think that being here [CBT] made me feel more professional than being in the other group" (UDM, CT)

Field notes show that one of the therapists who was randomly assigned to CBT group dropped out before the training started, complaining that the randomisation had not been done fairly. He was the only person to make such a claim. Another therapist from the CBT group dropped out nine months after the delivery of therapy started, and during the recruitment stage had mentioned feeling sad due to being randomly assigned to CBT group.

Being randomly assigned to BA-M group led to feeling lucky and happy as a new approach had been learned and applied, whereas being randomly allocated to CBT group, although in some cases causing reduced motivation, led to feeling more confident, as CBT had been already used in their usual practice. In general, this suggests that random assignment of therapists is likely to be feasible in future trials. Explaining the randomisation process in advance and offering future training in BA-M to CBT group therapists might help to prevent drop-out because of randomisation issues.

6.2.3 Motivational factors

There were some motivational factors which utilised recruitment and retention of both therapists and clients.

6.2.3.1 Endorsement

Endorsement through well-known people in the field, who can easily influence therapists, was one of the motivational factors. Some of the therapists got information on therapist recruitment through social media posts by Professor Hakan Türkçapar and Dr Elif Çelebi, who are well-known scholars in the psychiatry and psychology fields, respectively:

> "I saw Elif Çelebi's post […] then I saw Hakan Türkçapar's post on social media" (IM, CT)

Professor Hakan Türkçapar and Dr Elif Çelebi announced the details of the therapists' recruitment in different platforms when they were asked to help with the recruitment of therapists. They have extensive contact with and reach to many therapists across Turkey.

Some clients reached out to the therapists recommended by either close or trustworthy people:

> "I heard from a friend of mine that [my therapist] was going to be involved in a study like this […] The fact that it had been recommended by somebody whom I trusted. Really, that was why I went with a positive mindset." (Sena, C)

> "I had a teacher [at the university]. I told him I really needed psychological support. He was someone who was helpful to students, and he directed me to [a therapist]." (Enes, C)

The fact that the study was conducted under the auspices of the University of Leeds was also thought to be a facilitator by a therapist, related to the fact that it is perceived as a highly prestigious UK university:

> "When you mention Leeds University, and that the process here will be monitored from there, people get interested in the research […]" (RM, BT).

Having training that run by the University of Leeds was another motivational factor that affected the therapists' decision to take part in the study. Taking part in a study focused on cultural adaptation revealed feelings of excitement and curiosity, and engaged therapists' attention. The therapists wanted to know how a culturally adapted treatment works in practice:

> "[…] different training, trainers are coming from abroad, so that made it quite interesting, intriguing." (IM, CT)

> "It caught my interest because this is an area that is missing in Turkey, or rather, missing in CBT, so this approach, working with values—'How will it work out, activating this behaviour?'—was something I wanted to learn" (GBI, BT)

Being aware of that attention to values in a therapy is a missing area in Turkey was a facilitator to take part in the study.

These findings show the importance of endorsement in recruitment of therapists and clients and suggest that advertising a future trial through well-known scholars or practitioners in the field of psychotherapy and or through other people who are considered as trustworthy; and conducting the study under auspices of a prestigious university would probably help to increase recruitment of therapists and clients.

6.2.3.2 Timing

Timing was another motivational factor for the recruitment of participants. Some of the clients mentioned that they came across the study when they needed to access a treatment for depression:

> "I may have felt just a bit lucky, because this study happened to come along just when I needed it." (Zeynep, C)

> "I felt comfortable about it, there was a certain peace and calm that I was going to find a path for my life, because I was in a really bad way psychologically, and I can say that it gave me a guiding light." (Ayşe, C).

Zeynep and Ayşe had positive thoughts and expectations at the beginning of the study because they were offered the treatment when they needed it, which show importance of *timing* in recruitment.

6.2.3.3 Professional skills development and contribution to science

Professional skills development, and contribution to science were other motivational factors for the recruitment of therapists, including learning and applying a new approach, -networking with trainers from the UK, being involved in an adaptation study and working with new clients:

> "The fact that it was an adaptation was exciting. Also, I was curious, you know: 'How was it going to be in terms of technique, what will be different?' … this of course increased my [interest]: receiving therapy training from a foreign trainer, observing their style, all of this would be quite a change for me. […] My motivation was good." (UM, BT)

> "Working with someone else other than my clients, and trying to work on the basis of this approach excited me. […] I was very happy to attend. […] In my opinion it was wonderful, a great pleasure, to learn something new and to continue learning and [practicing] the system in the therapy session." (GBI, BT)

One therapist who also mentioned *professional skill development* as a resource for her motivation had high motivation throughout the study, and thought that it was highly beneficial, especially in terms of having support meetings and the dynamism engendered by learning a different approach and *contributing to science*:

> "[My motivation] was high… This was something where we were gaining a lot: we were learning something specific, and at the same time the supervision process was ongoing. There was that dynamism which you get from trying something different, the contribution that it was going to make for your development, and also the contribution it would make to science. That is why my motivation in terms of completing [the study] was very high" (UI, BT)

All therapists had positive feelings about the study process and similarly to UI, some other therapists emphasised the importance of contribution to science, which can be considered as one of the motivational factors for the therapists:

> "It [study] made me feel very good. … we are doing something which has a connection with science. […] [participating] is an honour, and I thank you for that." (UDM, CT)

Some clients, however, were not interested in contributing to research. One therapist felt that clients might not want to take part in a study if they thought that they would have been perceived as experimental objects:

> "The other person declined to participate because it was a study […] s/he did not want to get involved in [that process]." (GUD, BT)
>
> "People do not want to pay TL 350 and then feel like they are a guinea pig in a study group. I encountered that reaction, anyway. It is possible that the people I asked were the wrong people, but that was something I did experience." (GBI, BT)

Another possible reason for refusing to take part in the study mentioned was related to having *confidentiality* concerns:

> "… perhaps they had concerns about confidentiality." (UI, BT)

6.2.3.4 Values

Values of clients was another motivational factor that affected their willingness to take part in the study. Some clients decided to take part in the study as the treatment was in line with their

religious *values* and they were willing to align their behaviours with their values. One of these clients needed help whereas another one wanted to help to the study*:*

> "Previously I used to think to myself 'If I perform my prayers, if I become closer to Allah, my psychology would improve, I would have an objective in life.' But, well, unfortunately we cannot always manage to do what we think we can. So I found it interesting from that point of view." (Fatma, C)

> "First of all, of course, I felt slightly tense because when [the therapist] gave me the form [information sheet] and mentioned the recording device, I drew back, I thought 'What is going on here?'[…] [The therapist] had told me 'You would be able to leave whenever you like, you would not be obliged to continue with it, and if you prefer, you do not have to meet [take part in the interview]. This process is entirely under your control' so I told him/her 'Alright, I will participate.' and when I looked closely at the *Booklet*, I said to myself 'These things are not outlandish things at all, these are things which I have always known about, but they are things which I have not incorporated into my life. In fact,' I said to myself, 'it is because I have not incorporated these things into my life that I am seeing to a psychologist today […]' So when I realised that, I thought I ought to help." (Merva, C)

Even though there was something which demotivated Merva, having the option to withdraw whenever she wanted to and the alignment with her own views on religion positively affected her to take part in the study. She thought her need to get treatment arose from not incorporating religion into her life. This shows the importance of religion in her life and being away from it could cause to not feeling well. It also shows the impact of the *Booklet* on reminding her *values* to her as it guided her to join the study.

6.2.3.5 Finance

Having a chance to access treatment for a reduced fee through the study meant *finance* was another motivational factor for some of the clients to take part in the study. In the study process, a therapist from the BA-M group delivered therapy for free, while a therapist from the CBT and another from the BA-M group delivered therapy with a symbolic fee, in a room provided for the study by Professor Ali Köse who was the Dean of Marmara University. A therapist from the CBT group made discounts for the study, while another from the BA-M group delivered therapy in exchange for paying the rent for the room they were using. Some other therapists were also willing to work with a reduced fee to recruit clients for the study. Delivering the treatment for free or with a symbolic (reduced) fee was a facilitator of client recruitment:

> "People really do have a serious need, and they ask for this […] to come for that therapy process at a minimal token fee." (HB CT)

One of the clients' answer agreed with the therapists on reduced fees being a facilitator, because he decided to take part in the study as the treatment was offered to him for free:

> "The teacher said that he would look around among his circle. Then he said to me, there is a therapist who will charge a fee, but there is also a possibility within the context of this project. Because I could not pay a fee, I told him/her, 'Alright [I'll see somebody as part of the project]'" (Enes, C)

Suggestions made by the therapists on how to increase recruitment of clients in a future trial supports *finance* being as a motivational factor for recruitment of clients. For example, some therapists suggested to make discounts in the fee or to pay the fee on behalf of clients to increase recruitment of them in a future trial:

> "I am thinking about the clients who pay the fee, I mean, at least for them keeping the fee lower or somehow covering the cost of the therapy and taking clients free of charge might be an attractive dynamic [for participation in the study]." (UI, BT)

Only one therapist mentioned that seeing clients for free might not be healthy, and they suggested requiring a symbolic fee from clients:

> "It is debatable whether [seeing clients free of charge] would be a sound path because this is about the person engaging in the process long term, and we know from the fieldwork that it is about their perceptions. I think one could ask for a very token sum. But—I don't know" (HB, CT)

Although previous paragraphs have presented evidence to support finance being as a facilitator for client recruitment, in the case of treatment that was already free, one therapist felt that clients could prefer not to complicate the process by adding the dimension of participating in research:

> "In my opinion [their reasons for not wishing to participate] were that they knew that they would be able to receive service here even if they did not participate in this research, so they did not want to add an extra variable into their process." (---, BT)

This suggests that if a trial is conducted with the therapists who work in public services in Turkey, the recruitment rate might be low, as people know that without taking part in a study they can still get treatment so finance might not be a motivational factor. Given the relatively extensive reluctance to participate, this raises the possibility of incentivising potential clients to take part in RCTs in public settings. If public settings are preferred as research sites for future trials, some kind of incentives may be needed to motivate clients to take part. When this interpretation is considered, it should be noted that only two of the therapists were working in

public settings and this point only made by one of them, so this issue may need further investigation.

6.2.4 Capacity

Capacity was discussed in terms of client or therapist ability at some points; as well as clients' daily life circumstances or therapists' workload at other points. This theme covers how capacity of clients affected their decision to decline participation or continue to treatment. It also covers how capacity of therapists affected recruitment of clients. This section focuses on capacity in terms of the feasibility of a future trial and later -in Section 6.3.3, capacity is considered in terms of acceptability of the BA-M treatment.

6.2.4.1 Client capacity

When the therapists were asked potential reasons for clients to decline participation, clients' capacity issues appeared to be potential barriers for recruitment. From the total of 35 potential participants, 12 declined to take part in the study. It was not possible to directly ask the reasons for refusal to potential clients, as without consent the researcher did not have right to contact them; furthermore, it is a conventional ethical expectation that potential participants do not have to explain the reason for their refusal to participate, or even to subsequently withdraw from a study after initial participation. Thus, in order to gain some insight into the relatively high number of clients who did not wish to take part, the therapists were asked: "If you had any clients who declined to take part, why do you think this is?"

Clients' capacity to take part in the study could be affected by travel difficulties, current psychological state of clients and familiarity with research culture:

> "We did not continue therapy, somebody who went somewhere else because of travel difficulties" (ZM, BT)

One therapist felt that recruiting clients who lived close to her clinic or from her existing caseload would help:

> "If I were to take part in a study in the future, I would recruit from my existing client base, or from clients referred here. I think the most comfortable thing would be to see people in my own space [clinic]. […] it would always make it easier if it were someone I have worked alongside or somebody at a nearby location, and that would also make it easier for the person who was to come." (IM, CT)

One therapist mentioned that the psychological state of one of their clients probably made it hard for him to be involved in the study:

> "[…] one of them had a situation in which he already felt guilty, about a morality issue. […] Perhaps it was because of this, that he thought that it would be even more difficult […] And he really was in depression at that time, and also … he needed to resolve that problem quickly. I think that is why he rejected the offer." (GUD, BT)

One of the main reasons mentioned why potential clients refused to take part in the study was related to *not being familiar with research*. Age group was seen as a potential factor in clients' understandings of research:

> " In Turkey there is a reluctance to participate in this kind of study. The younger generation are more ready to participate and be part of important research like this, but because we work rather more with a middle aged group […] they are a little more reluctant with respect to these things. [They say things like] 'I would not be able to continue with it; I cannot attend on a continuous basis; I could come once but I could have difficulties in coming again; suppose I were to give wrong information?' It is a reluctance which arises from feeling overly responsible, and from being unfamiliar with the process." (UDM, CT)

In addition, a therapist thought that potential clients declined because of not being familiar with research and their unwillingness to share personal information, or not being ready for therapy:

> "One of those who did agree to participate, for example, was somebody who works at a university, someone who knows what research is, and tries to give it their support. But there are people who do not know what it is, like those people who, when they see those papers, become reluctant to give certain information about themselves. Also there are others who are not ready to enter into the therapy process anyway, and did not continue after the first interview. So I do not think there was a special reason [to decline participation] connected with the research itself." (IM, CT)

For future trials, this suggests that therapists might need to be trained to explain the study process with more detail and clarity, in order to increase recruitment among people who are not familiar with research.

The reasons mentioned about refusing to take part in the study appeared to be more related to the study *per se*, and not to any of the related treatments. For a future trial, issues related to not being familiar with research and confidentiality might be solved by training therapists to explain to potential clients the importance of studies for public and mental health in general, and the measures taken to protect clients' information.

6.2.4.2 Therapist capacity issues

Therapist capacity issues include autonomy, finance, workload and memory of therapists. The level of therapists' *autonomy* in their workplace and *finance* could create barriers to recruiting clients. One therapist who saw *finance* as a barrier thought that if they worked in public settings and had autonomy in their workplace, using a different method would not have been an issue. Working collaboratively in private settings, with less autonomy was an obstacle for some:

> "I work on a percentage basis with the psychiatrist, and my sessional fee is 350 lira. I cannot take 350 lira from a client involved in this project. I need to reduce this fee to a minimum. However, when I do bring it down to the minimum […] it amounts to breaking the deal I have with the place I work. So that was a problem for me there, to do with finding clients. […] If I were working in a state organisation, I would have applied this [BA-M] to every patient I saw but because I am now working in a private clinic and because they are referred to me by the psychiatrist, it is not something I could do to any great extent." (GBI, BT)

Another therapist who mentioned finance as a barrier also referred to not having autonomy as a barrier in collaborative work settings, because of psychiatrists' expectations:

> "If [the first] psychiatrist referred [the client] then they monitor the situation together with me […] but if I tell the patient they are monitoring "Wait a minute, I am going to do something else" then that gets difficult. Secondly, there are people who normally see me for a fee of 400 lira or thereabouts and when I tell them "I am going to do something like this [the therapy], hold on, I am not going to do that for you, I am going to do something else, so I'll reduce the fee" then there is a serious loss of income for me" (CGY, BT)

The barriers caused by collaborative working linked to therapists not having *autonomy* appear to be related to finance and psychiatrists' expectations. In a future trial, seeking approval of collaborators (therapy team members, e.g. psychiatrists) with whom therapists work might help to increase recruitment of clients, and to reduce concerns of therapists related to applying a new method, including the need for a reduced fee. Although, the therapists were not asked to offer the therapy for free or for a reduced fee, the previous two quotations indicate that the therapists from BA-M group appeared to assume they should offer therapy for a reduced fee as they were involved in a research project. This may suggest that when therapists learn a new method involving supervision, they work for reduced fee as they do not feel confident to use a new method.

Capacity to be involved in the study could be affected by extra workload because of offering treatment for free. This could also be linked to motivation in terms of study participation:

> "[…] if I were seeing three clients at the same time, I mean, I am really busy, and right now it might not have been a good thing, but I saw two of them at a time when I was less busy, and later, when I got busy, we had finished with those two by then, and I saw just one client. […] The reasons why the motivation of other colleagues was low could be looked into perhaps. One or two possibilities come to mind. One of these is doing it free of charge, because they may have viewed it as extra workload. (ZM, BT)

ZM thought that seeing clients in a busy time would reduce their motivation. Although they thought delivering treatment free of charge might be considered as an extra workload, none of the therapists mentioned that the study was an extra workload for them.

Memory may create another barrier to recruit clients. Only one therapist mentioned that they kept forgetting that they took part in the study, so they did not ask to some potential participants to take part:

> "What made it difficult was this: I might forget [about the study]. For example, immediately after I received the training, a few people did come to mind, and I asked them. But then time passes, and meanwhile I am unable to find [clients], and then it just slips my mind. I mean, if you were to write something on WhatsApp, or contact me about something, then I would remember… or patients would make me remember it. Once you have enrolled one person, then it becomes easier to include someone else because you are giving those scale scores every week […] it facilitates things, you get a continual reminder." (IM, CT)

This suggests that in a future trial, re-communicating with therapists can help remind them of their involvement in the trial, to increase client recruitment. Although similar to BA-M therapists, it was tried to have regular contacts with the CBT therapists, it was sometimes hard to reach them. As it is suggested in 6.3.3.2, providing face-to-face regular meetings might be more helpful as a reminder.

6.2.5 Confidence

Confidence could be a factor that affected client recruitment; and motivation of therapists during the course of study. The majority of the therapists from CBT group (3 out of 4) and about half of the therapists from BA-M group (3 out of 7) recruited clients through their existing clients. CBT group therapists were more likely to recruit clients from their own clients compared to the BA-M group, which might be due to them feeling more *confident* about using CBT compared to their BA-M colleagues, since the idea of being allocated to the CBT was a source of feeling *confident* to them (see 6.2.2).

Confidence was a barrier that affected recruitment of clients for BA-M group therapists. BA-M was considered as a new approach in which skills had not been fully developed; this perception impacted on recruitment which was limited to free or reduced fee slots:

> "It does not seem very ethical for a therapist to carry out this process which they are not prepared for (when I say 'not prepared for' I mean that it is something they have not tried before). It does not seem appropriate for me to receive payment for doing something in an area which I have not honed my skills up to a certain level, for something which I have not monitored through supervision. […] doing this for a high fee does not seem very ethical to me." (CGY, BT)

Although CGY's lack of confidence in their BA-M skills was a factor affecting clients recruitment, ZM's lack of confidence in the effectiveness of BA-M alone was the factor:

> "[…] the reason why I wanted to see those clients free of charge was really that […] it would have made me uncomfortable to deprive people of something which I would normally do, and which I believe would be somewhat more effective, and indeed even seeing a client free of charge there was something about this, underneath it all, which made me feel uncomfortable. I mean, not doing everything that I can might make me feel bad in some way. I mean even if in the background there is the knowledge that BA and CBT show the same effect, and [do not forget that it was] because I felt that CBT was also limited I supplement it with an existentialist approach, it is possible that this may also lower motivation perhaps. "(ZM, BT)

Feeling uncomfortable about not doing their best was mentioned as another potential cause of low motivation to deliver the therapy, which may be linked to not being confident in using BA-M and or to normally following an integrative approach. ZM related this to using a single approach (BA), as they were one of the therapists who used an integrative approach to treat depression (see section 6.3.4). Considering requirements in a study, it is normal to use a single approach in order to understand the impacts of a treatment.

Lack of confidence in using BA-M may lead to low motivation in the process of study as being concerned about losing a client was mentioned:

> "If it had been a client that I was seeing in my own private centre, I might perhaps have been a bit more worried, because it is not an approach with which I am totally familiar. Of course, we did have the training, but I might have been tempted to use a method I know better, or I might have felt concerns such as: 'If I cannot use a method that I am more familiar with, am I going to lose the client?'[…] so what could be done to keep therapists engaged [with the study] […] could we have been more engaged [with the study] if we did not have such worries?" (UI, BT)

Therapist confidence in BA-M, which impacted recruitment and engagement with the study, could potentially be addressed by presenting the results from the meta-analyses in a training to convince therapists about the effectiveness of BA alone, and supporting therapists with supervisions to increase their confidence in using BA in a future trial. If the therapy fee is covered by a research fund in a future trial, this will probably prevent possible therapist worries about losing clients regarding using an approach they are less confident about with clients who are paying their own fees.

Performance anxiety may also be linked to lack of confidence, as the scores presented on PHQ-9 could be viewed as linked to therapists' performance[7]. One therapist mentioned feeling uncomfortable about using scales due to such anxiety:

> "The therapist, while applying a particular approach there, is not convinced that it is being well implemented, but at the same time data [is being collected] and that data is going to feed into a conclusion. Having these two things going on simultaneously is not something which makes the therapist feel very comfortable." (CGY, BT)

Blinding procedures to anonymise therapists' information before passing the data to researchers –which will prevent to link a therapist's ID to their clients- might reduce performance anxiety that could arise from using scales in a future trial, avoiding reduced motivation.

6.2.6 Eligibility criteria

Eligibility criteria for recruitment of both therapists and clients could create an obstacle to recruitment. *Competency in English* for some therapists could be a possible barrier to feasibility of the training. Although English was not considered hard to understand by the majority of therapists, there were a few therapists who found it hard to understand the language of training:

> "I mean, it did not affect me at all, in fact, perhaps it was better that way because it meant that you were hearing jargon that was more consistent with the literature or, I don't know, I don't mean say more expert. […] Anyway it was positive for me that it was in English." (UI, BT)

[7] This may cause therapists to have low motivation as ZM (BM) mentioned: " Perhaps they [therapists] did not feel good about taking a measurement every session."

> "Of course, [the fact that the language of training was English] was certainly tough. Especially when it came to consolidating something. Of course you may understand in theory: 'Here they mean this, or they are doing that' but when it comes to understanding an example, it then gets a bit harder. […] It [the training] did prepare [me]. I really liked the Manual because it is expressed simply, and the fact that it is in the Turkish language was an extra advantage." (GUD, BT)

This supports that having the *Manual* in Turkish helped the therapists to understand the training better. One of the therapists' views affirmed this:

> "I suppose it would have been good to have interpretation, but the fact that we had the forms [referring to the *Manual* and *booklet*] and the slides in front of us made it easier." (RM, BT)

The majority of therapists did not find it difficult to have the training in English. This is because one of the eligibility criteria for the therapists was to be fluent in English, so in a future trial it might still be better to either deliver the training in Turkish or have simultaneous translation, to increase recruitment of potential therapists if the language is a barrier to them.

Eligibility criteria for clients was mentioned as another obstacle by two therapists. This was also mentioned as an issue in the support meetings during the fieldwork. The therapists found it difficult to find clients who met the eligibility criteria. They specifically mentioned the difficulty of finding participants with a primary diagnosis of depression:

> "Actually, quite a lot of clients came in the normal run of things, but unfortunately, because they never met the study criteria (in most cases because primary focus was not depression) we excluded the majority of those clients." (HB, CT)

> "What I found difficult, the thing I had most trouble with, was that it was hard to find patients whose main diagnosis was depression, but who did not also have much in in the way of comorbidities [referring to exclusion criteria]" (UI, BT)

This suggests that eligibility criteria for clients should be reviewed in a future trial.

6.2.7 Recruitment support

Recruitment support was also raised as a factor that could potentially increase client recruitment and this was linked to the motivation of therapists to participate in a future trial. The majority of therapists suggested that getting a referral from psychology consultancy centres and seeing clients for free could help to increase recruitment of clients. One of these therapists also suggested that informing psychology departments could be helpful:

> "[…] the psychology departments of universities could have been informed perhaps. Also the psychology consultancy centres could have been informed that they had an option to make referrals. […] It would also be an option to arrange for them to be seen without charge." (ZM, BT)

As a main cause for low motivation appeared to be related to the recruitment, recruitment support may help to keep therapists' motivation high. When some therapists could not find eligible clients, their motivation reduced, but turned back to normal after recruiting clients:

> "My [motivation] declined for the first three to four months. I thought I was not going to be able to find anyone… But later, when [clients] started to come, I picked myself up again." (GUD, BT)

Not being able to recruit enough participants appeared to cause stress in some therapists:

> "The only negative element was wondering whether we were going to find enough participants. That part caused me some stress throughout the study process." (UI, BT)

Stress of not being able to recruit enough participants should be handled in support meetings and recruitment support should be provided to eliminate any negative outcomes.

As highlighted earlier, successful recruitment could boost motivation to be involved in the study. GUD suggested increasing the number of therapists recruited could help with increasing client recruitment:

> "If there were a larger number of therapists, one could reach more clients." (GUD, BT)

6.2.8 Assessment tools

This theme covers feasibility of assessment tools used during the study and information regarding therapists' usual practice for monitoring depressive symptoms, which may help to inform which assessment tools and how frequently should be used in a future trial.

SCL-90-R was used in this study to assess eligibility of clients as it was already used by some of the therapists to screen and evaluate their clients' general symptoms. Most of the therapists thought using SCL-90-R was useful to identify eligible clients. Only one therapist mentioned that it took time for clients to fill it, but identifying clients through clinical interview would be confusing:

> "We had to keep it standard to some extent […] [SCL-90-R] is a widely used scale of course. It was a bit, you know, filling them out takes a bit of time, but in the end we do have to screen [the clients], it has to be something standard. If we left it just to a clinical interview, things could have become very muddled. So in my view, it was appropriate." (UI, BT)

This suggests that it was important for the therapist to use a standardised scale and a clinical interview was considered not to be standardised, which could cause confusions in assessment. Another therapist, however, thought that clinical interview was more useful than SCL-90-R but SCL-90-R was practical to use:

> "The SCL-90 does not really give a sufficiently good idea, but it was functional in terms of its practicality. It seemed to me more useful to make a decision on the basis of the clinical interview. That was my feeling about the process, anyway." (ZM, BT)

This suggests that although SCL-90-R was considered as functional, it may not always be sufficient in some cases and clinical interview could be used as either alternative or in addition to it.

To monitor depressive symptoms of clients during the therapy, the clients were supposed to fill PHQ-9 at each session and at 12 and 18 weeks as follow-up, if their treatment ended before the twelfth and/or eighteenth week. In order to assess feasibility of using PHQ-9 at every session, the participants' feelings about using PHQ-9 at every session were asked.

Most of the participants had positive views about using or filling PHQ-9 at every session. PHQ-9 was found to be useful, and as it is a short scale, the clients did not complain about it:

> "In my view it was good, and the clients adapted to it easily. The fact that the scale is brief was a definite advantage, they filled it out immediately before the session. I think it was worthwhile in order to obtain numerical data for the research, and also to assess their progression […] the situation did not arise [where any client was unwilling to fill it out]." (UI, BT)

A few therapists mentioned that sometimes clients articulated their aversion to completing scales a second time, but PHQ-9 did not cause any problem due to its brevity:

> "They just sometimes said: "What, am I going to fill that out again?" or something like that, but [there was no] serious loss of motivation or problem, and of course the form is a short one which you can fill out quickly." (HB, CT)

This suggests that it is important to inform clients in advance that they would be required to fill PHQ-9 at every session.

Only one therapist mentioned that they found it difficult to use PHQ-9 during each session, as they forgot it:

> "It was difficult to give it at every session, and it could happen that I would forget it. […] It reminds one constantly that one is part of a research study. It is good in that sense, it is at least important because it ensures that I comply with the study, but sometimes it could happen that it got forgotten, that is just my own shortcoming, I think." (IM, CT)

Forgetting to give the scale at every session was linked to doing something different from normal practice, as normally IM did not use a scale at every session. This suggests that for a future trial, it could be helpful to remind therapists that they need to use PHQ-9 at every session and give them PHQ-9 forms labelled with which session they are for to help with this.

One therapist mentioned that the clients thought if they scored badly that would affect the therapist badly:

> "Sometimes clients say 'Well, if I do not feel well, if I am not well, will that be bad for you?' thinking that it might affect me badly in an academic sense […] But I tried to explain and to set their minds at rest, I do not think this [using PHQ-9 at every session] in any way affected the subject we are dealing with, it was not an issue, and anyway, there was no problem." (UDM, CT)

This suggests that there is a possibility for clients to worry about therapist's performance and not feel comfortable about filling PHQ-9, so it could be helpful to explain to clients that a blinding procedure will be applied in a future trial.

Box 1 Reflexive Statement

I was not expecting to hear that clients would worry about the performance of their therapists, because if I were a client in this study, my main concern would not be how my PHQ-9 scores reflected on the therapist who was treating me. I think this was because of my background and experience of research. Hearing what UDM said made me think that some therapists might have also had similar concerns, which could have made them resistant to recruiting clients and using PHQ-9 at every session. I reflected upon the importance of helping participants to understand that researchers would not know which therapists treated which clients i.e. using blinding procedures, in a future trial and informing study participants about data management and analysis to reduce their concerns.

Some clients mentioned that they filled PHQ-9 in a really short time, and could see the change in their depressive symptoms:

> "It took me just a moment to fill out. The questions needed to be answered by entering a grade. They were completed straightaway […] on the form I filled out every week, I came from the worst state up to the moderate level. That amounts to a big difference, and even I noticed it." (Derya, C)

This suggests that using PHQ-9 at every session provided an opportunity to observe the change in their depressive symptoms.

The majority of the clients thought that questions asked in PHQ-9 were *appropriate*:

> "I saw no inappropriate questions at all. […] in my opinion they were important questions which were necessary in order for the therapist to make progress." (Ayşe, C)

One of the clients mentioned that he felt that there was a big difference between second closest option to "no" and "yes" for suicidal ideation, and thought would be better if there were another option in the middle of them:

> "The only problem I had was with that suicide [question]—'I think it would be better if I died,' or something like that. […] I never marked the other last two grading items, the difference between closer-to-positive and closer-to-negative was like a great gulf, I think it would be good if there were something in between." (Enes, C)

One client mentioned that, as she did not attempt suicide, asking about it was illogical so not *appropriate*:

> "Perhaps it could have been arranged according to the status of the patients […] If I were someone who had attempted suicide, then perhaps this question should be included, but because that was never the case, that question was ridiculous." (Fatma, C)

One client mentioned that after the first sessions the questions were inappropriate, and it would be better if it was broader; and rather about feelings and not behaviours:

> "It would have been good if it had been broader, because right at the beginning, it was very clear, and initially it went forward in a way that was very calm and coherent, I mean, I do remember that. OK, the feeling of not doing anything, well, feeling suicidal, when I first went, but later, once I realised what was going on, I was expecting more complex questions. Because, for example, they were positive with respect to the suicide thing when I first went, but later, it all became negative about everything. That thought never occurred to me at all, but in its place other problems arose, about other things. I just think that instead of allocating a number, there should have been …what can I say?… something verbal. Of course, other things came up in that therapy process and I think [the scale] was not adequate [to deal with those things]. I mean, in particular the subject of suicide, for example, [the numeric scale] was really not very functional other than in the first sessions. […] Not about feelings so much, it was rather more behaviour, perhaps because this was behavioural [therapy] of course. […] but I don't really remember." (Sena, C)

This suggests that during the course of treatment, the symptoms of Sena changed or improved, and so she expected to have different questions related to new problems that arose in her life. She struggled to remember questions asked in PHQ-9 directly, so her views about it could be limited in that respect. Although she suggested having a discussion about depressive symptoms instead of allocating numbers to them on PHQ-9, considering that PHQ-9 will be used to assess a client's progress and treatment outcome numerically in a future trial, it could be problematic to collect quantitative data through discussing depressive symptoms. The client can talk about further issues, as Sena mentioned, in therapy itself and measuring symptoms could be done by filling PHQ-9. In a future trial, it could be helpful to inform clients about what each part of treatment is for –i.e. SCL-90-R for screening across a range of mental health areas in response to inclusion-exclusion criteria and PHQ-9 for monitoring depressive symptoms- to help manage their expectations.

In order to explore feasibility of using PHQ-9 at every session for monitoring depressive symptoms of clients in a future trial, therapists' normal practice related to usage of depression scales was asked.

Box 2 Reflexive Statement

At the start of the study, I assumed that therapists would not want to collect PHQ-9 at every session since I knew that this was not their normal practice and I arranged less regular data collection points in the protocol as a result. At the same time, I was aware that I was not a psychotherapist, thus, following the suggestion of my supervisors, I asked the therapists during the BA-M training whether they could use PHQ-9 at every session; the therapists said that they could collect PHQ-9 in this way. Thus, we changed PHQ-9 collection time points. Being part of a research team with others who had previous experience in such research helped ensure this potential limitation was avoided. This process taught me that not using a measurement at every session in therapists' normal practice did not mean that they would not be happy to use it at every session and it was important to ask their views about it instead of following my assumptions and deciding on their behalf. Learning this led me to examine how therapists and clients felt about using PHQ-9 at every session by adding a question regarding usage of PHQ-9 in the interview topic guides in order to inform design of a future trial.

In usual practice, most of the therapists mentioned using Beck Depression Inventory (BDI), and some of them mentioned using Beck Anxiety. Both were usually used pre- and post-treatment:

> "It is my standard practice to apply the SCL, the Beck depression, anxiety and anger inventories to all clients, to all clients who come here. […] We do pre and post test." (RM, BT)

Although, SCL-90-R used only to identify eligible clients in this study, as mentioned above, some therapists used SCL-90-R also in their usual practice to monitor clients' symptoms during their therapy process

There was only one therapist who mentioned using BDI in every session, since it showed the change in the symptoms:

> "If there's no harm in it, I definitely use [the BDI] in every session because it shows everything very clearly, the ups and the downs. They also have something which relates to suicide, and I see that in every session. I think it is good to know this, especially if there is a critical situation." (UM, BT)

One therapist mentioned that they used BDI for all of their clients, but not at every session, as they evaluated clients' depressive symptoms:

> "In patients with depression, I use the Beck Depression Inventory, but I do not give it every week because I do the depressive evaluation myself, but when it has very much increased or diminished, I would feel the need to give it again in order to get an objective view on the trend." (IM, CT)

This suggests that Beck Depression Inventory so scales are considered as a tool for an objective assessment.

Some therapists mentioned using schema scales, and one of them mentioned using only schema scales where they thought this was necessary:

> "It [scales] is not something I choose for my own therapies. [I use] schema scale, by which I mean that where necessary I measure using schema that were obtained." (ZM, BT)

Another therapist mentioned that the scales could cause stress in clients, so they preferred assessing clients through observation; however, in the case of comorbidities, scales were thought to be essential:

> "[…] the client is already depressive and anxious; indeed, an aggressive client will tell us that the scaling adds a bit more stress. Consequently, I believe that measurement more by observations (provided, of course, that you are a sufficiently experienced therapist) will be good. But in my view, sometimes if there is a lot of, you know, comorbidity, scales really are essential in order to determine or to diagnose which symptom is becoming preponderant" (UDM, CT)

The feedbacks from the therapists suggest that BDI and SCL-90 were commonly used with the depressed clients, and in some cases assessment was undertaken through observation and schema scales. Those who used the scales used them at least at the beginning and end of treatment.

The findings presented in this section suggests that in a future trial, SCL-90-R can be used to identify eligible clients as a practical or standardised method. It also suggests that using clinical interview to identify eligible clients, in addition to SCL-90-R, could be useful if it is possible. Most of the participants had positive views about using or filling PHQ-9 at every session, suggesting that PHQ-9 can be used at every session in a future trial. There were two therapists who misunderstood that they needed to use PHQ-9 at every session and so used it at the beginning, in the middle and the end of treatment. To prevent any confusion, therapist should be clearly told that PHQ-9 needs to be used at every session in a future trial and this should also be reminded to them. To prevent clients' concerns related to therapists' performance when

filling the scales, clients should be told that blinding procedure will be applied and the study is assessing the approach rather than the individual therapists' performance, in a future trial.

6.3 ACCEPTABILITY OF TREATMENT

This section presents findings related to acceptability of treatment. It aims to answer research questions about whether BA-M and attention to religion in therapy were considered acceptable. Four themes identified to explore acceptability of treatment are presented in this section (see Figure 6.2).

6.3.1 Perceived benefits

This theme incorporates the perceived benefits of BA-M, including being aware of the BA-M model, a focus on becoming active and scheduling activities, the inclusion of values or religion in therapy, relevance of the approach to client's culture, having a positive relationship with the therapists and improvement in depression.

6.3.1.1 The BA-M model

One of the perceived benefits of the treatment was *being aware of the BA-M model*, which refers to one of the BA-M tools called the two circle model (see Figure 6.3). The two circle model is a simplified version of the BA formulation used by Kanter et al. (2014). Circle 1 refers to difficult life events such as financial problems, isolation and difficulties in acculturation for migrants. Circle 2 refers to common responses given to difficult life events. It consists of emotional –i.e. sadness, feeling depressed and fatigue- and behavioural –i.e. avoiding, staying in bed and stopping housework- responses. The two circle model conveys that when a client responds to difficult life events with common responses i.e. hopelessness and passivity, it makes problems worse and starts the cycle of depression so it is important for clients to realise this pattern (for more information look at the BA-M Manual (Mir et al., 2016, p.10-15) and Kanter et al. (2014)).

The majority of the BA-M therapists had positive views about the two circle model. It was thought that the model was the most convincing part of the treatment method and was understood by the clients:

> "That was the thing that was most convincing for me about how BA can work on its own, I mean, it was convincing on a theoretical level, and the section about, you know, when we shared this with the client, I think it was something that convinced the clients and worked. […] It made sense to them." (ZM, BT)

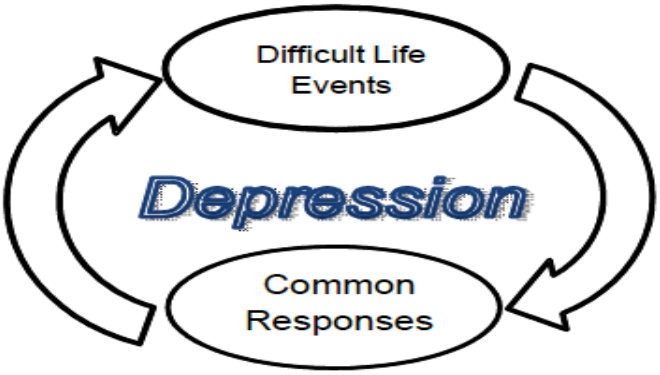


Figure 6.3 The Two Circles Model

The therapists' views affirm some of the clients' views, as the latter mentioned that they found themselves in that circle:

> "I am absolutely that person in depression, I myself experienced the difficult events which are experienced there [pointing the circle], and the problems in my environment, I mean, they are also the reactions that I showed to the events, I mean, it was me in this circle." (Ayşe, C)

One client thought that the two circle model normalised her situation, and changed her views about being the only person who experienced depression:

> "it normalises everything. Like this: when you are in depression, it is as if you are the only person experiencing it. […] I thought my own depression was something quite unique. That is to say, because they were very unique things, [this feeling of uniqueness] was fed by them, but when you look at it, I mean, similar things happen to people who are quite near me. For example, there are some people who experience much worse things but don't develop depression, and there are some people who make a big deal out of things which are quite minor, I mean, [the two circle model] explains that really as common reactions. What I mean by saying it normalises things: that's the thing, in one way, OK, it is very unique, but in another way, I mean, it is really normal." (Sena, C)

One client who also thought that there was a cycle, criticised the model by claiming that resisting common responses did not always get a person out of that circle, and even if the person tried to be active, the activities were done without any pleasure:

> "In my opinion there is a circle but not having this common reaction does not mean that you get out of [the circle]. I mean having this common reaction, it is not like one is punishing oneself. There is an internal crisis, and it somehow seems as if it's not going to go. I mean, I may not be shut away at home, but I cannot go out in the street. I mean, it seems as if I cannot go and do something enjoyable, and when I do do something without pleasure, it seems as if I feel I want to get it over and done with so that I can get away." (Enes, C)

He thought that he needed some time to spend at home first and then to try to become active so fixing some issues inside to become active. The BA, however, takes an outside-in approach to behaviour change(Martell et al., 2010).

There were a few clients who said that they either did not remember[8] or the model was not introduced to them[9].

One therapist and one client had concerns about the generalisability of the model:

> "I do think that one must accept that it may not be able to explain everything. … It is as if the clients also find it reasonable, yes, but still sense there is a question mark as to whether it could solve everything" (ZM, BT)

> "I think it is right […] [difficult life events] may not always result in depression." (Fatma, C)

This suggests that the two circle model might have some limitations. This was also consisted with another therapist's view, as they thought that something was missing in the model:

> "It is as if there were something missing, I mean, are there other things, I wonder? For example, there are difficult life events, yes. When we experience these, what do we do? Well, we react in a certain way. But are there no other factors intervening? Yes, there are. I think it might be necessary perhaps to introduce those too. For example, another thing that may come in, perhaps, is learned information […] it is not only the common responses here, I do not want to say schema for this, but there are certain patterns, or it seems like there must be other things, acting directly, because it is not like that in my opinion." (GBI, BT)

The original BA formulation includes more components to explain the depression circle (Martell et al., 2010). Concerns about generalisability of the two circle model –mentioned above- suggest that it might be better to introduce therapists the original BA formulation in addition to the two circle model in training for a future trial, as it can provide an opportunity for therapists to use either one of the BA models that they think might be more useful and comprehensible.

In general, the data showed that the therapists and clients had positive views about the two circle model and so being aware of the BA-M model was perceived as beneficial, suggesting evidence regarding acceptability of BA-M. For a future trial, it might be better to use the more comprehensive version of BA formulation in addition to the model. Also, therapists should be

[8] Zeynep (C)
[9] Kaan (C)

encouraged to introduce the model to their clients as it is an important tool of BA-M.

6.3.1.2 Focus on becoming active

Another perceived benefit of BA-M was *becoming active.* Focusing on behaviour was found to be beneficial by most of the clients, and helped them to feel better; the majority of them thought this was the approach they needed:

> "Really, I think this was precisely the therapy I needed to receive. […] When I look back at how I was, during a certain period there were times when I felt excessively happy. […] I wanted to be a person exactly like I was at those times. […] I wanted to return to these things, and it was really good for me to repeat the activities of that time, to bring those things I used to do back to life, slowly returning to those moments, and I think it was effective." (Enes, C)

Another client who also thought that focusing on behaviour helped her to feel better mentioned that she could change her thoughts and feelings by changing her behaviours:

> "The behavioural change, for example, I tended to internalise everything more, I built it all up in my head. The therapist said something like this to me: […] If your behaviour changes, your feelings and your thoughts also change" and I always apply that my life, when I experience something bad, I change my behaviour and automatically my thoughts and feelings also change." (Ayşe, C)

One client who did not know which approach was used in his previous treatment mentioned that he had needed that approach in that time (during childhood), but as he was an adult now, BA helped more in terms of self-confidence. He thought that the previous method prepared a foundation for BA-M and thought that although focusing on behaviour was difficult, it was a beneficial method:

> "At that moment, I needed [that approach], now that I am more mature, this [BA-M] felt better, that is, better in terms of self-confidence/reliance. The first time, I was in even more serious depression, I mean, I was doing nothing. […] For me, it was more […] it prepared the ground for me, got me ready for this therapy. I look upon them as separate in this respect: one gave me a foundation, the other permitted to put something there on that foundation. […] It was a difficult therapy, but beneficial in my opinion." (Kaan, C)

This suggests that he related severity of his depression with which treatment he needed and he got benefit from both treatments.

There was only one client who mentioned that she did not want to be active before solving problems related to her thoughts. She was treated by existential therapy after BA-M and mentioned that she felt more involved in the existential therapy, and felt like a student in BA-M

> "I cannot really say that I got no benefit from it all, but so long as I was unable to overcome the thought problems in my head, I did not feel like doing anything at all. I mean, in terms of behaviour, I did not much feel like activating anything. [...] With the other [approach] I felt myself more present in what was going on. Because the questioning took place more in my head and the person opposite me was someone who, to a certain extent, facilitated that, or pointed out aspects that I had not noticed. I mean, I felt that the main subject of discussion there was me, the main focus was me. But in the behavioural section, in the ten session section, I felt like a student again—someone who had to be given homework: 'Do this, do that.' I mean, I really am not saying this in order to run it down. I felt a bit like 'Am I wasting my time?' And of course [we must remember that] I was already in a state of depression, in a state of extreme despair, so I had thoughts like 'How useful is this going to be?'" (Zeynep, C)

It might be hard for depressed clients to *become active* if they think that thoughts should change in order to change behaviour and mood. Sometimes it might be hard to convince some clients that changing behaviour is more likely to help to change thoughts and feelings. Even after experiencing some benefit from becoming active, feeling that change in thoughts was needed as a precursor might show that focusing on behaviour alone is insufficient for some clients, which suggests that using BA-M alongside another approaches might increase its acceptability.

In general, clients thought that focusing on behaviour helped them to feel better and to change their thoughts. The majority of them already thought that this was the approach they really needed. These views provide some evidence about the acceptability of BA-M, at least for the majority of clients.

When the therapists compared BA-M with their usual practice to treat depression, some therapists mentioned that there was a lot of overlap between the behavioural aspects of CBT and BA[10]. Some of them mentioned that they focused on the cognitive part of CBT more, and did not use its behavioural part substantially. Although they thought that BA focused on behaviour and had quicker impacts on clients, CBT was considered by some therapists to be a more powerful option due to dealing with cognitions. One of those therapists thought that BA would be more effective for clients with first-time depressive episodes, but CBT would be necessary if the client had comorbid disease(s):

[10] Such as ZM (BT): "There is a lot of overlap in the behavioural part [of CBT] and Behavioural Activation is something I can normally use. That is to say I do use it depending on the specific case"

> "I thought that Behavioural Activation was more effective because it has more rapid effect, especially when working on behaviour, that it directly targets behaviour, and gives clients more of a role than in CBT, that instead of discussing/talking in a session, [asking] 'If you are uncomfortable about this, what can you do?' to let the client find it. But Behavioural Activation is not something I normally use much when I am applying CBT. [...] I normally work more with the cognitive aspects. […] CBT deals with cognitive processes and I think that is why it is more powerful. But I do think [BA] will be more effective with an individual who is experiencing depression for the first time, especially reactive depression, in setting the person back on the normal path when they have strayed away from that. This is because you are working directly with behaviours and if you give sufficient motivation you can get a more rapid effect, but in cases with comorbidity, for example, I think it has to be CBT." (UM, BT)

This shows that UM thought that the cognitive dimension was missing in BA-M, and so CBT was stronger overall. They suggested that focusing on rumination in the training would be better. It might be assumed that as they were not satisfied with the content related to rumination in therapy, they might have thought that part was missing in BA-M.

6.3.1.3 Scheduling activities

Scheduling activities or homework assignments was also perceived to be beneficial. All the clients thought that the scheduled activities were in line with their values and aims, and some of them mentioned the benefits of homework:

> "Yes, [it was consistent with my values and aims], to a substantial degree. It develops—what do they call it? Yes, mindfulness—over the course of the day, doing everything hour by hour and then in the day, say you have one hour of study, you fill it in on the program, and you put a tick, and you keep getting that feeling of satisfaction. That was really good." (Sena, C)

One client had difficulty in setting and working towards goals. The client's therapist decided to monitor weekly activities retrospectively, without setting any specific goals, and whereby the client was supposed to record any activity undertaken:

> "In a few therapy sessions, I mentioned that I found it difficult to set goals and carry them out. Quite the reverse, I set myself a goal in identifying goals with respect to the past. So currently we are proceeding by tracking the past. For example, the activity homework sheet […] is given to me completely blank. I fill it out myself having carried out the activities, and then we talk about those activities in the therapy." (---, C)

One of the clients thought that the reason for not reaching to some of her goals was related to giving less value to them:

> "I found it impossible to complete some of my goals, but when I later turned back and looked, I [realised] the reason why I had been unable to complete them was that in fact these things weren't as important to me as I had thought, and I noticed that this was why I had not been able to allocate time to them." (Merva, C)

Some of goals set by clients might not be as valuable as they thought at the beginning. In such situations, questioning the reasons for not completing homework with clients is a procedure in BA that appears to be beneficial for clients.

As monitoring activities retrospectively appeared to work for one client, it might be useful for some other clients who struggle to set goals in general, in a future trial.

6.3.1.4 Inclusion of values or religion in therapy

The majority of therapists mentioned that they met clients who wanted to talk about their religious views. The common points from the therapists were that religion should have been handled like any other subject that a client brought to a session:

> "In the training I received, the therapist's position vis-à-vis the patient is that the therapist does not give advice, and will not discuss something unless the patient brings it to the session, I do not direct the patient. But if the patient brings up the subject of religion (and there have been times perhaps when I have worked on values) then talking with the client on the subject of religion, supporting them with Socratic questioning is something which I like to do […] I mean, our position is that whatever [issue] the client brings, we will help them in that questioning process. So we do not take the view that it is better if the client talks about this subject rather than that subject. Giving them guidance so that they understand the connections they have established with whatever matter they have brought in is something that we do already." (CGY, BT)

Another therapist mentioned that if positive religious coping was used by a client, this was reinforced, but if negative religious coping was used then Socratic questioning would be used to solve the issue:

> "From time to time it happens. I would say we do use it [religion], depending on the client's situation, as a coping method, or if the client sees it as a way of strengthening himself/herself, strengthening their sense of self, then we reinforce that […] In the area of punishment or past sins, then environmental factors can sometimes be mixed up with religion. […] [S/he feels] as if s/he has been punished. Again, in the structuring section we resolve this with Socratic dialogue: […]" (RM, BT)

One therapist gave examples of using positive religious coping and hadiths in the therapy:

> "I first questioned this [her coping mechanisms] because she is a religious person. Then I saw that, on the contrary [to being distant from religion], she was praying more, she was engaged in certain charitable volunteer work, and she is going there more. We did [the speaker hesitates at this point], I wanted to support her in this. Apart from that, she had serious problems related to her father, and there was a big distance between them, a reaction to each other, and on that matter for example I used [a quotation/example from] the *hadith*. […] The client was not uncomfortable with that." (---, BT)

Some examples of trying to find an appropriate person to direct the clients when they had questions related to religion were mentioned by both therapists and clients:

> "She mentioned some thought about religion which she had some hesitations about. I gave her guidance, as we do in BA, asking 'Who can you talk to about this, where can you go for an answer?' It didn't make me feel uncomfortable. Yes, [this was helpful]" (UM, BT)

> "He guided me to speak to my hoja [spiritual teacher] … Well, for example, I said I could talk to my own hoja about this matter. Yes [found useful], because only my own hoja could answer these questions. […] [the therapist] encouraged me [to talk to him]." (Sena, C)

These views suggest that helping clients to find an appropriate person to ask their questions regarding religion was an acceptable approach.

One therapist mentioned that the way religion was included in treatment was important, and although they had an experience which could have been interpreted as negative, the way they included religion helped avoid this becoming an issue:

> "I suppose I feel that what is important is how it is included. […] in one of our sessions I did give an example from what I might term a religious story […] [the client] gave a response which was more or less: 'In terms of religion, this was wrong, and anyway it was a made up story.' Our mutual relationship was strong so there was certainly no problem, and I only used it as a story anyway. So it just means the way you include it is important. I used it in a really soft way, I think there would have been no problem. so therefore, I think there is not much difficulty there." (ZM, BT)

This suggests that there might be some clients who have different views, thus therapists need to use religion in a less direct way and be open minded about this, which may prevent them from being persistent about their views and also give opportunity for clients to express their feelings freely without causing tension in treatment sessions.

None of clients mentioned any issues related to the way the subject of religion opened up. One

of the clients gave an example of how the subject of religion opened up:

> "For example, it was like this: We did not openly touch directly on religious matters, we did not talk that way. I mean, we were talking, and I suppose I must have said something in the middle of a subject, for example, and she seized upon something in that, and we took it from there. It was great, I mean, we did not say anything directly." (Ayşe, C)

Some clients thought the reason for the subject of religion being brought up was probably because of the study, and they were happy with that:

> "It was great that the subject was brought up, and I knew that this was because the study was that sort of thing" (---, C)

These clients' views suggest that inclusion of religion in treatment and the way religion included in treatment via BA-M was acceptable.

BA-M therapists were asked to compare BA-M with the approaches that they normally used to treat depression in relation to inclusion of values, and the clients were asked to compare BA-M with a previously attended psychotherapy in relation to inclusion of religion, if they had any experience of therapy for depression before the study. Inclusion of values or religion appeared to be a plus for BA-M compared to some other approaches. One therapist thought that BA-M empowered clients spiritually, whereas this was not the case in CBT:

> "In CBT you are not doing something with a spiritual dimension. There [in CBT] you are going to work exclusively on behaviour, or if there are cognitive distortions you are going to work on them. But here [in BA-M] there is automatically an extra gain for the person because it adds something to their life, and adds something substantial if religion is important for them. [BA-M] offers an advantage for the person in that respect. […] I think that CBT is more useful, as I said—the behaviour sections are comparable anyway, unless I include the matter of values into the calculation. […] [BA-M] seems to me a bit more—how can I put it?—like an approach in which the client has to make choices. CBT is something that you can easily use for nine out ten people while this seems like something that you can adapt for one out of ten people." (GUD. BT)

GUD's views suggest that the inclusion of religion could empower clients spiritually, but they felt when considering the majority of clients, BA-M might not be suitable for all kinds of clients and CBT could be more appropriate.

Similarly, another therapist mentioned that integrating values was a plus for BA-M:

> "The cultural part, or the values part, is important for me, by which I mean that I would say using Behavioural Activation integrated with values seems good. This was a plus from my point of view." (ZM, BT)

One therapist mentioned that BA was something more than the behavioural part of CBT, as it was a standalone method, and BA-M takes the values of clients into consideration more explicitly and earlier in the treatment compared to CBT:

> "In my opinion there is a little more Behavioural Activation [than the behavioural element of CBT] because it treats this as the single approach. It does not go into cognitive restructuring, and because it does not go into that area, it puts more emphasis on these values, or why the person was left in that depressive cycle, and how they are going to get out of it. […] If I were to compare it with CBT, I would say this [BA-M] openly [takes account of values], and does so at a much earlier stage and in a more concrete fashion through the Behavioural Activation values scale. Consequently, when I compare the two, this takes [greater account of the client's values]." (UI, BT)

Although UI mentioned that BA-M considered values of a client more than CBT, another therapist was not sure whether BA takes the values of clients into consideration:

> "When we look at BA, there is a question mark as to whether BA takes much account of clients' values. It is more focused on practice. […] CBT does take account [of clients' values] to some extent." (RM, BT)

One of RM's clients said that the Values Assessment tool was not used in his treatment although the training of BA-M included this. Thus, the reason why RM did not use the VA is unclear but the quote above suggests that they were unaware of VA as part of BA-M.

When RM compared BA-M with Logotherapy, they mentioned that although the latter focused on client values, it did so in an abstract way, which could affect the duration of treatment, causing client drop-out:

> "Logotherapy does go into values of course, and it goes into meaning. But Logotherapy takes a more abstract existentialist approach […] it does not give much direct importance to activities and behaviours, though it may go on to tackle this at the later stage. In that case the intervention period may be prolonged. But then there may be dropouts with clients saying 'We're coming to all these sessions, and there's no change." (RM, BT)

This suggests that clients want to see an improvement in their symptoms as soon as possible, and when it takes a relatively longer time to start to see any improvements, this might cause the premature termination of treatment. Considering the symptoms of depression such as

diminished interest and hopelessness, having some improvements in depressed symptoms as early as possible appears to be important, which in turn can motivate clients to continue with their treatment.

Some clients did not have any therapy sessions before the study, so they could not make a comparison:

> "I never received therapy, perhaps because I had finally reached the end of my tether, Allah put this in my path." (Ayşe, C)

This suggests that having access to the therapy was seen as a spiritual event by Ayşe, this may be related to inclusion of religion.

In contrast to RM's view mentioned above, one of the clients who was previously treated with CBT mentioned that BA-M considered his values more compared to CBT. He did not like CBT, and liked BA-M more:

> "In my view, this approach may not appear to take much notice [of values], but in fact it pays great attention to them. […] [CBT] is not something that I can altogether accept. I really liked this approach more though I cannot assert anything with 100% clarity […] I did not work with experts [in CBT], I worked on a more amateur basis, with someone who was an amateur, what I have said is based on what I have read and seen, and what I know from lectures." (Enes, C)

In conclusion, there are clients who want to include religion in their treatments and the majority of therapists mentioned that they met such clients. There were no issues mentioned by the clients about the way religion was included in their treatment and they were happy to include religion in their treatments so this suggests that the inclusion of religion in treatment via BA-M was acceptable. Only one therapist mentioned having tension when he used religion in his client's treatment. Inclusion of religion in a less direct way helped him to not to have an issue in the treatment. Thus, this suggests that the way religion included in treatment is an important factor that effects acceptability of treatment.

The majority of therapists emphasised that there was considerable overlap between BA-M and the behavioural part of CBT (see also 6.3.1.2). The majority of therapists thought that BA-M took values of clients more into consideration compared to CBT. Some mentioned that BA-M empowered client spiritually which highlights one of the benefits of BA-M, considering effect of religion and spirituality on mental health (See Section 2.2.1) There was only one therapist who was not sure about whether BA-M considered client values and his client said that VA

was not used in his treatment although he trained in using the VA, which suggests that he was probably unaware of VA. In a future trial, the importance of VA should be emphasised to make therapists aware of the tool and also encourage them to use the VA as it is an important tool in BA-M, which is perceived beneficial. Some therapists thought that BA-M would be more beneficial than other treatments for some clients, but not for all. This could be due to not considering that everyone would want to include religion in their treatment as some therapists thought that BA-M without inclusion of values is similar to behavioural part of CBT. Considering Kaan who did not use the booklet and was not introduced the VA and had positive views about the treatment when he compared BA-M with his previous treatment, suggest that BA-M could still have potential to be beneficial for clients who do not include religion in their treatments. As only a few clients had experience of another therapy for depression, it is not possible to compare therapists views with the clients views in terms of considering appropriateness of different approaches.

6.3.1.5 Systematic approach for inclusion of values or religion

Another perceived benefit of BA-M was that BA-M was considered to be a *systematic approach* with defined methods for including religion. When BA-M therapists were asked to compare BA-M with the approaches that they normally used to treat depression, some of them mentioned that BA-M provided a more systematised way to include values in treatment compared to their usual practice:

> "In terms of working on values and beliefs, I was already working in this way… I sometimes used to recommend books or readings like those in your *Booklet*. After that I would give homework. I used to give exercises in order to give that person awareness of the obstacles facing them, and how they could be overcome. It seems like we are doing similar things […] now with BA, of course, there is a ready-made approach, systematised, and that suited me, and made my work easier. This turned out to be a more professional version of the approach that I use." (GBI, BT)

GBI had already tried to use religion with their clients if the clients expressed a preference for this, but they thought BA-M provided a more systematised and professional way to work with beliefs. A systematic approach might be better to help clients and to give therapists more confidence to use religion or beliefs in treatment, whenever appropriate. They thought that the *Booklet* provided them an opportunity to include religion in treatment more comfortably and they would continue to use the method, as it provides a more systematic way of integrating religion within treatment:

> "I normally work a bit more with a religious basis and therefore I liked [BA-M] because it is more systematic. Following those steps there made things easier for me. So I would use it. […] I didn't much use the verses, dhikr[11] or things like that which were mentioned in the *Booklet*. Right now, I think I would be able to use it, but only within the framework of that *Booklet*, and I am not thinking about adding in anything from anywhere else because what is there seems more satisfactory for me." (GBI, BT)

These comments show satisfaction with the content and language of the *Booklet*, and willingness to continue to use it in practice. This also shows that although the *Booklet* might not be acceptable for all the clients and therapists, it is deemed to be acceptable at least for some of them.

CBT group therapists mentioned that inclusion of religion in the treatment could be useful for clients if it was a value for them, and one of them emphasised that it would be good to put it in a standardised, structured, and evidence-based format:

> "I have positive views about it […] [religion] is one of the dynamics that encompasses human beings, and I have seen that if the person already has a leaning in that direction, it can be used as a major vehicle or material… The standardisation [of inclusion of religion in therapy] and evidence-based structuring in such a form would be really great. […] Certainly, culturally we are religious people even though we also have other secular structures… In my view, the use [of religion in therapy] would be excellent because as I said, it still has a wonderful and positive place for us all in view of our emotional and then our cultural patterns." (HB, CT)

This suggests that therapists recognise the need to have religiously integrated treatment in Turkey. Another therapist's view supported this; UM added that normally a good therapist and treatment method would not exclude religion, but in Turkey the situation was different:

> "Generally speaking people in Turkey behave as if there is no such thing as religion, and I don't believe that it has found much space for itself in therapy, so yes, it [inclusion of religion in therapy] is a good thing. But since a good therapist or a genuinely good therapeutic approach could not possibly ignore religion, there ought not to have been a need for something like this in the first place. Just at the moment it may be effective in rectifying a mistake, but I think that ideally therapy does not require additional religious work, since therapy is something which can very readily accommodate religion." (UM, BT)

UM's views highlight the need for a religiously integrated treatment in Turkey, as religion is ignored in treatment. Furthermore, she emphasised the importance of religion in people's lives

[11] Remembrance of God

in Turkey:

> "But therapy is at work with people who live in Turkey, and religion is an important thing in those people's lives, so excluding it results in this odd psychotic situation which is divorced from reality." (UM, BT)

She thought religion is a value in people's lives, which suggests that people may need to include it in their treatment process as like any other values in their lives but the current view – seeing religion and psychotherapy as alternatives to each other, in Turkey does not allow this:

> "In Turkish society there is a dualism that goes like this: religion and psychology are alternatives, enemies or competitors. You go to the *hodja [religiously wise person]* or you go to the therapist, and people who go to the therapist are told 'If you had gone to that *hodja*, the problem would be solved,' and the reverse also happens. There are people who belittle those who go to the *hodja* saying 'Whatever next! You should go and see a therapist!' But these two are always seen as alternatives. That's the way it is in society, and behind this there is something that is not so far from reality." (UM, BT)

This dualism between religion and psychology might make it harder for therapists to feel comfortable about involving religion in treatment. She linked the existence of this dualism to secular mentality in the field of psychology in Turkey, which could be one of the potential factors that caused discrimination towards religious people in the field:

> "I'm not sure exactly why, but up to 5 or 10 years ago, the academic field of psychology and the therapist community had developed with a secular mentality… And this meant that up to 5 or 10 years ago, religious people did not become therapists […] and in addition there were straightforwardly wrong, discriminatory practices which must have fed into the situation, such as the fact that women who wore the headscarf were not admitted to postgraduate clinical psychology programs. The result of all this was that in Turkey religion was not really an accepted element in therapy - though let me say that I am saying this not as a fact so much as my impression." (UM, BT)

This suggests that although religion is an important factor for people in Turkey, religion has been ignored and not accepted in the field of psychology for many years. This ignorance even caused discrimination of religious people by preventing them to become psychotherapist. If potential clients know this reality, it may cause them to be more concerned about seeking help from psychotherapists as they may think that they could face discrimination too or, as UM mentioned, they may not feel comfortable to bring religion in treatment. She considered BA-M as a potential solution for these issues:

> "If a person coming for therapy cannot bring their thoughts, emotions and upsetting patterns relating to religion or to Allah because they think that it is a highly secular process which has nothing whatsoever to do with religion or Allah, then that's a problem. This intervention we are talking about [BA-M] is something which can remedy that." (UM, BT)

This view shows that sometimes clients might not feel comfortable to talk about religion in therapy because of the perception that therapy is a secular process. This is seen as unhelpful for mental health, causing some further issues such as worsening their symptoms or preventing benefits from religion in some cases. This suggests that there is a need to change the current view of religion and psychotherapy being alternatives to each other, and BA-M could help erode this false dichotomy. A therapist needs to accommodate an environment in which clients will feel comfortable to bring their thoughts, emotions and religious views in therapy without considering therapy as a secular process.

One of the clients supported the idea that religion and science should not be two separate things, and she liked her treatment to involve religion:

> "I was really pleased that such work is being done because I am someone who has Islamic sensitivities. Science, knowledge and Islam are not things which should be kept separate. But unfortunately, what with secularism and all that, everything was kept separated out and this had the effect of promoting fanaticism among Muslims. So what I mean to say is that the inclusion of such a thing, Islam, religion, pleased me a great deal. I am very happy about it, really pleased, and, I mean, I must thank you very much for being part of this." (Merva, C)

Some of the therapists confirmed that before the study they had prejudice or concerns about including religion in therapy:

> "Because it would be a transmission of values, according to the previous ethical position, taught in undergraduate courses or in postgraduate studies, the transmission of religion, the transmission of values was not supposed to happen. We always received training to this effect, and therefore I had a prejudice about it. […] I cannot say that [my views] have changed all that much, but if a client with depression wants this, and it is appropriate for that client, it can be applied." (RM, BT)

There were a few more therapists who had initial concerns about including religion in treatment, but their views changed during the course of the study. One of them had concerns as they did not identify themselves religious and competent to engage with religion:

> "I was a bit worried because I don't identify myself as religious. With this I would be introducing something I'm not adequately knowledgeable about [religion] into the therapy, and I was concerned about what I was going to do about it. In fact, this approach is not like that. Later, when I realised this, I felt more comfortable, and frankly, after applying it, the subject became clearer for me, and I became less concerned." (UI, BT)

UI was worried as they were not a religious person, and some other therapists were worried about imposing or transferring values to clients. However, the client-centred nature of BA-M and inclusion of attention to religion following a Values Assessment increased the acceptability of the BA-M and meant therapists felt more comfortable about paying attention to clients' religious identity in treatment. Their confidence increased after having experience of using BA-M in practice.

One of the therapists mentioned that the boundaries of attention to religion need to be clear, otherwise there might be potential for the stigmatisation of therapists who used this approach. The approach might be seen as unscientific, reducing the status of their work. She felt that training could help with this issue:

> "It is important to know the limitations really well. You have to be very clear about where you need to stop and where you need to press onward. Otherwise, you're engaged in scientific work but you might be perceived to be something quite different. Consequently, I think this should be operated in a manner which is limited at a certain point, as with your [BA-M]. I think any other version could create a lot of problems in Turkey. I mean, firstly, the reputation of the profession could be damaged. Secondly, I think this work needs to be done by therapists who really understand this work, who are experienced in this matter… Do you remember, in the training session, questions were raised on the first day, but after that not so much. I mean, they had no idea how they were going to use belief in their therapy, I noticed one or two people like that. But the following day… they felt easier when saw that there were defined boundaries, when they saw what they were required to explain, and to what extent. This is something important in my opinion." (GBI, BT)

This suggests that the training helped to draw some required boundaries, and this helped some therapists to feel more comfortable, as UI also mentioned above. Having some boundaries and keeping the border between their "scientific" psychological work and their "non-scientific" holistic therapy care appeared to be an important aspect for therapists, who were anxious not to abuse their professional role, providing further evidence in relation to acceptability of BA–M.

Box 3 Reflexive statement

> Since I observed the effect of secularism when I lived in Turkey, I expected therapists to be slightly cautious about involving religion into treatment. The data, however, showed that some therapists demonstrated higher levels of anxiety than I expected, regarding the inclusion of religious values into treatment that might be considered as doing something unscientific. This highlights the importance of being open to unexpected themes and being able to modify my views based on evidence.

6.3.1.6 Relevance to culture

Most of the therapists thought that BA-M was *relevant* to the culture of Turkey. One of them mentioned that it could be more beneficial for people who lived in smaller cities in Turkey compared to big cities –probably by considering that people in smaller cities would be more conservative or religious compared to big cities, and focusing on behaviour appeared to be more appropriate for the culture in Turkey:

> "It is appropriate [to the culture of Turkey], I mean, I do not think there is anything about it that is inappropriate." (ZM, BT)

> "Yes, I do think that BA-M is appropriate to the culture [of Turkey]. Of course, it depends on the big city/small city factor. It is more useful for those small places than for here [Istanbul]. […] We first engaged in cognitive structuring, and shifted to behaviour. Now, when we engage directly with behaviour, actually it fits Turkish culture better. In the Turkish culture when the doctor, who is an authority figure really, gives these [tasks] directly: 'You are going to do this, you are going to do that,' or 'Write down your activities and bring them to me' off they go, do it, and bring you the list of what they have done. I myself have been surprised to see that they did such things." (RM, BT)

One therapist thought BA was more appropriate for the culture of Turkey in theory, but in practice, a therapist should not leave religion outside of therapy, so CBT should also be considered as appropriate to culture:

> "If we look at the theory, BA [is better suited to the culture of Turkey] but in practice, as I said, a real therapist should not make the client feel that they have to leave religion at the door [anyway], so we can say that CBT is also appropriate. I think it depends to some extent on the practitioner." (UM, BT)

Section 6.3.1.5 on systematic approach for inclusion of values or religion presents UM's explanation about how successive actively secular regimes in Turkey have excluded religion from treatment.

One therapist mentioned that there was a need for a culturally adapted treatment in Turkey, and except for a few points related to the application of BA-M in practice, BA-M was appropriate for the culture of Turkey:

> "I mean, the adapted version is definitely essential. Of course, we had some difficulty because most of the sources are western-based… In Turkey, for example, those schedules and things like that aren't implemented very much. But I know that this is because of, you know, the English or the Western mentality. […] But I perhaps I can say one thing, because I tried to apply some of this kind of thing to a client, that plan, those programs etc, and s/he was not very impressed. […] Some things, of course, vary from person to person, and I cannot speak for everyone, but apart from a few small things which I have just mentioned, the practice really is (apart from that) quite well suited to the culture of Turkey." (GBI, BT)

RM and GBI both thought that the treatment was appropriate to the culture of Turkey. RM mentioned that activity scheduling and filling homework sheets were useful, whereas GBI's observation was different as their client did not find those as useful. GBI mentioned having some difficulties and linked those to the tools been Western based and not being implemented in Turkey very much. This view raises an issue regarding whether these tools were not culturally appropriate. There was not any other therapist who mentioned similar concerns. As GBI mentioned, the usefulness of BA-M tools might vary between different clients. Homework sheet and activity scheduling are potential tools for use in treatment, but their application in practice may change.

Another therapist also mentioned that although BA-M might not be suitable for all Muslim clients, it could be highly suitable for some of them:

> "If we are defining the culture as Islam, then this approach may not be a perfect fit for every individual in this culture, but at least as far as I have experienced it is quite useful for some people, and perhaps it may turn into something more beneficial than CBT, though not for everyone. I mean, an approach which is adapted to a culture may be good for some people in that culture." (UI, BT)

In general, the therapists thought that BA-M was appropriate for the culture of Turkey, and while it might not be appropriate for all clients, it appeared to be appropriate for at least some of them. They also thought that BA-M considered clients' values and worldviews more than CBT. Answers given by the clients when they were asked what changes they would recommend to be made to BA-M agree with the therapists' views about appropriateness of BA-M for the culture of Turkey. This provides more evidence in relation to acceptability of BA-M. Most of them did not suggest any changes, and a few of them mentioned that, as the treatment was

beneficial for them, there was nothing to suggest:

> "I […] don't add anything or take anything out. […] You know, it was something that went wonderfully, I mean, I have never felt anything like that." (Ayşe. C)

Some of the clients [Kaan, Merva, Fatma Derya] mentioned that they did not know or nothing come to their mind about what could be changed.

The clients did not suggest any specific points which needed to be improved. This could be related to both the clients not being experts in the field, and/or them not seeing any missing parts in the treatment that they needed. The suggestions made by some therapists are already presented in each section (e.g. Section 6.3.2.1 -removing hadiths from the booklet mentioned only by two therapists- and Section 6.3.1.1 –providing an option of an additional more detailed model) separately, and are not repeated here.

6.3.1.7 Having a positive relationship

When the clients were asked about their relationship with their therapists, the majority of clients appeared to have a positive relationship with their therapists, meaning that it was possible to form constructive therapeutic relationships in the course of using BA-M. Most of the clients described their relationships with their therapists with some positive words and phrases, such as "loving the therapist," "sincere relationship," and "insightful therapist":

> "It was sincere, warm, understanding, and elucidating in a comprehensible way." (Derya, C)

> "Well I really loved my therapist. I really, really loved her; I mean at later times in my life I would want to see her […] And if I hear of anyone I will direct them to them [the therapist], because they have a really wonderful energy. I mean they explain things so wonderfully … the conversations really flow. You talk to them about it all without even thinking. I mean, because they give a, you know, energy, they communicate it." (Ayşe, C)

Ayşe's words show her trust to her therapist, as she emphasised that she could tell everything to her therapist without thinking. This also shows she could talk without hesitation. She wanted to see her therapist in the future and would suggest her therapist to anyone who needed therapy. This shows that they had a strong relationship.

Other emphasised aspects of the relationship with therapists were being listened to and not being found to be unusual:

> "[The relationship] was good, of course, warm, I mean. They always showed a lot of interest, listened to me at all times, in every way […] they never reacted as if what I was saying was unusual." (Fatma, C)

Another client also described her relationship with her therapist with positive words, but she felt that study restricted them:

> "It was great. I mean, ---[the therapist] was very understanding. They are a very polite and modest person of course, and this put me at ease, I felt that they understood, I mean. But there was something else, I was aware that the study was restricting them. For example, now they will say more, but they were very much aware that he was operating within the study, and consequently, as a psychologist, it was very helpful, I mean he maintained his boundaries." (Sena, C)

The reason why Sena felt her therapist was restricted by the study might be due to therapist transference of their feelings about being restricted by the study to their client. As described in section 6.3.4, some therapists referred to their concerns about being restricted with only one or newly learned method, as an obstacle during the course of study. Sena's words show that this restriction might be felt by clients too. This feeling might not be healthy for a client in the process of treatment, thus some measurements should be considered to prevent such feelings.

The majority of the clients felt that they had been understood by their therapists. Enes thought that he could not be understood better than he had been understood by his therapist. There was only one client who did not use positive words when he described his relationship with his therapist, but he did not use any negative words either:

> "I would say normal […] I mean, somewhat good." (Kaan, C)

However, as mentioned above, Sena felt that her therapist was being restricted by the study. Zeynep also felt this, although she had been understood well:

> "[The therapist] understood me, but I did feel quite clearly that they were constrained by the approach. Because I also have this advantage […] I have observed the therapist's own style and therefore I have a higher level of understanding, and I have had a chance to compare and see how restricted [the therapist] was. So I can say it was quite limiting." (Zeynep, C)

After Zeynep recovered from depression and she and her therapist decided to end the treatment (BA-M), she continued to have therapy with her therapist outside of the study after filling the PHQ-9 at the eighteenth week. Thus, she compared her therapist in terms of when she experienced during and after the study. Both Sena and Zeynep were clients of the same therapist. Consequently, the pattern of feeling that therapist being restricted by study appeared

to be unique to that particular therapist, as it was not reported by the clients of other therapists. This might be due to this therapists' familiarity with the research area, which might have provided them with awareness of the importance of sticking to BA during the study time. Thus, this might be the cause of feeling restricted, and transferring this feeling to the clients.

Having a positive relationship with therapists and so being understood by them probably affected clients' views on importance of becoming from similar backgrounds with therapists and led them not to consider it as something important. Because the majority of the clients said that coming from similar backgrounds, including religious background, was not something important for them as long as they were understood, and the backgrounds of therapists were not reflected in the treatment:

> "In my view it is not important if they are not from a background [similar to my own] so long as they respect me, so long as they can understand what I am saying and give me appropriate guidance, then it is not a problem for me." (Merva, C)

> "It really makes no difference, the only important point is this: irrespective of the religion of the person facing me, if, in the things they say […] they were to constantly bring in things that were not relevant or appropriate, then I would be uncomfortable with that. […] They can live their life as they choose, and I have no problem with that so long as they don't impose it onto me." (Zeynep, C)

Two clients mentioned that the religious background of their therapists was important to them:

> "Of course, whenever they [the therapist] said something religious, I mean we had common ground. This was important for me." (Ayşe, C)

> "It would be important for me that [the therapist I am going to visit] has an Islamic sensitivity." (Merva, C)

The nature of therapist-client relationship is important for the outcome of treatment (Krupnick et al., 2006). As mentioned above, the majority of clients appeared to have very positive relationships with their therapists. This might be due to both therapists and clients being from Turkey, sharing similar cultural backgrounds. This does not mean that they had identical cultural values, but it means that they are familiarised with the same cultural milieu and values, which is conducive to a positive relationship during the delivery of BA-M, providing additional evidence for its acceptability. The observed positive relationship between therapists and clients from BA-M group may be one of the contributors of clients' retention. Clients felt that they were understood. To reduce clients' feelings related to therapists' feelings about being restricted by the study, in a future study, therapists can be trained on how to cope with this

feeling, and how to avoid transferring this feeling to clients. Working in a study requires some boundaries, as it is important to prevent confounding, and to be able to measure treatment efficacy by removing some possible variables (Hotopf, 2002), such as using two therapeutic methods, but this should not lead to feelings of being restricted, as it can affect the performance of a therapist and treatment outcomes, reducing the quality of care provided.

6.3.1.8 Improvement in depression

Treatment was perceived beneficial as clients reported *improvement in depression*. Most of the clients mentioned how their depressive symptoms changed or decreased e.g. reduced guilt and increased self-esteem after the treatment. They also mentioned that it helped them, and some of them mentioned that when they subsequently faced any difficulties they remembered what their therapists told them:

> "Toward the end I started to feel better, compared to how I felt at the beginning […] It was the same with the final therapy [session], you know, because there were aspects where I considered that I fell short. The more we talked I realise that I did not have those shortcomings. There were things I felt very guilty about. Then, you know, I noticed that I was not seeing these things at the end of the therapy, well, of course, the things we talked about remained drilled into my head. When I experienced anything in my life, the things that the therapist said came immediately to mind, and I mean it was a real help to me." (Ayşe, C)

Ayşe mentioned what changed in her life after the treatment and how it helped her. She learned how to deal with difficulties she faced as she learned and experienced that changing her behaviour would help to change her feelings and thoughts (see 6.3.1.2). Similarly, Merva's views supported these ideas:

> "At the outset I was somewhat, you know, operating in a mode where I had no aim. I mean, I had lost my goal, I did not want to do anything, I did not even want to put one foot in front of the other. […] Even during Ramadan [at the end of day fasting] I neither ate nor drank. […] When I came out of the later therapy sessions [I said to myself] 'Life does go on, Merva' and I did find I had goals. Later, I even started to have different dreams for the future. […] [My reason for ending the therapy] was that I had resolved the matter. Basically, we talked about something related to a balance like this, and together [with the therapist] I was able to resolve it. I really did solve the matter, and applied it to my life. Yes, I did have a problem, and that problem sometimes comes up in my mind, and preoccupies my brain. I was able to continue with my life in a balanced way, and that problem of mine was not invading the whole of my life. So I thought, 'We can finish it now.' In my opinion [the therapy] worked for me." (Merva, C)

This suggests that Merva recovered from depressive symptoms during the course of the

treatment. She did not solve the problem completely; this might be due to the impossibility of changing the situation in some cases, such as bereavement. Nevertheless, she learned how to deal with and manage problems in her life.

Only one client mentioned that he was not sure what helped him, but he felt much better compared to before the therapy process:

> "Whatever it was that happened, I do feel good at the moment. I feel unsure about it, but in end the outcome is that I am well. When I compare myself with my previous state, I think the therapy did do me quite a lot of good. […] As for the type of therapy: let us say that it helped me help myself, I can say that in my opinion it ensured that I developed the awareness required to help myself, so that I could do something for myself." (Enes, C)

As seen in the views of Enes and Ayşe, raising awareness about themselves and what they can do appeared to help clients feel better. Recovery from depression has been perceived as a complex, personal journey and associated with higher levels of perceived social support and group memberships (Richardson and Barkham, 2020). This might be the reason for Enes being unsure about what exactly helped him.

Two clients had mixed views about BA. One of them mentioned that she felt like a robot, and the reason for her to start therapy was being in a bad state and at that time, and doing the things that therapists asked her to do was not really encouraging. When she could not complete the tasks she felt worse about herself. When she was able to complete some tasks she felt good, but she felt like a robot because of the study/BA, and was not sure whether it was the effect of the treatment or the expectation about feeling good that made her to feel good:

> "I felt that the approach was very limiting. […] I was in a poor mental state and the things [the therapist] said to me were: 'As part of your daily routine, even if you do not feel like it, try to do the things which you would normally be happy doing, and you will see that while you are doing them, you do become happier, and this will be something that will become self-perpetuating.' What I mean is, it was not very energising. In that state of mind, I did not have the strength to do it anyway. The opposite happened sometimes, when I felt bad because I was unable to do what [the therapist] told me. […] I do remember that I did feel good doing [some activities]. But as I said, I mean, I felt a bit like a robot doing that, I can tell you that quite clearly. Consequently, when I did do something and it felt good, I thought things like 'Is this authentically feeling good, or am I feeling like that because I am supposed to feel good now.'" (Zeynep, C)

The other client who had mixed views about BA stated that BA was direct, good for her, focused on the problem and its solution, but it did not resolve something deep down. She started

to use medication after the therapy as her issues were not solved:

> "In the end it was good for me. It was direct, like this: there was a focus on the problem, and he solved it. In the end, it silenced the stuff I was telling myself in my head. But I would say this, as feedback, it did not resolve something, deep down, and perhaps, how can I say, it covered it up. […] There is a problem deep down, probably in me. So for instance, I started on medication afterwards, that did not produce a solution, it just did, you know, by activating me, and I suppose this was the aim, and I believe it was successful because of that. I mean, by activating, it pushed [the issue] into the background. But it remains there, and another problem is that I was worried that it might come back." (---, C)

These two clients felt better at the end of therapy, but they did not think that it was enough for them. They thought that BA had some limitations. These views are consistent with the view of ZM (BT), who stated that BA might not be suitable for all clients. Considering that BA aims to reduce depressive symptoms by increasing activeness, BA seems to have worked, but it did not appear to meet in full the expectations or needs of some participants.

Clients also saw the potential benefit of including family members in the treatment process to support them but this was not always possible. Two clients mentioned the therapist asking whether the inclusion of a friend or family member would support the treatment process. Even though they had the desire to invite one of their parents, they felt that no one would come:

> "Yes, [the therapist] also suggested that, but I did not include them. [If I had included them] it would have been [good], but I thought that [the family] would not come. I mean, my mother, or my father, they would not have come. I had not experienced any problem with anyone apart from them." (Derya, C)

> "I don't remember much but I think we talked about my father most. And my answer there was quite clear, I said that my father would not come. If the [therapist] saw it as appropriate, I would want him [to be included] because I have some problems associated with him." (Zeynep, C)

Only two clients wanted to involve someone in their treatment process. The common issue for both was that they thought that involving their parents or father would probably help to solve their therapeutic issues. Other clients preferred not to involve someone in their treatment process[12].

One client who also mentioned that he found the treatment beneficial thought that the treatment had some shortcomings:

[12] For example, Ayşe and Merva (C)

> "I found [the therapy] useful. As I said, I had reached rock bottom, I was looking for something to hold onto, and indeed it did become something I could hold onto. Other than that, of course there are some shortcomings, but I consider that normal." (Kaan, C)

Although he got benefit from the treatment, he was not satisfied with it. It is worth mentioning that he was the client whose treatment still continued, as mentioned a few paragraphs below. He did not directly mention what were the shortcomings of the treatment, and when he was asked whether he thought there was a need to add or delete some aspects from the treatment, his response was: "No, I do not know".

One client who continued to have treatment with another approach outside of the study mentioned that the treatment was not enough, but she could not say that she did not get any benefit from it:

> "To be honest, I knew that I had a long way to go, and of course [the therapist] confirmed that there had not been enough [sessions], that there were still some things which had not been resolved. […] I got benefit [from the therapy], and I cannot say that it was without benefit. I can say that I feel good compared to the time when I started." (---, C)

In general, these findings show that all clients got benefit from the treatment to some extent. Most of them felt good after the treatment, and observed a decline in their depressive symptoms. They also show that BA-M taught clients skills that they could subsequently apply in their lives outside therapy contexts to manage their symptoms. This skill could increase resilience and self-efficacy while suffering severe depression episodes in the future, and prevent relapses in general. This data provides evidence in support of the acceptability of BA-M for the majority of clients, but it should not be forgotten that some clients may need other forms of support, as there is no universal model for the treatment of depressed clients.

Improvement in depression could be related to satisfaction with the number of sessions attended. The majority of the clients thought that the number of sessions attended were sufficient for them:

> "Toward the end I started to feel better, compared to how I felt at the beginning, my therapist also said this. […] I mean, it [the number of sessions] was enough in my opinion" (Ayşe, C)

One of the clients who thought the number of sessions were sufficient suggested that it would be good to have a booster session after a while:

> "We met 7 or 8 times. […] That was enough. Actually, we might have a break and then continue later. […] For example, if we used to meet once every 10-15 days and we might meet again in, say, three months' time." (Fatma, C)

This suggests that some clients might want to have additional treatment session with their therapists, a few months after their treatment ended. Thus, in a future trial, a booster session should be considered. This might help to collect follow-up data, meaning that for example, if a client comes to have a booster session three months after the end of treatment, a therapist can ask the client to fill the PHQ-9 at that time.

Only one client thought the number of sessions was not enough, and thus continued treatment with the therapist using a different therapeutic approach:

> "No, it was not really enough, and that's why I am still seeing [the therapist]. I mean, not in the context of the project, not with the same approach, but we are continuing with the process we started from there." (Zeynep, C)

Zeynep and her therapist decided to continue to the treatment process with another therapy approach, as mentioned in the previous paragraphs. Thus, this issue could be related to not having improvement in depressive symptoms with BA-M.

One of the clients mentioned that there was a problem for her when the treatment was finished as she did not consider herself to be well; rather, this was the judgment of her therapist. She related her recovery to her PHQ-9 score and her therapist's decision about ending the treatment. Although she perceived the decision of her therapist like an approval about her wellbeing, that positively affected her, she perceived that decision as sudden:

> "The only problem was this: […] at the previous session because on the basis of the last forms [referring PHQ-9] that I had filled in, […] they [the therapist] said 'You appear to have been well for three weeks, therefore let us conclude.' they said we could finish. […] After that, well, I went to the last session, I mean, they said, "We have decided to finish" or something like that. But they said "I will still support you outside the study," or something like that. That took me aback a bit, to be honest, […] perhaps because it was not me that finished it, perhaps it was as if I did not feel that I was ready. […] but I had still not, you know, in an active way finished it by saying 'I have decided that I am well.' It was [the therapist] that finished it. But the fact that somebody gave their approval by saying 'You are now well' did make me feel good. But I was a bit nonplussed by the way it finished, saying to myself: so it seems I am well now, and it is over." (Sena, C)

This suggests that she was confused because of the therapist unilaterally deciding to end her treatment. Consequently, it might be better to make a joint decision with clients on when to

end treatment.

Although the majority of the clients thought the number of sessions attended were sufficient, one client did not think it was enough, and another client had mixed feelings about it. One of the clients was still in the process of treatment. For a future trial, it can be suggested to offer joint decisions with clients about the time to end treatment.

6.3.2 Personal values

Personal values affected the acceptability of treatment for both clients and therapists. For the clients, therapists' knowledge about their values was considered to be beneficial and religion was an important value whereas the therapists' values focused on being client-centred.

6.3.2.1 Clients' values

A 'Value Assessment' tool is used in BA-M (Mir et al., 2016) to give clients the opportunity to share their values with therapists, which in turn helps therapists to design the treatment plan in accordance with clients' values. All clients had positive views about the tool, and thought that it was beneficial for therapists to know their values:

> "I think it is very beneficial, in terms of knowing me better, for the therapist [to know] what I value and what I do not." (Enes, C)
>
> "It was beneficial. We set our priorities." (Sena, C)

The therapists found it helpful to use the value assessment tool in order to identify which clients chose religion as a value, so the therapists felt comfortable to ask those whether they wanted to use religion in their treatments:

> "Giving an account on the basis of values is really good in my view. After all, if we were to say 'Now we are only going to use religion and we will adapt a religious model' it would be more off-putting. Indeed, worse than off-putting, it would mean nothing to a person, but when I say: "Yes, what are your values, because we are going to engage in work related to your values?" then when religion does come into the business, it is really great. I mean, I think it was smart to integrate religion [in treatment] with this model, it was great."(GUD, BT)

Including religion in treatment when a client chose religion as a value appeared to be a safe way for therapists to follow. Another therapist's view complied with GUD, as they thought that the tool provided an appropriate way of including religion in to treatment. Value assessment helped to identify which clients choose religion as a value and want to work on it. The BA-M model involved therapists offering the *Client Self-Help Booklet* if a client chose religion as a

value and wanted to work on goals related to this.

When clients were asked how important religion was for them, scoring it from 1 to 5, 1 being the lowest, and 5 the highest, the majority of them chose 5[13], demonstrating the profound importance of religion for them. The lowest score given to the importance of religion was 2, reported by only one client[14].

Most of the clients mentioned religion in the process of their treatment, and one of them considered religious surrender as an important source of healing so never hesitated to talk about religion:

> "In the end, surrender of a religious nature is important for me to feel well at a particular point. The matters we discussed in connection with those subjects were religious matters. I never felt uncomfortable about including my religious beliefs in the therapy." (Ayşe, C)

One of the clients mentioned her friend who would get benefit from BA-M, as she had some existential questions related to religion:

> "I have a friend at the moment and I would recommend that she comes to you. I mean, because I am aware that she has undergone postpartum [depression] and I cannot help her. […] [This form of therapy] would help her a little, perhaps. […] because she has now started to question her, you know, her faith. […] this is really quite a personal experience, and not everyone opens up to everyone." (Sena, C)

Sena suggested that it would be more beneficial for her if the therapist could answer religious questions:

> "[…] the therapist directed me toward an imam, more in the manner of an imam, not for comforting but for example, the therapist might also be living their religion in that way and, well, I mean, if there had been someone whose agenda is religion, who could also answer religious questions, then perhaps that could have been more beneficial" (Sena, C)

This shows that some clients might prefer to have a therapist who can answer clients' questions related to religion. In the section 6.3.1.5 GBI mentioned that there would be some boundaries about the way religion is used. What Sena wanted, however, somewhat contradicted this idea, as she wanted the therapist to be more active and to be in the position of answering her

[13] Ayşe, Derya, Sena, Merva, Kaan (C)
Fatma (C) said she would choose either 4 or 5.
[14] Enes

questions. This might suggest that some clients wanted to include religion much more substantially and directly in their therapy. The *BA-M Manual* suggests that when a client needs advice on religion, the therapist should help the client to explore religious experts and resources for actual religious guidance within their spiritual tradition, should not cross their professional boundaries or give advice on areas in which they lack expertise.

Clients' values affected their views on the *Booklet.* The *Booklet* was offered to 9 (out of 14) clients by the therapists; specifically, to those who chose religion as a value. Only four of them used the *Booklet* during therapy, while the others only had a look at or examined it. The time that *Booklet* offered to the clients varied between the first and fifth sessions[15], and the majority of clients thought that the timing of offering the *Booklet* was appropriate[16] and claimed that the function of *Booklet* was explained to them[17] except one of the clients (Enes) as he did not remember whether its function was explained to him. Three of the clients who used the *Booklet* found it beneficial and relevant:

> "I have found the booklet beneficial. […] It was a pretty relevant booklet for me." (Enes, C)

One of the therapists mentioned that although their client liked the *Booklet*, the client did not want to use it as she was already practicing the exercises suggested in the *Booklet*:

> "I asked her 'What did you think of the booklet?' She liked it and said 'Something like that could be helpful.' But because she usually did those things herself anyway—she does the rosaries, reads Koranic verses, and prays—it did not have a big impact on him/her." (GBI, BT)

This suggests that suggested activities in *the Booklet* were in line with the client's values as she already practiced them in her life.

However, one of the clients who studied Islamic sciences thought the *Booklet* was not relevant for her, and wondered whether she was a suitable participant in the study, as the *Booklet* was based on a mainstream Sunni Islam perspective, while she was more inclined towards the Ibn 'Arabi school of Sufism, which means she had a different understanding of Islam:

[15] It is confirmed by ZM (T), Derya, Enes, Merva, Sena (C)
[16] It is confirmed by Ayşe, Derya, Enes, Fatma, Merva (C)
[17] It is confirmed by Ayşe, Derya, Fatma, Sena.

> "[…] your thing [the *Booklet*], that was written in the style of Sunni Islam, I mean, the *Booklet* was that sort of thing. But ours takes up a rather extreme position. That is why I thought 'I wonder if I am the right person for this study.' The Ibn 'Arabi school of Sufism I am rather convinced by it, and I have acquired faith in it, I mean. I have moved somewhat away from the Sunni Islam mentality. […] when they [the therapist] say 'You must have patience' […] We are not understanding the same thing. […] this is something to do with being involved in the field of theology—for example, I have written articles in connection with that matter. […] But because of this […] it was not right for me in that respect […] because I think differently, that popular understanding of belief, that popular faith, did not really speak to me. […] What I said was a particularly personal response, I think it will be helpful to someone else. […] Really, it could appeal to all but it seems a bit simplistic to me. […] it seems like something [written by and for] the Sunnis, by which I mean, this standard understanding of the majority population. But, well, that is indeed the general attitude in Turkey, and that is why I am saying that, for example, I think it would be helpful for my friend." (---, C)

Aforementioned client felt her understanding of religion was effected by the Ibn Arabi school of Sufism and by studying theology. The booklet, therefore, seemed to be written in the style of Sunni Islam. Her therapist's advice about patience seemed to be wrong for her as she had expertise in the field of theology, she felt that she thought differently. In fact, the therapist seemed to have moved away from BA-M approach by advising her to have patience. According to the BA-M approach, the therapist would normally need to explore whether teachings on patience were helpful to the client, which could have given the chance to bring her own understanding of patience and teachings that she found relevant. She thought that it was more likely to be beneficial to general population in Turkey, which suggests that the *Booklet* might not be relevant to some clients as it might not be in line with their personal values. The views of one therapist supported this, as they thought the *Booklet* indicated a certain religious perspective and that it might not be relevant to all clients. A few therapists thought if the *Booklet* was based on Quranic verses and included less hadith it might be more objective and appeal to general population:

> "I do have a concern about the functionality of it, I had a concern at the outset and I still have that concern. I mean, there may have been a lot of work and a lot of thought put into the *Booklet*, but it indicates a certain religious perspective and it seems like there might not be a positive response in every client. […] I do not know what discussions are taking place throughout the world, the world of Islam, but at least in Turkey, for example, serious problems might arise from the hadith. […] The Quranic verses could be used as a basis of reference to some extent." (ZM, BT)

Muslims believe in the authenticity and truth of the Quran as a divine revelation but have

varying perspectives towards the Sunnah in general and the status of particular hadith (Brown, 2014). Similarly, as mentioned above, ZM considers that there might be different views regarding the acceptance of hadiths among Muslims in Turkey.

The aforementioned client mentioned finding the *Booklet* simplistic was kind of a negative view, however, one therapist mentioned as a positive factor since they thought it could be understood by everyone:

> "In terms of structuring, for example, the preparation of that booklet was, in my opinion, a really good job […] The *Booklet* really is a wonderful *Booklet*, the style is very simple, of course, I mean, it is pitched at a level at which everyone [will be able to understand]." (GUD, BT)

Box 4 Reflexive statement

Similar to Sena when I read the booklet, I considered it as basic. Although this made me have doubts about the acceptability of the booklet at the start of my study, I was aware that most people in Turkey would not have extensive formal training in Islam as I and Sena did. Thus, I expected that most participants would not consider the booklet to be basic or see this as a negative issue. From the views of participants, this appears to be true, considering what is mentioned about the booklet earlier in this chapter. Having statements from the participants describing the booklet as basic could be considered both negative and positive, depending on context. Furthermore, it made me reflect upon the purpose of the booklet beyond my assumptions; for some the booklet would act as a reminder and for some it would be an accessible resource as GUD mentioned above.

6.3.2.2 Therapists' values

The therapists' values appeared to affect their views on including religion in therapy. All the therapists mentioned that if religion was a value for clients, including religion in therapy was in line with their profession, as long as they did not direct or impose any values on the client. Thus, as the Values Assessment was used in this study to determine clients who might benefit from the involvement of religion in treatment, and clients had the option of not using the *Booklet*, therapists felt comfortable about involving religion in the treatment via BA-M:

> "What we did there [in BA-M] was not exactly planning a change in that area [religion], or giving a series of recommendations, or guiding the client by giving them advice. It is one door among a number that we open up for the client. The client chooses which door they will open, and the client decides what s/he will do on the other side of that door, and I, as therapist, have no decision in the matter of the extent to which a particular subject is going to be incorporated or not, or what will be done with it if it is incorporated. This really put me at ease […] For example, a client may have decided on the area of family [as a value], or s/he may have decided on the area of religion, the approach does not permit us to discriminate between them. Both of them are steps which I would implement of course, and these steps would be similar in either case, and the client decides [which is going to be addressed]. So in my view there is nothing here that conflicts [with my profession]. No situation arose which made me feel uncomfortable, despite my concerns at the outset." (UI, BT)

UI was initially uncomfortable about including religion in the treatment, but after the training and using BA-M with a client who benefited from the *Booklet*, and in general from BA-M, they started to feel more comfortable. This shows that they followed a client-centred approach and use of BA-M in practice increases confidence in therapists. This could also be related to inclusion of religion based on Values Assessment, and providing an option for clients of not forcing them to use religion, but giving an opportunity of including it if they wished to. As UI's client liked the *Booklet* and even shared it with friends, this led the therapist to think that the *Booklet* could be useful for at least some clients:

> "The client loved that *Booklet*. In fact, when she shared it with her friends, she said that it seemed meaningful to them too. On the basis of the feedback I received, I also found it very meaningful. Some clients, at least, willingly use it and get benefit from it, and indeed they made it known to their social circle. It really is good, in my opinion." (UI, BT)

Some therapists mentioned that they felt comfortable about using religion in the treatment as it was a value for their clients:

> "I was comfortable with this because of course it presents [religion] as a value, so you can speak comfortably about it." (GUD, BT)

There were a few therapists who mentioned that they had already included religion in their treatment sessions before the study. There were some therapists who mentioned that using religious beliefs and teachings in treatment was helpful for clients:

> "I was already using it with suitable clients. […] If there is something faith-related in the individual's dynamic, and if the client is expressing complaints related to this sensitivity, I cannot remain unresponsive to this. At the very least, right at the outset I need to be able to understand them, and in order to be able to understand, I need to have owned that knowledge. Consequently, it is not like an intervention, it is a priority condition in order to establish that therapeutic relationship. But over and above that, the most I might do is recommend certain [Quranic] recitations. […] I think I would be able to integrate [religion in therapy] more easily now within the framework of your *Booklet*." (GBI, BT)

The therapists' values may have an effect on their openness to discuss religion. Most of the clients thought that their therapists were open to discuss religion:

> "They [the therapist] were open to discuss. […] I felt so comfortable to talk about religion" (Enes, C)

Some clients mentioned that when they talked about religion, the therapists were sensitive to their religious views:

> "Because it was a discussion which was very sensitive [to my belief], and moreover I did not experience anything that stuck in my mind as being bad." (Zeynep, C)

All the therapists appeared to be open to discuss religion in treatment sessions, as religion was handled like other values of clients:

> "In my opinion, [I approached it] in quite a neutral way, because we can see it on that value scale. That is an area on which the person places value and is mentioning something related to that area. In my view, as a therapist, one should not have positive or negative feelings in response to this." (UI, therapist)

The therapists' values appeared to play a role in whether they would want to continue to use BA-M in their practice. The therapists who were client-centred –which was most of them- mentioned that they would continue to use BA-M with suitable clients:

> "I can say that for the client I applied it to, we achieved a great outcome. Yes, if another suitable client came along, a client with depression, we could try it." (GUD, BT)

> "I made myself a BA file and started to implement this, that is, the forms, with my other clients as well. I apply it actively and will continue to apply it in the future. […] Speaking for Bakırköy [area in Istanbul], we cannot use the *Booklet* actively, but I apply the BA section actively to almost every client. I use [BA] for those who come with depression, social phobia or anxiety. I definitely apply it in cases of depression." (RM, BT)

RM had already started to use BA-M with their other clients. Bakırköy is an area where the

majority of the population is assumed to be secular, which is why the therapist thought they might not use the *Booklet* actively. It should be noted that RM was the therapist who was not sure whether BA-M takes values of clients in to consideration and their client claimed that Value Assessment tool was not introduced to him (see 6.3.1.4). They used the treatment for clients with other disorders too. There was another therapist who mentioned that they used some tools of BA to treat clients with anxiety. A future trial should re-consider the exclusion of anxiety clients (when anxiety is comorbid with depression and is the primary focus of therapy), as the primary focus on depression (6.2.6) appeared to be an obstacle for client recruitment and some therapists already used the method to treat anxiety clients. Another therapist had also started to use BA techniques with their clients:

> "If there is anything related to devout religious belief, I would want to use the *Booklet* and I am sure that I would use the other techniques. Currently I am also using it when I have CBT work. Generally speaking, I think that for certain situations BA is better, and if I feel that is the case then I will use it." (UM, BT)

A few therapists mentioned that they would use BA-M by combining it with the methods they already used. One of these therapists said that they used the treatment and asked their students to use BA-M as well and they thought the adapted part of BA would be the *Booklet*:

> "Combining it with the methods I use, definitely yes [will continue to use BA-M]. […] currently, in my own therapies and especially with students who are candidate therapists to whom I provide supervision, I am asking them use right now. What I have experienced in connection with BA, I pass it on to them so they are also benefiting from it […] the adapted part would be the *Booklet*" (---, BT)

Only one therapist mentioned that they would not use the *Booklet*, but they could use BA after improving their BA skills and seeing its impact in practice:

> "I am not thinking of using the *Booklet*. The motivation [to use BA] might come later when I have developed myself a little [with BA], and after seeing the effect of my own practice on the patient […] The therapist's own beliefs may not fully coincide with what is written in that *Booklet*, and I would only say that in that way there is a difference" (---, BT)

The aforementioned therapist did not have a chance to recruit any clients so they did not experience of using BA-M. The reason for them not being willing to use the *Booklet* was probably because of their personal values as they mentioned above. Their approach appears to be an example of not being client-centred as they expected the Booklet to be in line with their beliefs. BA-M promotes a client-centred approach and so clients should be in the position to

decide whether they want to use the Booklet. As mentioned by the clients and therapists in previous sections (such as Section on Clients' values and Inclusion of values or religion in therapy), the Booklet appeared to be in line with most of clients' values who used it and perceived it as beneficial. Thus, if a therapist prefers not to offer the Booklet to future clients who value religion, s/he will deprive the clients of a potential source of healing. In a future trial, the importance of being client-centred and possible benefits of BA-M and the Booklet should be emphasised in the training of therapists.

In general, there was willingness to continue to use BA-M with depressed clients, as most of the therapists saw the effect of BA-M in their practice, and some therapists had already started to use it with their other clients. A few therapists mentioned that they would use BA-M in combination with other methods that they used. Only one therapist mentioned that they would not use the *Booklet*, but could use BA. Overall, these findings give evidence in support of the acceptability of BA-M in Turkey.

6.3.3 Capacity

This theme incorporates how capacity of the participants –e.g. previous training (skills) of therapists, and life circumstances (restricted ability) of clients- affects their views and experiences about acceptability of the treatment.

6.3.3.1 Training

Previous training of the therapists affected therapists' views on BA and the BA-M training. Participants were asked for their views on BA before the study, and whether those views changed after participation in the study. The majority of the therapists had ideas about the behavioural part of CBT, but not Behavioural Activation as an approach by itself. Thus, they had not previously used BA with any clients:

> "I had a little knowledge about activity planning, related to the Behavioural Activation element of CBT. That was a technique that I had also used for my clients but I had never before pursued a client's therapy using Behavioural Activation." (UI, BT)

One of the therapists mentioned that although they had heard of BA, they had hesitations about how to apply it, but their views about its efficacy had changed after the study:

> "I had heard about it to some extent but of course I had some hesitation, about the forms, and also about how it was to be applied. There is a behavioural element within CBT but of course I was not completely familiar with applying BA on its own because I did not know about it. […] I changed my ideas about its effectiveness."(RM, BT)

Only one therapist mentioned that they were aware of research findings on efficacy of BA, that BA could work alone, and that they had already used BA piecemeal in their practice, but they did not think that BA could work alone with every client, and even after the study they still thought that:

> "I was already aware of the research findings in efficacy studies on this matter which indicated that behavioural activation alone could provide an outcome as effectively as cognitive behavioural therapy. So for that reason, […] it did not make me feel as if it was something new, and it was something that I used in my own therapies in a piecemeal fashion. Later, it was like this—I had no scientific prejudice but nevertheless I did always have the idea that BA alone could not be deployed with every client. And that is what I still feel to some extent, I mean, with some clients. BA alone may really be something very functional, but not in every case. But it has been informative to me in terms of a more systematic approach. […] It [the training] gave me the idea that it is not just one simple technique but something which, taking a holistic view, can be used to facilitate therapy. " (ZM, BT)

Another therapist also had some negative views about BA, but their views changed after the study:

> "I used to think it was too superficial, I had a fundamental reservation about behaviourism, of course, that it was inflexible. Later I realised that I had missed some elements of it, so I don't believe now the things I am going to talk about now. In particular, I thought that there was no place for the therapeutic alliance in Behavioural Activation, but now I know that is not the case. I thought it consisted merely of "do this, do that, go there, come here" and therefore my views were not very positive, I suppose. […] but have definitely changed. There are two reasons for this: I used some of the [BA-M] techniques on myself as one of the trainers recommended it. […] Secondly, after the second session, s/he [a client] did not come any more. I found myself to be very inflexible there. I felt that we were not going to be establishing any relationship, and that we would just be setting homework, but I think this came from me. And that has definitely changed. I feel now that I am giving more emphasis to behaviours in the normal therapeutic process." (UM, BT)

This shows that having training in and experience of using BA might change the negative views of some therapists. It also shows that some therapists might have some prejudiced views about the therapeutic relationship in BA, and so it could be helpful to explore this during training in a future trial.

Previous training on CBT was one of the eligibility criteria for the therapists to participate in the study. It was considered that therapists with CBT training would already know how to apply the behavioural part of the CBT, thus they would not need to have a full training on the BA. The views of some therapists, however, indicated that some of the CBT trainings they had received in Turkey did not focus on behavioural aspects:

> "In Turkey not all CBT training is the same. In the CBT training that I received, the cognitive side was preponderant: I could say 90% cognitive, 10% behavioural. But in other cognitive behavioural training it is not like that. There are also training fields that give more active training, using BA." (CGY, BT)

Nevertheless, for some therapists, parts of the training on BA-M, which included an introduction to generic BA, seemed to repeat their earlier training and was not felt to be engaging:

> "In my opinion, they went into too much detail on some points. […] We have all previously used CBT and therefore at a certain level, we know about emotion, thought, and behaviour etc. […] I am not opposed to the fact that it was explained in detail but speaking for myself, it was something that I knew so I got bored." (GBI, BT)

This suggests that a future trial should consider that the delivery of comprehensive training on generic BA might be repetitive for some therapists, but not for others. It could be helpful to discuss this with therapists before deciding the duration and content of the training in a future trial.

BA-M training was provided to help therapists to develop the required capacity to implement or deliver BA-M (details of the training programme are presented in Section 4.5.2). To explore acceptability of training therapists were asked whether the training prepared them to deliver BA-M, feelings on the language of training and appropriateness of suggested examples, and exercises in the training and *Manual*. All the therapists thought that the training prepared them to apply BA-M:

> "The training prepared me [to apply BA-M]" (GBI, BA-M)

Although all the therapists thought that the training prepared them to apply BA-M, some of them suggested that the training could be delivered over more days, and that it could include case analysis:

> "It could have been a little bit longer. […] It could have been delivered in the form of foundation training, then case analyses, it could have been conducted on the basis of examples." (RM, BT)

The majority of therapists found the examples given in the training and *Manual* relevant and useful:

> "Yes, it was definitely beneficial because I was unable to go straight over into practicing [BA-M] immediately after receiving the training. Later I worried a bit, about whether I was going to remember it, and whether I was going to do the right thing. [The manual] was really helpful, it refreshed [my knowledge], and made sure that I was confident in implementing it." (UI, BT)

There was only one therapist who thought that the examples could be more relevant, and who suggested that it could be beneficial to have examples about more specific cases:

> "I mean, it could have been more relevant. It was right in terms of understanding this model, but in terms of implementation, it fell short in my opinion. […] For example, what can I recommend? They could have given an example such as 'For a client who is in rumination, for example, you can use this technique, this will help him/her to emerge from that state.' […] there could have been examples of what we should do in specific and complex circumstances." (GUD, BT)

This suggests that the examples given in the *Manual* can be broadened, especially in terms of covering rumination.

In general, all of the therapists were satisfied with the content of training and other documents provided. One of them suggested that having a session-by-session *case example* of treatment delivery could be presented in the training:

> "Actually no [there was nothing that needed more detailed explanation] because it lasted for three days […] Perhaps there could have been sharing of cases: Session 1 it was like this, session 2 it was like that, and session 3 it was some other way. I think they could have presented us with a fully elaborated model." (GUD, BT)

Only one therapist did not feel confident to deliver the therapy after the training (see Section 6.2.5).

6.3.3.2 Support meetings

The therapists were provided online support meetings. One of the therapists suggested that

having *face-to-face supervisions* (support meetings) would be better:

> "In my view the training was great, and it got me ready too. Perhaps in the supervision section it could have been more productive if it had been face to face." (UM, BT)

Face-to-face meetings, which could be supervision meetings, were suggested by majority of the therapists in order to keep therapists engaged and motivated:

> "Perhaps if we met once a month - that's just a suggestion - some people find social activities motivating, when they get together, so that might get them motivating each other there. Perhaps supervision arranged at certain intervals would motivate people, and also keep people on the ball, continually reminding them. In meetings like this the group would come together with practitioners, in the form of a social activity. Social activities usually keep people together, it reminds them. Also, supervision is motivating in terms of receiving training, and also - that last supervision we did was very beneficial for me - well, now I'm managing the therapies this way, and monitoring things which we need to be careful about will also keep the therapeutic process productive. I mean, there is a flow in the therapy which one has to keep in step with, and which reminds one not to go off track, and when something does veer off, the supervision helps you to keep within that cycle, and it also motivates you." (IM, CT)

> "Supervision sessions were not something I participated in very much. I did not actively participate there, for example, because they, you know, took place when I was in a meeting, or during the evening when I was leaving work, or at times when I would be tied up in traffic, and I do think that there is also a disadvantage in being a long way off. I mean, perhaps if something was done in Turkey, at some university, if there was already someone there who we are in dialogue with, then certainly I would have made the time, and I would have gone there when I was available. […] Consequently, the fact that you were a long way away was a disadvantage. If you had a presence here, someone with whom we could exchange information more frequently at times which suited us, if there had been people we could talk to face to face, I think that perhaps it might have been better." (GBI, BT)

This suggests that monthly gatherings of therapists in a future trial might be good to keep them motivated and engaged. It might not be possible in a future trial to provide face-to-face supervision meetings with supervisors, as finding qualified supervisors on BA-M might not be possible. Thus, arranging monthly face-to-face gatherings for therapists and connecting supervisors online to those gatherings might be an alternative option. If it is possible a small office can be arranged for a future trial and be used for supervision meetings and recruitment. It could be helpful to have one of the study researchers present in the office for a future trial, with whom therapists can consult.

One therapist suggested that giving homework to therapists might help to keep them engaged:

> "There could be mini homework tasks […] to keep a person in that process, with mini homework tasks. […] I mean, a short report, describing the difficulties you yourself have encountered, it could be bilateral […] or it could be based on your own case presentations." (HB, CT)

The suggested gatherings of CBT group therapists might include the presentation of case reports, which in turn can help them to learn, as it will be held in peer settings.

6.3.3.3 Personal circumstances of clients

Personal circumstances affected some clients' views on the treatment. For some clients it was difficult to complete homework due to *life circumstances* and responsibilities. For instance, one client found that having a baby made it hard to find time:

> "What makes it difficult is just the conditions imposed by life itself—the fact that I don't have much time. If I had time, probably, I mean, if I were free and if I could have left the house I could have put it into practice to a greater extent. But when you have a child, well, there are the household responsibilities and all that, I had no time. But whenever I did find a moment, it pushed me into my study room, I mean, in that respect it was good." (---, C)

As she used the time found to complete her homework, this might indicate that having assigned homework could help clients to get active (as opposed to general encouragement to undertake desired activities). This might be due to the feeling of responsibility engendered by specific homework tasks, galvanising clients who need to be pushed a little bit to become active.

Some clients mentioned that sometimes they had difficulties to complete their homework:

> "I experienced problems with regard to implementing [the goals] but that's my problem. Receiving homework was not a problem for me." (Zeynep, C)

Zeynep said that feeling down and hopeless were reasons that made it hard to complete her homework, and even daily tasks, and she thought that feeling better would make it easier to complete her homework:

> "At that time I really felt as if I was at rock bottom and in fact, I was in a state of despair. It was as if nothing I could do was going to help make me feel well. It all seemed meaningless. Actually, it was not just the homework that I couldn't do—there were times when I could not do my other daily tasks. […] When my mental state is good, it feels to me as if I can manage everything, do anything, but it all depends on what is going on in my head." (Zeynep, C)

One client who also mentioned her mental state made it difficult to complete her homework

thought that seeing the happiness of children made it easier for her to complete the homework [volunteer work]:

> "What made it difficult was that sometimes a person has no urge to do anything, it is difficult and a person gets closed off, and that is how I was during those times. Later, what made things easier was when I saw someone, or a child smiling, for me, I mean, that was a whole different world. Their happiness was definitely more important than my own happiness." (---, C)

She said what gave her the most contentment was "helping people, that when my heart touched people I felt great contentment." Thus, as her homework was to do some voluntary work, which in return made it easier for her to continue to do the assigned homework because she got kind of a reward from doing it. This shows the importance of setting homework in line with clients' goals and values

6.3.4 Following an integrative approach

Following an integrative approach appeared to be a commonly followed method when the therapists were asked how they would describe their normal therapy style to treat depression. The reason to ask this question was to investigate the normative approach used by therapists to treat depression in order to understand the acceptability of BA-M, and to explore what BA-M should be compared to in a future trial.

The majority of the therapists used CBT in their usual practice for the treatment of depression, but they generally followed an integrative approach, combining CBT with other treatment approach(es) to treat depressed clients:

> "I would say CBT [the approach I usually use to treat depression], but I usually manage my therapies by combining that with an existentialist approach, so we can say: a CBT plus existentialist approach." (---, BT)

> "That first introduction to CBT, giving those simple basic core thoughts to the client is fairly straightforward, so I make a prologue out of that. Then I continue more on the basis of schema [therapy]. […] Because [neuro-psychoanalysis] needs a slightly higher level of work, after getting to the place we want, I manage the process by applying more boosting, reinforcement. (---, CT)

Only one of the therapists mentioned that they used mainly meta-cognitive therapy and schema therapy even though they have training in CBT, so they did not commonly use CBT in their practice:

> "I apply metacognitive therapy and schema therapy, and I have training in cognitive behavioural therapy, but usually it is mainly metacognitive therapy and schema therapy. I choose one of these two and then go forward with that." (---, BT)

They mentioned using approaches in which they were already trained. The approach they use depend on clients' mental health disease(s):

> "In cases of border personality disorder or in patients with personality disorder accompanied by depression, it may occasionally shift towards schema therapy. If it is trauma-related, then I use Logotherapy plus CBT. Let's say that it is a situation linked with the source of depression." (---, BT)

Using an integrative approach might be suggestive of the limited acceptability or efficacy of CBT as a standalone therapy, which led one therapist to feel constrained:

> "You do feel restricted and I know that after a certain point, for example, when I thought I could really be of assistance to the client using another approach, I really felt myself constrained by the scope of the study." (HB, CT)

Similarly, one therapist from BA-M group mentioned that using only one method made them feel confined, so they normally used an integrative approach to have more freedom:

> "Always taking the BA line made me feel confined, it made me feel as if I would not be able to go outside that. And the reason why I do not follow the CBT line exclusively, the reason why I add an element of existentialism, is because that integration affords me a little freedom. [So BA] made me feel as if I were a bit constricted." (ZM, BT)

The common usage of integrative approach to treat depression shows why it can be difficult for therapists to stick to only one approach for the study. It should also be considered that the majority of therapists in this study had 5-10 or more years of experience; it can be suggested that in a future trial, less experienced therapists or therapists with less training can be included in the study. It might be easier for such therapists to use only one approach to treat depression during the course of a trial, compared to more experienced therapists who are more adept and confident in deploying multiple techniques.

6.4 SUMMARY OF SUGGESTIONS FOR A FUTURE TRIAL

Findings about the feasibility of a future trial to test efficacy of BA-M highlight the need for: publicity about the approach; endorsement by influential people in the field; financial support to address therapists financial concerns and clients' motivation; recruitment support to increase recruitment and therapists' motivation; familiarity with research (for clients); addressing

concerns related to confidentiality to increase willingness to take part in a study; and therapists' confidence and autonomy in the work place to increase their motivation and willingness to recruit clients. In order to address these issues, a future trial could be publicised in different platforms such as on social media and endorsement through well-known people in the field could be sought to increase recruitment of therapists and clients. Financial support could be provided through research funding to pay therapists' fees, and subsidise client treatment (so it is free, or costs a symbolic fee), which will help to reduce therapists' financial concerns and increase their willingness to recruit potential clients.

Recruitment support such as referrals from psychology consultancy centres could be provided to increase recruitment of clients and motivation of therapists as the stress of not being able to recruit enough participants was a factor that reduced their motivation. Issues related to not being familiar with research culture and confidentiality might be addressed by training therapists to explain to potential clients the importance of studies for public and mental health in general, and the measures taken to protect clients' information. The confidence of therapists could be increased by providing them with clinical supervision. Blinding procedures might also be helpful to increase therapists' confidence to recruit clients and collect data; this may also help to prevent clients' concerns related to therapists' performance when filling the scales. Issues related to autonomy of the therapists in the workplace could be addressed by seeking approval of therapy team members or colleagues who might help to increase recruitment of clients, and to reduce concerns of therapists related to applying a new method. A room in which therapy could be delivered could be provided for therapists if they wish to deliver treatment for free or outside of their clinics, in order to prevent any possible issues that might arise because of lack of autonomy in their workplace.

Findings about feasibility highlighted the importance of training, skill development and networking and contribution to science as motivational factors to take part in and engage with the study. Thus, future trials should consider offering training to control (CBT) group therapists at the end of trial to increase willingness to take part in the study, motivation and engagement throughout the study. Involvement in a study as contribution to science could be emphasized to facilitate recruitment of therapists. On the other hand, findings highlighted some potential barriers to recruitment including the language of training being English, memory (forgetting about the study), eligibility criteria (primary focus on depression), public settings as site (finance not being a motivational factor for clients) and travel difficulties that clients may have.

In order to address these issues, in a future trial, the BA-M training could be delivered in Turkish or via simultaneous translation, to increase recruitment of potential therapists if the language is a barrier to them. There should be more frequent contacts with the therapists to prevent them from forgetting the study. Arranging booster session(s) might be another motivational factor, which may utilise collection of follow-up data.

For a future trial, eligibility criteria for clients need to be revised. This revision should be done through consulting with therapists working in Turkey and determining whether BA can be beneficial to treat depression, when related conditions such as anxiety are the primary focus and whether BA is beneficial for anxiety, or some forms of anxiety. If a future trial is conducted with therapists who work in public services in Turkey, finance – offering treatment for free or at a subsided fee - will not be a motivational factor for clients to take part in the trial since these services provide free treatment but the recruitment pool might be larger in public services since more clients are seen. Transportation to treatment clinics or providing clinics in different locations could overcome travel-related barriers.

The findings suggest that SCL-90-R could be used to identify eligible clients as a practical/standardised method for therapists in Turkey. Using clinical interviews to identify eligible clients could be useful as an alternative or in addition to SCL-90-R, if it is possible. The findings suggest that PHQ-9 could feasibly be used at every session in a future trial to monitor depressive symptoms of clients. To prevent any confusion regarding time points to use PHQ-9, therapist should be clearly told and then reminded that PHQ-9 needs to be used at every session.

For a future trial, findings related to acceptability of treatment suggest discussing the delivery of comprehensive training on generic BA with therapists before deciding the duration and content of the future training; presenting a session-by-session case example of treatment delivery; including a more comprehensive version of BA formulation and broadening the section on rumination in the BA-M Manual drawing on the generic BA Manual by Martell et al. (2010).

The findings related to acceptability of treatment highlighted that there is a need to change the current view of religion and psychotherapy being alternatives to each other in Turkey, and BA-M could help to integrate them. The *Booklet* might not be relevant to all clients as it might not be in line with their personal values, but the findings suggest that it might be appropriate for

the majority of clients in Turkey. The findings also highlighted that there might be some therapists' concerns related to inclusion of religion in treatment if religion was not a value in their own lives, prejudiced views about therapeutic relationships in Behavioural Activation, and feelings about being restricted by the study. These issues could be addressed by reminding therapists to follow a client-centred approach and so make decision based on clients' values. Presenting the findings from the current study about the positive therapeutic relationships built and the effect of religion on mental health in general, in training for a future trial may help therapists to feel more comfortable about inclusion of religion in treatment and reduce prejudiced views about therapeutic relationship in BA-M. The issue of therapists' feelings about being restricted by the study could be addressed by training them on learning how to cope with this feeling, and how to avoid transferring this feeling to clients. This may also be addressed by inclusion of less experienced therapists or therapists with less training in the study. It might be easier for such therapists to use only one approach to treat depression during the course of a trial, compared to more experienced therapists who are more adept and confident in deploying multiple techniques.

The findings suggested arrangement of monthly gatherings and/or face-to-face clinical supervisions helped to keep therapists motivated and engaged. Gatherings of therapists allocated to the CBT group might include the presentation of case reports, which in turn can help them to learn, as it will be held in peer settings. It could be helpful to arrange face-to-face clinical supervisions if possible for BA-M group therapists. If not, arranging monthly face-to-face gatherings for BA-M therapists and connecting supervisors online to those gatherings might be an alternative option. If it is possible a small office could be arranged for a future trial and used for supervision meetings and recruitment. It could be helpful to have one of the study researchers present in the office for a future trial at certain times, with whom therapists can consult. The findings also suggested to offer joint decisions with clients about the time to end treatment.

CHAPTER 7
COMPARISON STUDY

This chapter is based on a comparison of findings from the pilot study of Mir et al. (2015)[18] with findings from the feasibility study (Chapters 5 and 6). The chapter starts with presenting the comparison study's aim, and is followed by a summary of the pilot study and baseline characteristics of the clients from both studies before presenting differences and similarities between the two studies regarding their mainly qualitative findings and quantitative results, focusing on study/treatment settings, acceptability and outcome. While presenting the summary of the pilot study, the differences between study settings are highlighted as it may help to understand the similarities and differences in the findings of the two studies.

7.1 AIMS OF THE COMPARISON STUDY

The meta-analysis results (see Section 3.3.5) showed a culturally adapted treatment might be more efficacious for people who constitute the majority of a population, compared to the minority of a population. If the potential reasons for this difference are known, it might guide researchers about how to improve mental health treatments for minority groups. Thus, this study compares a pilot study of culturally adapted BA for Muslim (BA-M) clients with depression in the UK (Mir et al., 2015) with the feasibility study of culturally adapted BA-M clients with depression in Turkey (Chapters 5 and 6). The majority of people (98%) in Turkey identify as Muslim (Cesur and Mocan, 2018), whereas Muslims (5% of the whole population) are a minority group in the UK (Office for National Statistics, 2018). Thus, this comparison study aims to explore similarities and differences between treatment acceptability and outcome of BA-M among Muslim clients and therapists[19] in Turkey compared to those in the UK, by comparing findings – mainly qualitative – from the feasibility study (Chapters 5 and 6) with the pilot study (Mir et al., 2015).

As explained below, all the therapists were working in public health care in the pilot study, whereas most of the therapists who took part in the feasibility study (12 out of 14) worked in private practice. Chapter 6 includes information regarding potential barriers and facilitators for

[18] The information regarding the pilot study which is presented in this thesis is based on the pilot report and from my main supervisor (GM) who was the principal investigator in the pilot study.
[19] The therapists in the UK were psychological wellbeing practitioners who had one year of mental health training.

a future trial if it is conducted in a public health care setting. It is important to further evaluate these in order to guide a future trial. Thus, this comparison study also aims to explore differences and similarities between these two settings regarding recruitment of clients and engagement of therapists, in order to guide a future RCT of BA-M.

7.2 SUMMARY OF THE PILOT STUDY

After the development of BA-M, a pilot study was conducted in Bradford in the UK, to explore the acceptability of the treatment. Therapists from Primary Care Mental Health Teams who had at least one year of psychological training on CBT, and their supervisors were invited to join the study. National Health Services (NHS) Primary Care Mental Health Teams, based in general practice or primary care centres, deliver the Improving Access to Psychological Therapies (IAPT) service in Bradford. Thus, the pilot study was conducted within the NHS where the treatment is delivered for free.

Ten therapists, either voluntarily or because of being selected by their managers, attended two days of training on BA-M. All the therapists in Turkey, however, joined the study voluntarily, which may have had an effect on their engagement in both studies. As previously mentioned, in the pilot study, the therapists were working in the NHS –public settings, whereas in the feasibility study, most therapists (12 out of 14) were working in private practice, although there was no criterion regarding the work settings of therapists in the feasibility study (for the details of therapists' recruitment, see Section 4.5.2).

Potential clients in the UK needed to be referred to the therapists in the pilot study by either primary care mental health professionals, general practitioners (GPs), secondary care therapists or community organisations, but the clients in Turkey were self-referred. This indicates that the settings of the studies (public vs private and referral by professional vs self-referral) were different, which may have affected the recruitment and retention of clients.

In the pilot study, the recruitment period for clients was planned to take place from April to September 2011; because of the low recruitment rate, it was extended until January 2012. The therapists did not feel comfortable to take full formal consent from potential clients so they obtained consent from clients to pass on their contact details to the researcher who would ask for the full formal consent. The consent form included recording therapy sessions, which were used to check adherence to the therapy manual in the pilot. The eligibility criteria for clients were the same as those used in the feasibility study (see Section 4.5.3). The therapists in Turkey

asked for full formal consent from the potential clients. However, the therapy sessions were not recorded in Turkey.

The clients who consented received BA-M in the pilot study. Based on the manual, it was aimed to deliver a minimum of six and a maximum of 12 sessions in the pilot study. There was no limit regarding the maximum number of sessions in the feasibility study, as it was aimed to assess the number of sessions required.

One of the most important differences regarding the methods of the two studies was that the feasibility study had two arms (BA-M vs CBT) while the pilot study only had a BA-M arm. Thus, this difference should be considered when an interpretation is made based on the number of therapists and clients recruited in both studies.

PHQ-9, General Anxiety Disorder Assessment (GAD 7) and the Work and Social Adjustment Scale (WSAS) were used in evaluating mental health and functioning in the pilot study. When written translation of these measures into some relevant languages was not available, verbal translation was used for clients with limited English skills, by therapists who were either supported by a bilingual therapist or an interpreter. In the feasibility study, only PHQ-9 was used to assess depressive symptoms, and the written translation of it into Turkish was already available and validated (Sari et al., 2016). Comparison results related to PHQ-9 scores are presented in Section 7.6.

The therapists in the UK already had regular supervision sessions with usually a senior member of the primary care mental health service, and sometimes a secondary care mental health professional (not specific to the study); in addition to these sessions, bi-monthly peer supervision (support) meetings were arranged for the therapists and supervisors by the research team in the pilot study. The therapists in Turkey, however, did not have regular supervision meetings in their normal practice and, similar to the pilot study monthly support group, meetings were provided by the research team.

Table 7.1 presents the number of therapists and clients recruited and who dropped out – with percentages – in both studies. Ten therapists and 19 clients (14 females and five males) were recruited in the pilot study. The clients included four ethnic groups. Table 7.2 shows that most of them or their families had migrated to the UK (Peach, 2006); only one of them was White British. Even though most clients were British Pakistani (16 out of 19), the treatment was delivered in Urdu for nine and Hindko for one and in English for the remaining nine clients.

This indicates that language could create a barrier for some clients. If the therapists were not bilingual, an interpretation service would be required so one more person would be involved in treatment sessions. The presence of a third person in the sessions might be challenging for both clients and therapists as it may make it harder to build trust. This issue of language was not apparent in the feasibility study sample since all the clients were fluent in Turkish, so the treatment was delivered in Turkish for all clients, although three were Kurdish.

Seven (70%) of the therapists and eleven (58%) of the clients dropped out from the pilot study. This indicates a high dropout rate, whereas the dropout rate for the BA-M arm in the feasibility study was 21% (N=3) for the clients and 12.5% (N=1) for the therapists.

Table 7.1 The number and percentages of therapists and clients recruited to and who dropped out from the feasibility study and pilot study

	Feasibility (TR)						**Pilot (UK)**	
	Therapists			Clients			Therapists	Clients
Group	**BA-M**	**CBT**	**Total**	**BA-M**	**CBT**	**Total**		
Recruited	8	6	14	14	8	22	10	19
Dropped out	1 (12.5%)	2 (33%)	3 (21%)	3 (21%)	2 (25%)	5 (22%)	7 (70%)	11 (58%)

In the pilot study, qualitative interviews with 15 therapists, including three therapists who delivered the treatment and five who only attended the training, supervisors (n=5) and team managers (n=2) who attended the training, were conducted. One of the supervisors and one of the BA-M (UK) therapists were males. Four therapists were Muslim, two of whom delivered the treatment. The details regarding the characteristics of the BA-M (TR) therapists are presented in Section 5.2).

In the pilot study, 13 clients (service users) – including those who dropped out – were also interviewed. In the feasibility study, the clients who withdrew from the study were not interviewed because of ethical considerations as they would have needed to give consent for the interviews separately (see Section 4.5.6). Similar to the feasibility study, a qualitative framework analysis was used in the pilot study to analyse the interviews. The topic guides in the feasibility study were based on those in the pilot study (for the guides used in the feasibility study, see Appendix D and E).

7.3 CHARACTERISTICS OF THE CLIENTS FROM BOTH STUDIES

Before exploring differences between the two studies in terms of study or treatment settings, acceptability and outcomes of BA-M, it is important to understand the characteristics of the clients from both studies since these could have an affect on clients' treatment experience and outcome. Thus, this section presents the baseline characteristics of BA-M group clients in the feasibility and pilot study.

Table 7.2 presents baseline demographic characteristics and PHQ-9 scores of clients in both BA-M groups in Turkey and in the UK. For group comparison p values, a Chi squared test (with continuity correction) was used for categorical variables and t-tests were used for continuous variables. Most of the clients were female in both groups. The only available data regarding age of participants in the UK study was that the clients were aged from 23-56 years old, with the sample being more skewed towards older service users, thus it was not possible to use age as a factor in the analysis. In Turkey, the BA-M clients were from 21-48 years old with a mean age of 28.79 (SD= 7.62). This indicates that the clients in Turkey were somewhat younger than those in the UK.

Table 7.2 Baseline characteristics of BA-M clients in Turkey and the UK

	BA-M(TR)	BA-M(UK)	p test
n	14	19	
Gender (n, %)			1.000
Female	11 (78.6)	14 (73.7)	
Male	3 (21.4)	5 (26.3)	
Ethnicity (n, %)			<0.001
African	0 (0.0)	1 (5.3)	
British Pakistani	0 (0.0)	16 (84.2)	
Indian	0 (0.0)	1 (5.3)	
Kurdish	2 (14.3)	0 (0.0)	
Turkish	12 (85.7)	0 (0.0)	
White British	0 (0.0)	1 (5.3)	
Occupation (n, %)			0.107
Employed/student	10 (71.4)	7 (36.8)	
Unemployed/housewife	4 (28.6)	12 (63.2)	
Number of Sessions Attended (n, %)			0.082
6 or more	11 (78.6)	8 (42.1)	
Less than 6	3 (21.4)	11 (57.9)	
Baseline PHQ-9 (mean (SD))	16.69 (4.75)	18.56 (6.23)	0.374

n: number, SD: standard deviation

The ethnic background of clients was different in both countries as was expected. The UK sample constituted clients from British Pakistani, African, Indian and White British backgrounds, while the sample from Turkey constitute clients from a Turkish and Kurdish background. The majority of the clients in the UK (63%) were either unemployed or housewives while most of the clients in Turkey (71%) were either employed or students, but this difference was not statistically significant. This might be due to the difference in the settings of the studies (NHS versus private practice), meaning that the clients in the UK did not need to pay for the treatment, so work status would not matter, whereas in Turkey most of them needed to pay for the treatment, so having money (being employed or a student, as students could have a scholarship) was necessary to access the treatment.

The number of sessions attended was categorised in two groups: (1) six sessions and more, and (2) less than the minimum six sessions required in both studies. Although less than half of the clients in the UK (42%) and the majority of the clients in Turkey (78%) attended more than six sessions, the difference between them was not statistically significant ($p= 0.082$). The average baseline PHQ-9 score for BA-M (UK) was 18.56 (SD= 6.23) and for BA-M (TR) was 16.69 (SD= 4.75), and although the difference between the baseline PHQ-9 scores was about two points, this was not a statistically significant difference.

7.4 SIMILARITIES BETWEEN THE TWO STUDIES

The diagram below shows the similarities regarding qualitative data between the two studies (see, Figure 7.1). In this section, the similarities are presented, and the following section presents the differences.

Four common themes were identified between the two studies relating to the therapy approach, experience with and of clients, and the study design. Each theme is explained in detail below.

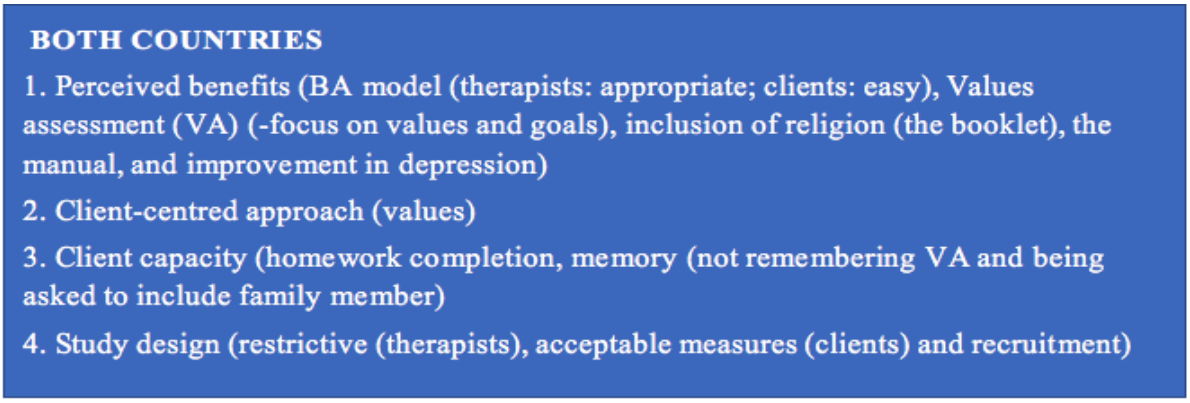


Figure 7.1 Themes showing similarities regarding the qualitative findings from the both studies

7.4.1 Perceived benefits

The benefits of the BA model, VA, involvement of religion in treatment and the BA-M manual were reported by both clients and the therapists from both studies. Furthermore, as BA-M can lead to improvement in clients' depression, it was considered a beneficial treatment by the clients and some therapists.

7.4.1.1 The BA model

The BA model refers to the two circles model, which is a tool used in BA-M (for further details, see 6.3.1.1). The BA model was perceived as an appropriate approach by some therapists from the pilot study and by the majority of the feasibility study therapists (see Section 6.3.1.1). Some clients from both studies thought that the model was easy to understand.

Some therapists from the pilot study preferred using a more comprehensive model – the three or five areas model of CBT, which they routinely used – instead of the two circles model as they felt it was too simplistic to help clients understand their experience of depression. Similarly, a few therapists from the feasibility study were doubtful about the generalisability of the BA model and thought something could be missing in it, such as "learned information" and "certain patterns" could be between difficult life events and common responses. It could be beneficial to introduce a more comprehensive version of the BA model, in addition to the two circles model, to therapists in the training of a future trial.

7.4.1.2 Values assessment

Most of the clients from both studies had very positive views about the VA tool. The clients thought that it enabled them to focus on their values and goals. The pilot study clients considered that the tool provided an opportunity to talk about their values, and understood that

it was important for them to focus on these as well as goals. Similarly, the clients from the feasibility study considered that it was beneficial for the therapists to know clients' values. This client feedback validates the use of the tool to learn about clients' values and give them an opportunity to express these freely.

Some therapists from the pilot study and one[20] from the feasibility study also perceived VA as beneficial as it focuses on aspects of life that are important for clients. The pilot study therapists thought that a discussion regarding clients' values that were important to clients' wellbeing might not have occurred without the VA tool, as normally they did not directly discuss values. This finding highlights the importance of using the VA tool as the clients considered it as beneficial. Some therapists from the feasibility study had the view that BA-M considered the values of clients more than CBT when they were asked to compare BA-M with their usual practice.[21] This is likely to be because the inclusion of values in treatment is explicitly addressed via the VA tool.

7.4.1.3 Inclusion of religion

The inclusion of religion in treatment was perceived to be beneficial by clients and therapists. For example, the clients in the UK had very positive feelings about the inclusion of religion in their treatments. They emphasised that incorporating religious teachings in their lives by "reading the Quran and praying" helped them to feel better, and religious advice and teachings could be very beneficial tools to cope with depression. Similarly, most BA-M (TR) clients mentioned religion in their treatment process, and some of them were pleased to include it, as religion, according to one participant, was considered "part of [my] life" and another considered "religious surrender" (submission to God's will) as a source of healing.

The clients in both studies had the opportunity to use the client self-help booklet, which included relevant teachings from the Quran and Hadith, and found it useful.

In the pilot study, religious activity was reported to assist clients to cope with boredom and

[20] There was not a direct question related to the VA tool in the therapist interviews that were conducted in Turkey. As a result, although, therapists mentioned the importance of inclusion of values in treatment, only one of them directly mentioned the VA tool.

[21] In the pilot study, there was no direct question which asked to compare BA-M with the usual practice, thus there was no information reported on it.

inactivity, especially in in-patient settings.[22] The therapists and supervisors from BA-M (UK) felt that a belief or behaviour should be encouraged by the therapist if it was perceived as not harmful and was possibly beneficial to the client. Similarly, one BA-M (TR) therapist mentioned that in usual practice he encouraged his patients to use positive religious coping strategies to deal with depression when he learned that they were already using these.

Religion was an important value in most of the clients' lives in both studies. For example, according to one BA-M (UK) therapist, two of her female clients showed a strong desire "to be more religious and have Islam as a refocus in their life". She, however, mentioned that this was not the case for all the clients as some preferred different therapy approaches. Similarly, some BA-M (TR) therapists also mentioned having clients who wanted to become more religious and align their lives with their religious values. Some of their clients confirmed this, and one of them mentioned that she always considered if she performed her prayers, if she became closer to Allah, she would feel better and would have an objective in life (See Fatma - 6.2.3.5).

Some clients from both studies did not present themselves as observant Muslims, but the findings from their interviews suggested that religion was important to them and their wellbeing. In the pilot study report, it is suggested to ask all Muslim clients about religion and not to make assumptions based on how religious a client appears to be. Similarly, this can be suggested for clients in Turkey too, and the VA tool can be used to assess the importance of religion in a client's life, as suggested in the manual.

7.4.1.4 The BA-M manual

Some therapists from both studies mentioned finding the manual beneficial. Most BA-M (UK) therapists found the cultural issues covered in it informative. For example, the manual instructs therapists to consider inclusion of a family member in treatment, and alternative ways to understand and interpret depression. Explanations on the somatic expression of emotional discomfort also meant that therapists did not ignore somatic symptoms of depression. The BA-M (UK) therapists used the manual as a reference when they had questions. Similarly, BA-M (TR) therapists mentioned that it helped them to understand the training better as it was in Turkish, whereas the training was in English. One BA-M (TR) therapist emphasised that she

[22] The clients in the pilot study were not inpatients. Since the interviews with mental health workers who did not deliver treatment were conducted, some of their views were not specific to delivery of BA-M to BA-M (UK) clients.

really liked the manual as “it is expressed [the content] simply”. This may indicate that it was a good guideline and easy to understand.

7.4.1.5 Improvement in depression

Most of the clients from both studies had positive views about the treatment and said it helped them feel better. It was considered beneficial as it positively changed how they felt about life and their motivation to keep going. For some BA-M (UK) clients and one BA-M (TR) client, the treatment was a step to recovery but not a complete cure. Only one severely depressed client from BA-M (UK) who withdrew early from the treatment said that she did not benefit from it. (For the details about the feasibility study, see Section 6.3.1.8).

The clients from both groups gave examples of achieving their valued goals. For example, BA-M (UK) clients mentioned restarting a business, performing prayers and learning more about Islam. On the other hand, BA-M (TR) clients mentioned being able to work on a thesis,[23] spend more time with family,[24] and read a Turkish translation of the Quran to understand it better.[25]

7.4.2 Client-centred approach

Another common theme was following a client-centred approach in relation to including religion in treatment. Most of the therapists from both studies, including CBT therapists, felt the inclusion of religion in treatment was appropriate if it was an important value for a client. Some therapists from both groups did not feel comfortable about including religion in treatment, but following a client-centred approach led them to feel more comfortable using it with clients who valued religion. Although some BA-M (UK) therapists struggled to imagine how they would deliver a faith sensitive treatment, they mentioned that if their clients wanted to try it, then they would try it too.

Some BA-M (UK) therapists had concerns about the relevance of including religion in the therapy, but, as mentioned above, accepted that delivery of a faith-sensitive treatment might be worth considering when religion was important to their Muslim clients, which indicates a client-centred approach. One of them said that bringing faith into treatment should be done carefully. Similarly, BA-M (TR) therapists emphasised the importance of the way religion was included in treatment, for example, without imposing any values and in line with clients’

[23] Sena
[24] Fatma
[25] Enes

values.

One of the BA-M (UK) therapists mentioned that “a therapist’s own religious identity and views, and the views of, particularly senior, colleagues in a team could impact in their willingness to deliver the therapy”. This indicates that when there is a conflict between therapists’ personal and professional values regarding a treatment approach, this may affect their willingness to deliver the treatment even when the approach aligns with their client's values. One therapist from the BA-M (TR) group mentioned that some of the teachings in the client booklet might not be consistent with a therapist’s own religious beliefs. Although he would consider using BA-M with his clients, he would not use the booklet. The therapist was Muslim, so even differences in the sect that a Muslim therapist follows could affect their willingness to use the approach. This is not consistent with a client-centred approach and may cause some issues such as not paying attention to clients’ needs and desires and so depriving them of a potentially beneficial treatment that aligns with their values. Not considering clients values in treatmentcan create a barrier to accessing mental health services and can potentially reduce positive treatment outcomes.

7.4.3 Client capacity

Some clients from both studies had capacity issues regarding homework completion and/or memory. The reasons for not completing the homework reported in the pilot study were related to being busy, forgetting about it, not having motivation, physical health problems, relationship problems or caring responsibilities. In the feasibility study, similar to the pilot study, life circumstances, responsibilities, or lack of motivation affected homework completion. In addition, mental state was reported as another factor that affected homework completion in the feasibility study.

Some clients had a capacity issue related to their memories. For example, some BA-M (UK) clients had difficulty in remembering to bring homework sheets to the sessions. In addition, some had difficulty remembering whether the VA tool was used in their treatments, but sometimes they recalled making a hierarchy of their goals. On the other hand, a few BA-M (TR) clients had difficulty in remembering whether they had completed PHQ-9 at every session and whether its function had been explained to them. One BA-M (TR) client also had difficulty in remembering whether the two circles model had been introduced to him. Issues related to memory may be due to being interviewed a few months after their treatments or just because it is one of the symptoms of depression (Zuckerman et al., 2018). Difficulty in remembering may

also be linked to reduced attention in depressed clients (Zuckerman et al., 2018, Oberauer, 2019).

One BA-M (UK) client did not remember whether the therapist had asked if they were willing to include a family member or friend in the treatment process although it was recorded that the therapist had offered this at the start of the treatment. Similarly, some BA-M (TR) clients did not remember whether their therapists asked this. As the sessions were not recorded in the feasibility study, it is not possible to check whether the BA-M (TR) clients had difficulty in remembering or the therapists had never asked them to include their family members in sessions. This suggests that it might be useful if therapists check with clients again, after a few sessions, whether they are willing to include a family member at that point. (See Section 7.5.1 for details about how therapists might not be keen to include a family member in therapy.)

7.4.4 Study design

Another common overarching theme in both studies was related to study design, which includes feeling confined to using only one treatment method and views on depression measures used.

A few therapists from both studies, including a therapist from CBT (TR), mentioned feeling confined to using only one method to treat depression. For one therapist in the BA-M (UK) study, this was due to the preference to use a less behaviour focused treatment. In the feasibility study, therapists' usual practice included following an integrative approach, therefore this may be the reason for feeling constrained.

In general, the clients from both studies did not mind completing depression measure(s).[26] Their function was understood in terms of monitoring their depressive symptoms. The clients reported positive views regarding being able to monitor changes in their depressive symptoms. There was no data about the BA-M (UK) therapists' views about the depression measures, which were routine for them and, therefore, could not be compared with those of therapists from the feasibility study.

Both clients and therapists made some recommendations about how to increase the recruitment of clients from both studies. The BA-M (UK) clients recommended recruiting through GP surgeries or holding recruitment sessions in community centres to address low recruitment rates

[26] In the UK study, more than one measure was used (see 7.2)

to mental health treatments. The clients in Turkey suggested publicising a future study on different platforms, including social circles and social media, to improve recruitment, but they did not suggest recruitment through GP surgeries. This is related to the aforementioned different health settings in each country. Clients who were treated in private settings would probably consider a similar setting for a future trial, where there would be no need to have referral by a clinician, for example, a GP.

Similar to BA-M (UK) clients, BA-M (UK) therapists suggested that engagement with GPs and promoting the study with them could help to improve recruitment, whereas the therapists in Turkey suggested that engagement with psychology consultancy centres could help get referrals to increase client recruitment. BA-M (UK) therapists also recommended using schools as recruitment sites – this probably did not mean recruiting children but rather reaching their parents – since it was considered that it might help reduce stigma towards mental health services. Such stigma was not mentioned by therapists in Turkey.

The therapists in the pilot study suggested that regular face-to-face meetings between researchers and the teams being asked to deliver the treatment should be set in order to remind them of the project and the importance of the study, to encourage recruitment. The therapists in Turkey also stated such meetings could increase therapists' engagement and recruitment of clients. This indicates the importance of having regular face-to-face interaction with therapists in future trials rather than regular online meetings which took place, as attendance was low. As they suggested, face-to-face meetings could increase their attendance and engagement in general.

7.5 DIFFERENCES BETWEEN THE TWO STUDIES

The differences between the two studies regarding their qualitative findings are presented under three themes (see, Figure 7.2) in this section: differences in views or experiences about or issues related to the therapy approach, religion and culture, and differences in service settings.

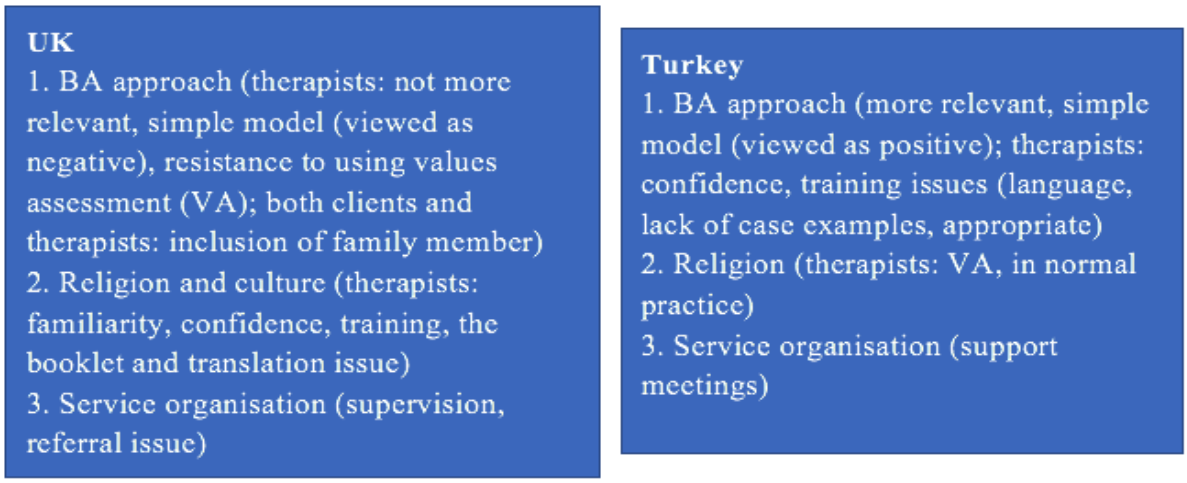


Figure 7.2 Themes showing differences regarding the qualitative findings from the both studies

7.5.1 Therapy approach

Views or experiences of therapists from each country differed about the therapy approach. These differences were based on the perceived relevance and simplicity of the BA-M model, the use of a VA and the inclusion of family members in treatment. In addition, a lack of confidence and need for more training was mentioned by therapists; in Turkey this was related to the treatment approach, whereas in the UK this was related to engaging with culture and religion. Issues which were raised in Turkey are presented in this section whereas those relating to the UK are presented in the next section.

BA-M (UK) therapists believed that a single therapeutic approach was not more relevant to Muslim clients than clients from other backgrounds. They suggested that Muslim clients must be treated on an individual basis, as with any other client, in order to determine the appropriate treatment approach for that person. This suggests that UK therapists compared Muslim clients with other clients when they thought about the relevance of BA-M, without focusing specifically on cultural adaptation, even though culturally adapted treatments have been found to be more effective compared to control conditions (see Chapter 3). This, however, might be due to the pilot study being conducted in 2011, so some evidence regarding effectiveness of cultural adaptation was not available at that time (e.g. Chowdhary et al., 2014, Kalibatseva and Leong, 2014). Some BA-M (UK) therapists questioned the relevance of incorporating faith into treatment, but acknowledged that if people in the Muslim community value their faith, then providing faith-based therapy may be worthwhile. The therapists in Turkey, however, made a comparison between culturally adapted treatment (BA-M) and their usual practice, including CBT, Logotherapy, and Schema Therapy. They thought that BA-M was more relevant for at

least some Muslim depressed adults in Turkey.

Some BA-M (UK) therapists had some negative views about the BA model being too simplistic when it came to helping clients to understand their experience of depression. As mentioned in Section 7.4.1.1, the BA-M (UK) therapists already had the experience of using a more comprehensive model; however, clients thought it was easy to understand, which indicates a positive aspect of the simple model. Most BA-M (TR) therapists, however, considered the BA model's simplicity as a positive aspect of the treatment because they thought it made it easy for clients to understand their experience of depression.

In the manual, it is suggested the VA form is introduced in Session 1, from the treatment adherence assessment, BA-M (UK) therapists appeared not to use the VA tool in the first session. One therapist thought "it was a complicated and clumsy form". Findings from the interviews with the BA-M (UK) therapists indicated that the form was not part of their usual practice, and they would expect to be trained in using it, which could be the reason for their resistance or scepticism about using the tool. There was no issue mentioned in the feasibility study regarding the use of the form. This may be because it was introduced to the therapists in Turkey as part of the BA-M training, whereas in the UK it was incorporated as a result of discussions during the training sessions. This suggests that therapists may need to be trained in using the form to use it more effectively and to reduce resistance to using it.

The manual has guidance on involving family members in sessions. This occurred in the UK, while none of the clients in Turkey involved their family members in their treatment process (see Section 6.3.1.8). Some clients from BA-M (UK) chose to involve a family member in their treatment for some sessions, while others preferred to tell a family member they trusted they were receiving therapy. Family involvement provided general psychological support and practical help in remembering appointments or completing homework. Some BA-M (UK) therapists had prior experience involving a family member of their clients in their therapy sessions for moral support. Interviews with some supervisors, however, suggested that therapists were not always enthused about including family members in treatment because of previous difficulties in managing the dynamics of having extra people in the treatment sessions. This suggests the need for training or supervision to help therapists feel more confident about it. Further discussion about the potential benefits (and problems) of involving others may also be helpful. Although this issue was not explored with BA-M (TR) therapists in the feasibility study, prior to a future trial training, therapists' thoughts on this issue should be explored to

understand whether they need extra support in relation to family involvement in treatment.

The training in the pilot study included only one hour of BA training since the research team was advised that the therapists would be familiar with it, as their basic training included behavioural techniques. In the training evaluation form, however, one therapist suggested that more information on the theory of BA could be useful. In addition, one of the supervisors said that the therapists had basic BA training but not much on behavioural theory. Confidence with the BA approach, however, was not mentioned as an issue in the pilot report, but it could have been overlooked and could have affected delivery of treatment and motivation of therapists. On the other hand, this was reported as an issue by some BA-M (TR) therapists that affected their motivation and recruitment of clients, even though one and a half days of the training was on core BA. The details related to this issue are presented in section 6.2.5.

The suggestions made about training in Turkey were related to the approach. A few therapists in Turkey recommended that it could be better if the training sessions were delivered over more days, and one suggested that having case examples of treatment delivery session by session would be helpful. Another therapist recommended that it could be beneficial to have examples of more specific cases. Generally, BA-M (TR) therapists' concerns were more related to the approach. Training for a future trial should consider these recommendations.

7.5.2 Religion and culture

This theme incorporates issues related to being unfamiliar with religion, confidence in using a faith sensitive treatment, the self-help booklet, training, and translation of measurements mentioned by the BA-M (UK) therapists. The theme also incorporates BA-M (TR) therapists' thoughts on and past experience of including religion in treatment, and views of the VA tool.

Being unfamiliar with clients' religious beliefs affected BA-M (UK) therapists' willingness to participate in the study or deliver the treatment, as it was faith-sensitive. One therapist thought that they needed to have a deeper understanding of what was needed in the sessions. Like the therapists in Turkey, BA-M (UK) therapists mentioned having past experience working with clients with religious beliefs, but the examples given in the UK were related to working with Christian clients. A therapist in the UK is probably more likely to be familiar with the religious beliefs and practices of Christians, the majority religious group, even if the therapist is not religious. None of the therapists in Turkey mentioned an issue regarding not being familiar with religious beliefs and practices mentioned in the manual or the booklet. This is probably

because therapists in Turkey, even non-Muslim ones, are more likely to have experience working mostly with Muslim clients, who are the majority in Turkey. Therefore, therapists in Turkey are less likely to have concerns about not being familiar with Islamic teachings and activities than therapists in the UK. As being unfamiliar could affect therapists' willingness in taking part or delivering the treatment, this suggests that therapists should be reminded that they do not need to be experts in religion, and they can explore clients' religious beliefs by asking them.

Some therapists in the pilot study suggested that the inclusion of a session on Islam covering education on common beliefs and values could increase the engagement of therapists in the UK. This may also help to increase their confidence related to the inclusion of religion in treatment, as it was a barrier that impacted the delivery of treatment. Some therapists who delivered the treatment in both countries mentioned that their confidence increased over time. This suggests that, in future trial training, it should be explained that their confidence will increase with experience of using the treatment.

The therapists and clients in the UK reported a need to have a greater link between the therapists' manual and the clients' booklet, and guidance on how to use it. Not knowing how to work with the booklet caused one BA-M (UK) therapist to drop out. The clients in the UK reported that there was a lack of guidance about how to use the client booklet. As a result, it remained largely unused as a resource for some clients in the UK. The pilot study suggested that the function of the booklet should be made more explicit in the training, so it could be used more effectively in the treatment. These issues were not presented in Turkey, perhaps because after the pilot study, some refinements were made to the manual, booklet and training in response to feedback. Suggested scripts were included in the manual to guide the introduction of the booklet in ways that emphasised it is a client's choice to use the booklet, while also acknowledging therapists' own identity and limits. Text was added to the booklet, creating a link between the manual and the booklet and explaining how clients could use this. These refinements appear to have addressed issues mentioned in the UK as they were not mentioned as issues in Turkey.

In the UK, there was an issue related to using some of the translated depression measures. When therapists did not check the written translation of the measures, despite knowing the language (for example, Urdu), or when the available translated version of the questionnaire provided by IAPT was either too complicated or not accessed by the therapist, difficulties with

completion of the measures arose (for example in Arabic). In Turkey, however, there was no issue related to language as only a validated Turkish version of the PHQ-9 was used, and all the therapists and clients were fluent in Turkish. This indicates that language might create a barrier if treatment is delivered to minority groups, but it is less likely to create a barrier in majority settings. The language was not a barrier in the feasibility study, but it can create a barrier for access to treatment by minority Muslim clients. Turkey accommodates languages of Kurdish, Arab and Laz people who are minorities (Ozfidan et al., 2018). When considering Kurdish and Arab Muslims in Turkey, although by being Muslim they are a majority, their ethnicity makes them a minority group. Almost all Kurdish people in Turkey are fluent in Turkish, apart from the older generation and Kurdish people from other countries (Kreyenbroek, 2005). Some of these people have been there since the establishment of Turkey, but others recently migrated to Turkey. For the latter, language can create a barrier to access Turkey's health and education system, for example (Ozfidan et al., 2018). This indicates that if a future trial aims to explore the effectiveness of BA-M across different ethno-cultural groups in Turkey, it should consider recruiting clients who are and are not fluent in Turkish, having bilingual therapists, and translated versions of depression measures should be checked in advance.

As mentioned in the previous section, BA-M (UK) therapists had resistance or scepticism about using VA because of lack of training in it, after training on VA, therapists in the UK may feel more comfortable regarding attention to religion in treatment through VA.

7.5.3 Service organisation

In Turkey, as previously mentioned, most therapists were working in private health, whereas the pilot study was conducted in NHS centres. As a result, there was an issue related to lack of referrals in the UK as clients needed to be referred, but in Turkey, clients did not. Muslim clients, particularly those with limited English skills, tend to be under-referred for therapy in the UK (Mir et al., 2019, Conner and Heywood-everett, 1998). One BA-M (UK) therapist stated that the stigma of mental illness was a barrier: “they might find it difficult to tell … that they are suffering from depression etcetera, so maybe it is a stigma thing”. Others believed that the issue was due to lower rates of GP referral and services that did not meet the requirements of Muslim clients. This indicates that if a future trial is conducted in the public health system in Turkey, the referral route could create a barrier because, as mentioned in Section 4.4, mainstream mental health treatment is most likely to be based on medication rather than

psychotherapy. Working collaboratively with psychiatrists in public settings to get referrals, may help to reduce this barrier and increase client recruitment in a future trial.

The therapists in the UK did not mention any barriers related to finance, as clients could already access treatment for free, therefore, finance could not be a motivational factor for them to take part in the pilot study. This was different in Turkey, as finance affected clients' recruitment. Some therapists worked for reduced fees or for free, which was a motivational factor for some clients to participate in the study (for details, see 6.2.3.5). On the other hand, finance and levels of autonomy could create barriers for therapists to recruit clients (for details, see 6.2.4.2). Working in private versus public settings highlighted different facilitators and barriers. Sometimes lack of autonomy could be an issue in both settings, as explained below. Finance, however, could either create a barrier or be a facilitator only in private settings.

BA-M (UK) therapists had routine supervision sessions in their organisation. Bi-monthly reciprocal support meetings, which were designed to be peer supervision with the research team, were arranged for BA-M (UK) therapists, in addition to regular supervision meetings. In Turkey, however, the therapists did not normally have routine supervision meetings. Monthly support meetings with the research team were arranged for BA-M (TR) therapists, and bi-monthly support meetings with the research team were arranged for CBT (TR) therapists (see 4.5.4). Attendance to those support meetings was low in both countries. At the training of the pilot study, the necessity for an extra hour of supervision time to allow for discussion about client recruitment was mentioned. Although no more information was supplied, feedback indicated that this was not permitted by senior managers. This may indicate that some issues may arise during a trial because of the hierarchy or system where the trial is conducted. A therapist who works in public settings or does not have autonomy in the workplace may face some issues when they take part in a study. This can be solved by only recruiting therapists who have autonomy in the workplace or getting approval from broader team members of therapists for required arrangements in a study, for which researchers may need to take up feedback from therapists at a more senior level, rather than leaving them to organise this themselves. These arrangements may include extra supervision time to discuss the recruitment of clients, issues raised in the treatment of recruited clients, and referral of potentially eligible clients to therapists who participate in the study. The approval from team managers may help therapists to feel more comfortable about taking part in and recruiting clients for a study and delivering a newly learned treatment method.

7.6 COMPARISON OF PHQ-9 SCORES

Results related to the change in depression score of the feasibility study clients (both CBT and the BA-M group) are presented in Section 5.4. PHQ-9 scores for BA-M group clients in the UK and Turkey are analysed and reported in this section.

More than 50% of the clients did not complete the PHQ-9 after five sessions in the pilot study; this was probably due to the fact that 57% of them attended fewer than six sessions (see Table 7.2). The research team could determine the total number of PHQ-9 scores that were expected in the study since they knew when each client left. If each client completed PHQ-9 at every session before they left the study, 108 possible scores on PHQ-9 would be expected. Based on that, they reported that only 35% of the data were missing. The pilot study's report only included clients' initial and final PHQ-9 scores, although the clients were asked to complete PHQ-9 at every session. As access to the whole data set was not obtained by the current study, in this part of the study, PHQ-9 scores for the baseline (initial score for the pilot study) and post-treatment (final score for the pilot) of all the clients in both studies were used for analysis. Baseline data for one client and post-treatment data for five clients were missing in the pilot study, whereas only baseline PHQ-9 scores for one client from the BA-M group were missing in the feasibility study. As mentioned in Section 7.3, there was not a statistically significant difference in baseline PHQ-9 scores of BA-M (UK) compared to BA-M (TR). Figure 7.3 presents a spaghetti plot showing the change in PHQ-9 scores from baseline to post-treatment for each group separately. As can be seen in the plot, the change in PHQ-9 score was notably greater in the feasibility study compared to the pilot study.

The available data were used in multilevel analysis to anticipate potential differences in terms of efficacy of treatment in both countries. Only the two level random intercept model was used as there were no data available regarding which clients were treated by which therapist in the UK study, meaning that it was not possible to add therapists as a level in the model.

In the two level random intercept model, fixed effects included the main effects of treatment groups (BA-M in Turkey vs BA-M in the UK), time (baseline and post-treatment) and the group by time interaction; and the dependent variable was the PHQ-9 score, which was treated as a continuous variable. The model included a random intercept for PHQ-9 scores nested within the clients. Thus, the model accounted for differences between baseline PHQ-9 scores. A random slope model was not used as there were only two-time points which are less than the minimum required six-time points recommended to have in a random slope model (Wright,

2017). The results of the model are presented in Table 7.3

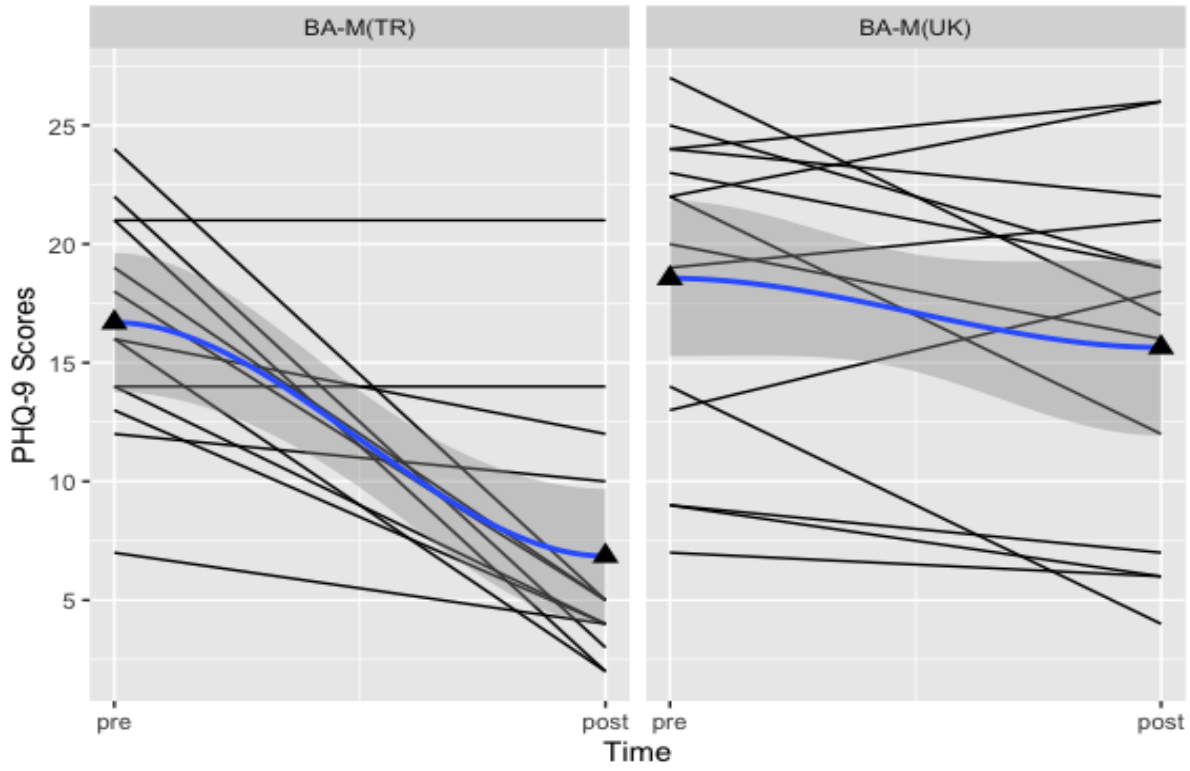


Figure 7.3 Change in PHQ-9 scores from baseline to the post-treatment for BA-M groups in Turkey and the UK

The results of the model (see Table 7.3) showed that the estimated mean PHQ-9 score for the

Table 7.3 Results of two level random intercept model

Fixed effects:	***Est. Coef. (SE)***	***95% CI***	***t value***
BA-M(TR)	26.39 (2.9)	20.1, 32.04	9.021
BA-M(UK)	–4.98 (3.9)	–12.5, 2.54	–1.28
Time	–9.77 (1.7)	–13.05, –6.5	–5.82
BA-M(UK): Time	6.91 (2.3)	2.41, 11.4	2.9
Random effects:	***Est. SD***	***95% CI***	
Clients (Intercept)	4.24	2.34, 5.96	
Residual	4.3	3.27, 5.52	
The Model: Score ~ Group*Time + (1|clients)			
Intra-class correlation coefficient: 0.49			

Est.: Estimated; Coef.: Coefficient; SE: Standard Error; CI: Confidence Interval; SD: Standard Deviation

BA-M (TR) group was 26.39, whereas it was 21.41 (–4.98 plus 26.39) for the BA-M (UK) group at the baseline. There was a statistically significant difference in the effect of time on

PHQ-9 scores of BA-M (TR) clients compared to BA-M (UK) clients ($p < 0.0001$, which is obtained from the t-value). The effect of time for the BA-M group was –9.77 and for BA-M (UK) it was –2.86 (–9.77 plus 6.91). This indicates that the clients from both studies improved from baseline to the post-treatment, but this improvement was about three times bigger for the clients in Turkey compared to those in the UK.

7.7 CONCLUSIONS

Potential reasons why culturally adapted treatments might be more effective for majority groups than minority groups are explored by comparing the two studies. The findings suggest that potential reasons for the difference might be because: (1) Therapists in minority settings might be less familiar or unfamiliar with the culture of minority groups, which can affect their confidence and willingness in using the treatment. (2) Difficult life events mentioned in sessions might be different in minority groups compared to majority groups. Minority groups may have acculturation issues, language barriers and experience of discrimination (Mir et al., 2015), which may affect the efficacy of treatment.

In these particular studies the difference in treatment outcome could also relate to other factors i.e. BA-M (TR) therapists were more experienced compared to BA-M (UK) therapists, and were using the refined version of the training, manual and booklet in the feasibility study, drawing on refinements made following the pilot study. Some issues presented in the pilot study regarding training and the manual were not reported in the feasibility study as they were addressed in line with the suggested improvements following the pilot study. This suggests that if a treatment is piloted for the first time with either a minority or majority group, the effectiveness of the treatment might be further enhanced by refinement following the initial phase of introducing it. It is important to explore whether the studies that targeted minority groups included treatments that were not previously piloted and refined in line with therapists' and clients' suggestions.

Exploration of similarities and differences in the study settings showed that the study settings may affect therapists' engagement, motivation and supervision. For example, finance might be an issue in private settings, whereas referral might be an issue in public settings.

CHAPTER 8
DISCUSSION

The main aim of this thesis was to examine the feasibility of conducting a full Randomised Controlled Trial (RCT) of BA-M for depressed Muslims in Turkey. To reach this aim, three studies were conducted: (1) a systematic review and meta-analysis of face-to-face culturally adapted psychotherapies (CAPs) for the treatment of depressed adults, presented in CHAPTER 3, (2) a mixed methods parallel group feasibility study of BA-M in Turkey, and (3) a comparison study based on the findings from the pilot study of Mir et al. (2015) with those from the feasibility study.

This chapter aims to answer explicitly the research questions specified in Section 1.2.3 to examine the feasibility of conducting a full RCT of BA-M for depressed Muslims in Turkey, by integrating quantitative results (CHAPTER 5) with the qualitative findings (CHAPTER 6) and discussing these in the light of the comparison study (CHAPTER 7) and current literature. It includes two main sections on the acceptability of BA-M and feasibility of an RCT. Implications of the study, limitations and suggestions for future studies are also identified and examined in this chapter.

8.1 ACCEPTABILITY OF TREATMENT

The acceptability of BA-M was influenced by a number of facilitators such as awareness of the BA-M model, a focus on behaviour and use of a values assessment (VA) tool. Some barriers to acceptability were also identified, such as concerns about generalisability of the model, clients' restricted capacity and the historical separation of religion and psychology. The acceptability of BA-M in Turkey could be further supported by suggested refinements to the manual and the booklet and evidence of the potential efficacy of BA-M. This section focuses on facilitators and barriers of using BA-M in practice, views on the booklet and experience of using it, suggested refinements of the manual and the booklet, and potential efficacy of BA-M.

8.1.1 Facilitators and barriers to using BA-M in practice

The findings suggested that being aware of the BA-M "two circles" model was perceived as beneficial. It helped the clients understand what they were going through, and the therapists understand how BA works. Similarly, some therapists perceived the two circles model as appropriate in the pilot study of BA-M conducted in the UK (see Section 7.4.1.1). There were,

however, some concerns about its generalisability expressed by a few therapists from both studies and clients from the feasibility study. These concerns were probably because the therapists had training in CBT, which explains depression with a five areas model (Williams and Garland, 2002), thus, a few of them might have expected more areas in the BA-M model. The five areas model consists of (1) life situation, relationship and practical problems, (2) altered thinking, (3) altered emotions, (4) altered physical feelings or symptoms, (5) altered behaviour or activity levels (Williams and Garland, 2002). The BA-M model actually covers all five areas under the two circles: the life events circle is the first area, and the common responses circle consists of the other four areas. Furthermore, the model in the BA-M manual is a simplified one developed for clients rather than therapists. Explaining this to therapists in a future trial may help prevent concerns about the generalisability of the model. Although a more comprehensive version of the model (Martell et al., 2010) was introduced to the therapists in the training, this model is not introduced in the Manual, which may cause therapist to think that they needed to use the model mentioned in the Manual. Thus, a more comprehensive version of BA as an alternative, such as the one presented by Curran et al. (2012), in addition to the two circles model in the Manual could be introduced to give an option of a more detailed model.

Most of the clients found that focusing on behaviour was beneficial and helped them feel better. The majority of them thought that BA was the approach they needed, which provides some evidence about its acceptability, at least for the majority of clients. There was a concern that focusing on behaviour alone might be insufficient for some clients since feeling that change in thoughts was needed as a precursor to change behaviours and feelings. As mentioned in Section 2.1.5, BA considers cognitions as behaviour, so when a patient is ruminating, BA focuses on this behaviour and tries to activate alternative healthy behaviours (Kanter et al., 2012). Presenting evidence regarding the efficacy of BA to clients and focusing on how to deal with cognitions with BA in training of a future trial may help address this issue and increase acceptability of treatment.

Similarly, scheduling activities or homework assignments was also perceived to be beneficial, which provides further evidence of the acceptability of BA-M. Some clients, however, did not reach the goals that they targeted. When the reason behind this issue was investigated by the therapists, the clients realised that they gave less value to those goals than they had initially considered. This shows the importance of scheduling activities in line with clients' values and

examining the reasons behind not reaching some goals. Values are not static so they may change during the course of therapy (Rokeach, 1971, Beutler, 1972) and personal goals may change as therapy helps clients to work out what is most important to them. This finding confirms the importance of value-driven activities highlighted in other research on BA (Stein et al., 2021b).

Clients' restricted capacity that is difficult personal circumstances including life circumstances, responsibilities, and psychological state, appeared to make it harder to complete the assigned homework. This is consistent with previous research in which clients receiving either BA or CBT reported finding homework challenging, but they considered it as an important part of treatment (Richards et al., 2017). Completing homework might be challenging from time to time, which could have been considered as a barrier to treatment acceptability. Considering that homework assignments, however, are an important and essential factor in treatment and that no clients complained about these and even found scheduling activities beneficial, their restricted capacity should not be considered as a barrier to treatment acceptability. Training for a future RCT should emphasise that a balance in terms of amount of goal setting and homework should be established by therapists. This should be based on having enough to help a client's motivation and activation but not be too much since clients could fail to reach their goals and become demoralised. Taking into account clients' main values or priorities and jointly agreeing plans may help with this process and could further increase the acceptability of BA-M.

The VA tool is used in BA-M to learn about the client's values and design the treatment plan according to these values. The tool increased the acceptability of BA-M to clients as it was found to be beneficial. It also increased acceptability to therapists because some mentioned feeling more comfortable about including religion in treatment after seeing that it was a value for the clients. Some therapists emphasised the importance of the way religion is included in treatment and had some concerns about imposing values and failing to follow a "scientific approach". Similar concerns were raised in a study conducted in Turkey, investigating psychological counsellors' views, experiences and thoughts about spirituality in their own counselling practice (Ekşi et al., 2016). These concerns may be linked to the secularisation in modern society, which has caused the separation of psychology and religion (Reber, 2006) and also the promotion of the biomedical view in the healthcare system since the establishment of Turkish Republic in 1923 (Dole, 2004). Perceiving psychology and religion as alternatives to each other because of secularism was highlighted by a few therapists and clients in the

feasibility study. This potential barrier to acceptability of BA-M, however, has been challenged in Turkey. A speech from Ali Kose, a well-known professor of psychology of religion in Turkey, describes this situation:

> A student who has studied psychology at the university for four years will graduate without hearing a single pro or con related to religion. Why? Because psychology ignores religion. However, many individual or social issues that are under the field of religion, are under the field of psychology. Mental health is the most fundamental subject of psychology. The contribution of religion to mental health is one of the most popular topics in the psychology of religion today. (Karaaslan, 2011)

Furthermore, as mentioned by one therapist, religious people were not admitted to clinical psychology programs until about ten years ago in Turkey. The aforementioned issues show that there was no place for religion in psychology, which was probably the reason why the therapists had concerns. Additionally, the findings highlight the need for therapist boundaries in attention to religion and the potential stigmatisation of therapists who used this approach. The aforementioned issues help to understand why therapists emphasised the necessity for them to be neutral, and that clients should be the ones who bring religion into their treatment. BA-M was considered as providing a systematic way of including religion in treatment, thus it addresses therapists' concerns regarding this issue and increases the acceptability of inclusion of religion in treatment.

Although religion is an important value for the majority of people in Turkey, and has an effect on mental health, it has been ignored in the field of psychology for many years. Yet, the findings of this study indicate that there is a need for a culturally adapted or religiously integrated treatment in Turkey. This need is linked to some evidence regarding the acceptability of BA-M. According to the therapists, BA-M provided a systematic way of including religion in treatment and had the required boundaries (see 6.3.1.5). This suggests that BA-M is an approach that has a potential to address some therapists' concerns regarding imposing values and failing to follow a scientific approach. This does not mean that attention to religion should apply to every client, rather it may be considered where deemed therapeutically useful for individual clients, giving them the opportunity and freedom to bring whichever subjects they want into therapy. This may help to reduce inequalities that religious people might have faced when accessing therapy, or indeed that therapists might have faced when addressing religious values in their treatment provision. It might also help to increase access to psychotherapy in general since respect and understanding of a client's religious beliefs were considered as

essential for a therapeutic relationship to be valuable (Weatherhead and Daiches, 2010).

Findings suggested that the client booklet was in line with clients' values and considered beneficial by most who used it, which provides some evidence regarding acceptability of BA-M to clients. Further evidence regarding its acceptability was provided by some therapists as they mentioned that the booklet supported the more systematic way of addressing religion. There was a general willingness to continue using BA-M and only one therapist mentioned that they would not consider using the booklet with their clients in the future because of their values. This was a Muslim therapist who only believed in the Quran, not the hadiths. Another therapist in the feasibility study suggested reducing the numbers of hadiths in the booklet, but was still willing to continue to use BA-M in practice and did not mention anything about not using the booklet in the future. Some Muslims do not believe in any hadiths or believe in only some, but others believe in hadiths as the second most important source of Islamic teachings after the Quran (Düzenli, 2012). Within the sample of this study not-believing in hadiths was a minority position, suggesting that more research is needed to explore whether the booklet could be further adapted for this group. The difference in these perspectives appears to have affected a few therapists' willingness to use BA-M in practice, which was consistent with the pilot study findings about therapists' own religion identity being a potential barrier to acceptability (see 7.4.2). Findings from the feasibility study, however, suggested that coming from a similar background to the therapists, including religious background, was not important for most clients as long as they were understood and the therapists' backgrounds were not reflected in the treatment. This indicates that therapist's attention to their own values of background does not align with what clients want.

Unwillingness to deliver a treatment that is not in line with a therapist's values is also not consistent with a client-centred approach. Therapists' religious values may sometimes conflict with their professional values (Grimm, 1994) and, according to Farnsworth and Callahan (2013) sometimes their religious values may conflict with their client's values; these value conflicts are an unavoidable part of psychotherapy and the greatest protection for clients is for all therapists to gain a deeper personal and professional awareness of their own values and realise how they affect the services they deliver. According to Giglio (1993) there is a consensus that therapists must not impose their values on clients. Therapists' spiritual and religious values, however, may be directly or indirectly expressed in the course of psychotherapy because value neutrality is largely known to be an illusion in psychotherapy

(Peteet, 2014, Grimm, 1994). To avoid covertly affecting a client, especially when there are differences between a therapist's and a client's religious views, self-disclosure by the therapist is considered to be important (Giglio, 1993). Disclosure of a therapist's spiritual and religious views may have a good therapeutic influence for many clients, whether it involves therapy progress or outcome or is limited to the client's choice of therapist. As a result, therapists must not only be conscious of their spiritual and religious beliefs if they have any, but also be well-informed about how to represent these values in their activities. This suggests that training in a future trial should include explanation of this potential issue and how to overcome it, as mentioned above. In the English version of the manual, there was a statement about therapist disclosure: "I have had training to deliver the therapy I will be using with you and have learned about some Islamic teachings as part of this training. I am not a Muslim/ expert in Islam, but the people who have developed this treatment have worked with experts and developed some approaches that I hope will be helpful to you. This treatment is about you, your beliefs and what is important to you, so I have tried to develop my own knowledge in order to be as helpful to you as possible."(p.33). The part of statement –"I am not a Muslim"-, however, was removed from the Turkish manual as it thought that this would not be appropriate in Turkey. The importance of therapist disclosure suggests it should be encouraged, and religious views could be added in the manual via statements such as "I don't believe in hadiths" or "I have a different understanding of Islam", or "I am not a practicing Muslim". Therapist disclosure may help further increase the acceptability of BA-M to therapists.

The therapist-client relationship built during the course of treatment increased the acceptability of BA-M to clients since most used positive words to describe their relationship with their therapists, for example, "loving the therapist," "sincere relationship," and "insightful therapist". This confirms that constructive therapeutic relationships can be formed in the course of using BA-M. Similarly, qualitative findings from a study that examined the Cost and Outcome of Behavioural Activation for depression (COBRA) versus CBT for depression (Finning et al., 2017) suggested that the therapist was a positive element in both treatments for many clients as someone who was patient and understanding (Finning et al., 2017). Considering that therapeutic alliance predicts psychotherapy outcome and treatment drop-out (Sharf et al., 2010, Sijercic et al., 2021, Constantino et al., 2002, Klein, 2003), being able to construct a positive relationship via BA-M suggests some evidence regarding its potential efficacy and impact on improving retention, thus, its acceptability.

Only one BA-M therapist found themselves being inflexible as they had initially considered there was no room for a therapeutic relationship within BA and thought that it could be the reason why their first client had dropped out from the study (See Section 6.3.3.1). This issue was not mentioned by any clients, suggesting that the therapist's initial feelings might have been related to a lack of experience in using BA-M because they did not have this feeling while delivering BA-M to two further clients. In the COBRA study (Finning et al., 2017), a few BA clients described their therapists as rigid and lacking confidence, whereas the clients in the feasibility study did not raise similar concerns. The BA therapists in the COBRA study were lay mental health workers, which might explain why they appeared to lack confidence, whereas all the therapists in the feasibility study had considerable therapeutic experience. Thus, this issue identified in the COBRA study might be related to a lack of confidence in delivering therapy in general and not specific to BA. These findings suggest that having a positive relationship in BA-M was possible, and the level of therapist experience may affect the nature of the therapeutic relationship.

Therapist-client match, in terms of religious background, did not appear to be an important factor that affected acceptability of BA-M to most clients, suggesting that therapists from different backgrounds can deliver treatment. Only a few clients mentioned that their therapists' religious background was important for them. Considering that most clients mentioned having a positive relationship with their therapists, this finding is consistent with the pilot study (Mir et al., 2015) and a previous study that found that the strength of therapeutic relationship was not related to religion or spiritual values (Kellems et al., 2010),

Most therapists thought that BA-M was relevant to the culture of Turkey. Furthermore, focusing on behaviour appeared to be appropriate as well, providing further evidence regarding acceptability of BA-M. Only one BA-M therapist mentioned they were not impressed by activity scheduling and filling in homework sheets. The therapist linked this issue to the tools "being Western-based". Making plans in advance or scheduling time and activities might be more related to Western cultures. For example, a study, which was conducted in the Netherlands and investigated academic performance differences among ethnic groups, found that Western students – the ethnic majority – had a higher preference for scheduling and organising their time and work compared to ethnic minority students (Meeuwisse et al., 2013). This could indicate that activity scheduling might not be appropriate for every client in Turkey, but as activity scheduling is one of the core components of the treatment (Kanter et al., 2010a),

it is important to consider that this view was mentioned only by one therapist among seven and none of clients mentioned such an issue. Thus, using the activity scheduling tool appears to be acceptable and should not be considered as a barrier to acceptability of BA-M in general.

8.1.2 Views and experience of the booklet of use

Qualitative findings showed that the clients who used the booklet and the majority of therapists had some positive views about and experiences in using it and most thought that it would be relevant at least to some clients in Turkey, providing evidence of its acceptability. One therapist mentioned that the relevance of the booklet would depend on clients' views about hadiths. This suggests that if a client does not believe in hadiths, the booklet may not be relevant or may only be partially relevant to that client. Furthermore, another therapist thought that if the booklet was based on Quranic verses and included fewer hadiths, it could be more objective and appeal to the general population. Reducing the number of hadiths may help to increase the acceptability of the booklet, although one client with a background in theology thought it would be relevant to the majority of people in Turkey. It is clear more research is needed on this topic regarding the proportion of Turkish people who believe in hadiths and more importantly how to adapt for those who don't.

Quantitative findings showed that religiosity did not necessarily lead to use of the booklet. In the interviews, reasons given for not using the booklet included being already a practising Muslim and knowing the topics mentioned in the booklet, coming from a theology background so being aware of the concepts mentioned in the booklet and having some different explanations for some terms used in the booklet. The clients who chose not to use the booklet could, nevertheless, be supportive of it since they had positive views about it. These findings suggest that the level of religiosity may not always determine the tendency to use the booklet, thus, it is important to offer it to all clients who choose religion as a value in the VA tool. This finding confirms the pilot study findings since it suggested presenting this finding to therapists may help increase the acceptability of BA-M as it can help them to feel more comfortable when they offer the booklet to clients who self-identified as less or not religious.

8.1.3 Suggested refinements for the manual and booklet

The acceptability of BA-M was also supported by the fact that there were not many suggested refinements for the manual and booklet, perhaps because they had been refined in line with findings from the pilot study. This suggests that the refinements were successful, which is supported by the results of the comparison study, as the issues related to the manual and

booklet in the pilot study were not apparent in the feasibility study.

The acceptability of BA-M was also supported by most therapists' positive views that the manual was simply expressed, contained relevant and useful examples, and the Turkish translation was helpful. This suggests that the translation process worked well. Introducing a more comprehensive version of the BA model in addition to the two circles model in the manual is likely to further support the acceptability of BA-M (see 8.1.1). A few therapists suggested that examples given in the manual could be broadened, especially in terms of covering rumination. Thus, acceptability of BA-M could be further supported by broadening the section on rumination.

Further refinements to the manual and the booklet relating to derogatory terms used for depression in Turkey could also increase relevance of the booklet to the Turkish context. During the translation development meeting, it was not possible to add the derogatory terms used in Turkey in the manual and the booklet, instead, those specific to Muslims living in the UK were kept (see 6.1). These terms were identified after the feasibility study had begun, from a master's thesis which investigated labels, opinions, beliefs and attitudes regarding mental illness among university students (Karahoda, 2010). Derogatory terms including "*deli* (mad)", "*normal değil* or *anormal* (abnormal)", "*garip* or *tuhaf* (weird)" and "*kafayı yemiş* (crazy)" will be added to the manual and booklet.

8.1.4 Potential efficacy of treatment

Quantitative findings showed that the mean change from baseline to post-treatment for the BA-M group (n=13) was –9.69 (SD=7.26), minus referring decrease in PHQ-9 scores. Considering a 2.59 to 5 point change on PHQ-9 is accepted as a minimum clinically significant change (Löwe et al., 2004), findings suggest that there was on average a clinically significant improvement for all except three BA-M clients – two of whom dropped-out from the study before completing six sessions (see Table 5.5). As this is a feasibility study, a conclusion based on efficacy of BA-M cannot be drawn, but this finding provides some evidence in support of potential efficacy of the treatment in Turkey. This is consistent with the qualitative findings because most of the clients mentioned how their depressive symptoms changed/ decreased, for example, they had reduced guilt and increased self-esteem after the treatment (see 6.3.1.8). This is also consistent with the comparison study findings as most of the clients from both studies had positive views about the treatment and mentioned it helped them feel better and positively changed how they felt about life and their motivation to keep going. These findings

indicate that BA-M has the potential to be an efficacious treatment for depression in Turkey, and provides further evidence in relation to the treatment's acceptability.

A comparison of PHQ-9 scores of BA-M (UK) with BA-M (TR) clients showed that the clients from both studies improved from baseline to post-treatment but this improvement was about three times greater for the clients in Turkey compared to those in the UK (see, Section 7.6). This difference might be because of the improvement in the training and refinements made on the manual and booklet after the pilot study, suggesting the refinements improved the treatment.

Information regarding the clients' physical health and past psychiatric history were not recorded, and how adverse a client's life circumstances currently were were not assessed. Since these factors could affect treatment outcome (Tunvirachaisakul et al., 2018, IsHak et al., 2011), information regarding them should be recorded in a future trial. This may help to identify whether there is an imbalance between clients in both groups and help to interpret results of the trial.

8.2 FEASIBILITY OF AN RCT

The key criteria for determining the feasibility of an RCT were: 1) to recruit at least 10 therapists and 30 clients within six months, 2) to retain 60% of clients to completion of six sessions of BA-M, 3) PHQ-9 should be completed by at least 80% of clients at baseline, 60% of clients at six weeks, 50% at 12 weeks and 40% at 18 weeks. This section starts by presenting sample size estimation (Section 8.2.1) for a future RCT based on the quantitative findings and broader literature. Section 8.2.2 highlights the important factors that affected therapist recruitment and randomisation, and provides suggestions for a future trial based on these factors and the broader literature. Section 8.2.3 focuses mainly on how to increase clients' recruitment, by highlighting the potential facilitators and barriers that affected it and how these could be addressed in a future trial. Section 8.2.4 focuses on therapist and client retention, highlights an issue regarding required minimum number of sessions attended and how to address this issue in a future trial, and general satisfaction with the number of sessions attended, and suggests providing booster sessions in a future trial. Section 8.2.5 focuses on assessment tools used and their frequency, issues faced with usage of these tools and how these can be addressed in a future trial. Lastly, Section 8.2.6 explores issues related to conducting a future trial in the private and public sector.

8.2.1 Sample size estimation

An objective of this thesis was to inform design of a future RCT of BA-M for depressed Muslim clients in Turkey. Thus, it is important to provide sample size estimation for the future trial. As RCTs are longitudinal studies, their primary outcome may be collected at different time points (Walters et al., 2019, Vickers and Altman, 2001). In the feasibility study, PHQ-9 was required to be completed at every session and, if treatment ended before, at 12 and 18 weeks. All clients had baseline (except one), and final session PHQ-9 scores. For this kind of RCT design, using continuous primary outcome, there are different methods for sample size calculation depending on analysis method used. The analysis methods can include comparing post-treatment scores (T1) between intervention and control group using a t-test or Analysis of Variance (ANOVA), comparing change from baseline (T0) to post treatment (T1) scores (T1 – T0) between the two groups using a t-test; and analysing T1 or T1-T0 in a linear regression model that includes intervention group and baseline scores as independent covariates by using Analysis of Covariance (ANCOVA) (Borm et al., 2007). ANCOVA has an advantage over the other two methods because it adjusts for baseline differences in groups and has more statistical power than a t-test or ANOVA (Borm et al., 2007, Vickers and Altman, 2001, Van Breukelen, 2006). Thus, the sample size calculation was done based on ANCOVA in this study.

As CBT is considered as a control arm, a future trial will be a non-inferiority trial because of comparing a new treatment (BA-M) with an existing established therapy (CBT) (Flight and Julious, 2016), aiming to demonstrate that BA-M is non-inferior. In order to calculate sample size, the non-inferiority limit needs to be known. This can be decided based on minimum clinically significant difference for PHQ-9 (Borm et al., 2007). The minimum clinically important difference for PHQ-9 is 2.59 to 5 and the standard deviation for population is 5.7 according to Löwe et al. (2004) and based on this, three units on PHQ-9 were chosen as the minimum clinically important difference. In the multilevel analysis, the residual was 3.5 in model 3, which was the final model, so a 3.5 variance was used in the sample size calculation. With 90% power, a significance level of 0.025 and allocation ratio of 1:1, the sample size was calculated by the SampSize app as 30 clients in each group. If a therapist recruits four clients, there should be eight therapists in each group. Considering that there might be a variation in the number of clients recruited by each therapist, the Variance Inflation Factor [1+(m-1)ICC] formula – where m refers to number of clients in each cluster – was used to inflate the number of clients. (ICC was considered as 0.01). This is equal to 1.03 and when it is multiplied by 30, it is equal to 30.9, so 31 clients. Considering that clients' attrition is likely to be approximately

80%, 37 clients and nine or ten therapists will be needed in each group.

8.2.2 Therapist recruitment and randomisation

Feasibility criterion (1a), recruiting at least ten therapists, was met since more than ten therapists were recruited. Endorsement by well-known scholars in the field appeared to be one of the motivational factors that enhanced therapists' recruitment. Thus, future trials should consider advertising via well-known scholars in the field. This finding extends previous evidence that endorsement by clinicians was one of the facilitators for recruitment of patients into trials (Hughes-Morley et al., 2015, Sheridan et al., 2020). This is probably because clinicians are viewed as experts, so well-known scholars in the field are likely to have a similar effect on therapists, as clinicians have on patients.

Another motivational factor was the opportunity to have the training – learning and applying a new approach. Thus, the three days of training might be considered as an incentive for the therapists as this was free and provided by international researchers, which was mentioned as a motivational factor. According to a systematic review, many clinicians thought that taking part and recruiting clients for RCTs would have personal benefits and participating in activities with colleagues from various disciplines was considered important, both personally and professionally (Fletcher et al., 2012), so learning and applying a new method, and networking with therapists from abroad were considered to have personal and professional benefits to therapists as well. Thus, emphasizing these aspects of a future trial may help to enhance therapists' recruitment.

One of the eligibility criteria for therapists was having good English skills; thus, the language of training being English was not mentioned as an issue in the current study. In a future trial, however, especially if it is conducted in the public health sector, language could create a barrier for therapists' recruitment because people in Turkey generally have low English proficiency, according to the Education First English Proficiency Index (2020), so reaching more therapists might be limited if only therapists with good English skills are included in a future trial. To address this barrier, future BA-M training should be delivered either in Turkish or via simultaneous translation. This would help to recruit at least eighteen therapists as required for a future trial.

It was intended to randomly allocate therapists in order to assess feasibility of randomisation. As mentioned in Section 5.1, only nine out of 14 therapists were randomly allocated. There

was an issue of potential confounding affect for two therapists, since they attended the translation development group meeting. This suggests that therapists would need to be screened in a future trial in order to address this potential issue. The reason for not randomly allocating the remaining three therapists was that they had another training event, which they had to attend, on the third day of BA-M training. Since this was a feasibility study, not randomly allocating some therapists was not an issue but this would be an issue in a future trial. Since it was possible to randomly allocate nine therapists, randomisation for a future trial could be helped by emphasising the importance of randomisation, screening therapists for possible confounding affects and checking their availability for a future trial training before taking consent.

Since most therapists had positive views about randomisation, therapists' randomisation is likely to be feasible in a future trial. The BA-M therapists felt lucky as they learned and applied a new method, whereas the CBT therapists felt more confident as they already used CBT in their normal practice. There was only only one negative reaction from a therapist who dropped out after learning they had been assigned to the CBT group. Randomisation could also be helped by the offer of post trial training (Moorey et al., 2009) and information that the trial includes an active control group (Jenkins and Fallowfield, 2000). Giving therapists who are assigned to the CBT group a chance to attend BA-M training at the end of the trial might help increase feasibility of randomisation, recruitment and retention of therapists. It may even help to keep them motivated throughout to the trial as they will get reinforcement at the end.

8.2.3 Client recruitment

Recruitment of clients has a key role in the success of a trial (Newington and Metcalfe, 2014). The recruitment rate of clients was lower than planned, with 22 as opposed to 30 clients, and longer than expected, a year as opposed to six months, so the progression criterion (1b) was not met in the feasibility study. As better understanding of facilitators and barriers to recruitment can play a role to increase the success of a future trial, these were explored via qualitative interviews and suggestions were made based on these findings in order to inform future definitive trial recruitment strategies. This section includes a discussion of these facilitators and barriers to recruitment and suggestions made based on these in the light of the literature.

Finance – having treatment for free or a reduced fee – was a motivational factor for some clients to take part in the study. Similarly, a study with 403 patients of community mental health clinics

in the United States found that the patients had relatively high preference for working with the therapists who charged less (Boswell et al., 2018) and financial reimbursement has been found to be a motivational factor for taking part in trials as reported by systematic reviews (Sheridan et al., 2020, Tromp et al., 2016). Finance is a potential barrier to access to psychotherapy in the private sector in Turkey (Cosan, 2015), therefore, financial reimbursement would be a motivational factor for taking part in trials, and could be used in a future trial to increase recruitment. There might be a concern about the possible effect of paying or not-paying, on treatment outcome and attendance, as this is an issue investigated in the literature (Bishop and Eppolito, 1992, Clark and Kimberly, 2014, Jensen and Lowry, 2012) and concern regarding this issue was mentioned by one CBT therapist as she thought that providing free treatment might reduce its outcome. Jensen and Lowry (2012) summarised findings from three reviews addressing the impact of fees on attendance and outcome of psychotherapy. The findings that Jensen and Lowry (2012) drew from these reviews were similar to those of Bishop and Eppolito (1992); both studies stated that it was not possible to draw a conclusion based on current studies about whether paying for treatment has an impact on treatment outcome or attendance. Furthermore, a study, which reviewed 1125 clients' records to determine how paying fees impacted therapy outcome and attendance, found that the amount paid did not predict therapy attendance or outcomes (Clark and Kimberly, 2014). Therefore, paying clients' treatment fee in a future trial to motivate them to take part in the study may not be a problem and would help not only to increase clients' recruitment but also to reduce therapists' financial concerns about losing clients and losing income as a result of using a new method.

Being unfamiliar with research was mentioned as one of the barriers to client recruitment in the feasibility study. A similar issue was found in a systematic review of clinicians' attitudes towards recruiting in RCTs, as poor community awareness and understanding of research studies were found to be one of the perceived barriers to recruitment. Furthermore, clinicians often appeared to think that barriers to recruitment were more related to patients including such as poor understanding of RCTs and community awareness (Fletcher et al., 2012). Promotion efforts may help to address these barriers (Fletcher et al., 2012). This could be done by publicising a future trial on social media and psychology consultancy centres, as suggested by the participants in the feasibility study. This issue might also be overcome by improving awareness of research through training relevant to running trials, by targeting poor understanding of trial methodology and recruitment methods among professionals (Fletcher et al., 2012), which subsequently could increase the number of clients willing to take part in a

future trial. Training might be adapted from that developed and evaluated by qualitative research integrated within trials teams, which is based on three one-day workshops lasting five hours (Mills et al., 2018). The workshops comprised interactive presentations, group activities, and discussions focused on significant recruitment difficulties for different healthcare practitioners. The training goals were to: (1) share skills and evidence-based information, (2) raise awareness of and address important recruitment problems, and (3) boost self-confidence in recruiting patients for RCTs (Mills et al., 2018). Mills et al. (2018) evaluated this intervention in a study with surgeons and research nurses. Following RCT recruitment training provided by the team, surgeons and research nurses reported enhanced self-confidence when discussing RCTs with patients, increased understanding of hidden barriers, and a favourable influence on recruitment practices.

The current psychological state of clients appeared to be another factor that affected recruitment in the feasibility study (see 6.2.4.1). According to a systematic review of factors affecting recruitment into depression trials, the psychological state of clients when approached by the research team has an effect on clients' decision to take part in a trial because depressive symptoms such as low motivation and lack of confidence were noted to be barriers to participation (Hughes-Morley et al., 2015). This suggests that recruitment of depressed clients might be more challenging because of their depressive symptoms. As interventions that do not include antidepressants were found to be a motivational factor for clients to take part in depression trials (Hughes-Morley et al., 2015), a future trial of BA-M compared to CBT could be appealing to clients with depression.

A sense of being an experimental object could be barrier to recruitment of clients as mentioned by a few therapists in the study. Feeling like an experimental object – a guinea pig – has been mentioned by clients in other studies on mental health (such as Anderson et al., 2000, O'Keeffe et al., 2020, Swarbrick and Roe, 2011). Mentioning this issue and having a discussion about how it can be overcome in the therapists training regarding running trials, mentioned above, might be helpful to overcome this barrier in a future trial. Furthermore, a study exploring reasons for depressed clients to take part in a trial reported that researchers being friendly (for 95% of 250 participants), helping others with depression in the future (94% of them), being interested in the research (87% of them) and encorugament of general practitioners to take part (71% of them) were important or very important factor for taking part in the trial (Tallon et al., 2011). Similarly, some clients got involved in the feasibility study due to this being

recommended by a trusted person (e.g., friend, professor at the university) or willingness to contribute to science and to help research. Thus, promoting a future trial through trusted people, such as therapists or people from clients' social circle (Fletcher et al., 2012, Sheridan et al., 2020), having friendly reseachers and emphasising the contribution of study to help other depressed clients in future may be helpful to increase client recruitment (Tallon et al., 2011).

Findings from the feasibility study showed that the autonomy of the therapists in the workplace was a factor affecting recruitment of clients. Not having autonomy, which appears to be related to finance and psychiatrists' expectation, among some therapists who worked collaboratively appears to be a barrier to client recruitment in the feasibility study. This suggests that asking approval from therapy team members may help to increase clients' recruitment in future trials. Recruiting therapists at an organisational level is more effective (Fletcher et al., 2012) and can be suggested for a future trial of BA-M.

Some therapists' lack of confidence in using BA-M was one of the barriers for clients' recruitment. In an RCT of BA, Richards et al. (2016) used the 'Quality of Behavioural Activation Scale'[27] to assess therapists' competence after delivery of trial training. Positive assessment can be considered as an approval of their skills and further training can be provided if the required competence is not demonstrated. The same scale might be used in a future trial. In addition, the competence assessment may also help to reduce performance anxiety of therapists, which was considered as a potential barrier to client recruitment in the feasibility study. Therapists should also be reminded that, after delivering treatment, their confidence will improve as it did in the feasibility study and the pilot study.

If a therapist feels unable to provide sufficient treatment during a study, they may not want to recruit clients. A systematic review by King et al. (2005) mentioned that clinicians might not want to randomise their clients to treatments they are not confident to use, and one ethical requirement for an RCT is that the research team and practitioners (therapists) recruiting clients be in a state of clinical equipoise, that is, that the new treatment's (BA-M) effectiveness is not known to be worse or better than the usual treatment (CBT), so the findings could go either way. Few therapists, however, have totally neutral opinions about relative efficacy of any two therapies. Many therapists might be unaware or sceptical about evidence for or against the

[27] They obtained the scale through their personal communication with Dimidjian S, University of Colorado.

therapy investigated (King et al., 2005). A study which investigated doctors' perceptions of equipoise as they undertook RCT recruitment in six different RCTs (three of them were feasibility studies) that had low recruitment rates, found that although doctors were willing to gather robust evidence, they felt discomfort and were concerned about patients' eligibility and safety. Most admitted to having "gut feelings" about certain therapies or patients, some of which undermined recruitment (Donovan et al., 2014). One clinician's view was similar to views expressed by a few therapists in this feasibility study:

> Staff have a feeling that to cut out, as they see it, the option of referring to [the intervention] might deprive the patient of something valuable. Now, we don't know if it's a deprivation because we've no idea if this works yet but in their eyes, it is, you know I can see why they'd think that (Donovan et al., 2014, p.917).

This feeling could be due to viewing treatments as unequal (Hetherton et al., 2004) or not having an active control group (Woodford et al., 2011) both of which were reported as causes of low recruitment in these studies. In the current study, both treatments are evidence based so the control group was an active treatment. It is possible for some therapists/clinicians to have a preference towards one treatment over the other one, but presenting evidence about effectiveness of both treatments -BA has been found to be as effective as CBT (Uphoff et al., 2020), may help therapists to feel comfortable about using only one approach, and in turn, this may help in increasing recruitment.

Furthermore, regular support meetings with therapists to discuss any feeling of inadequacy, and development of the trial in general might help to preserve equipoise and keep therapists motivated and engaged in the study, and subsequently could increase client recruitment in a long-term trial (Bill-Axelson et al., 2008).

Preference for following an integrative method appeared to be another barrier to recruitment in the feasibility study. A parallel-group pilot randomised study reported that therapists' preference to use other methods, and underuse of BA affected both the number of clients invited to their study and randomised clients who went on to receive at least one BA treatment session. Their analysis of routine service data showed that only 2% of depressed clients were receiving BA (59 of 2660) and the rest were receiving different treatments (Pentecost et al., 2015). In this study, as the therapists normally followed an integrative approach, this potentially affected recruitment in both arms because recruitment for the CBT group was not better than for the BA-M group, although CBT was used in their normal practice but integrated with other

treatment methods.

The therapists mentioned that excluding clients whose primary treatment focus was anxiety, when depression was comorbid with anxiety, was a barrier to recruitment. There are some studies which focus on treatment of depression, although a criterion of depression was not the primary focus (Richards et al., 2016, Crits-Christoph et al., 2021, Armento et al., 2012). For example, anxiety could be the primary focus and some studies have shown evidence in favour of BA reducing anxiety (such as Chu et al., 2009, Uphoff et al., 2020, Turner and Leach, 2010, Stein et al., 2021a). Considering that the primary focus was on depression, in the feasibility study, excluding clients with anxiety disorders may have been problematic as it might not be representative of clinical practice (Uphoff et al., 2020). Therefore, a future trial should consider including depressed clients with anxiety in order to be more representative of clinical practice, and also increase recruitment. BA-M could include supplementary techniques appropriate to the BA protocol as clinically indicated for management of anxiety, as in Richards et al. (2016). TRAP (Trigger, Response, Avoidance Pattern) and TRAC (Trigger, Response, Alternative Coping) techniques were used to help people consider, then change avoidance strategies to deal with anxiety in the COBRA study.[28]

One BA-M therapist mentioned feeling stressed about low recruitment at the start of the study. This can make participants feel demoralised, and inconvenience staff in trials (Donovan et al., 2009). Thus, addressing barriers to recruitment could help to address this issue in a future trial.

The recruitment rate per therapist was two clients although at least three clients per therapist was the target of the study. Thus, the recruitment rate was lower than expected. This issue was present in other studies. For example, in an RCT of counselling in the management of minor psychiatric morbidity, only one patient was recruited by 25 general practitioners in five months period (Fairhurst and Dowrick, 1996). Furthermore, in another trial which aimed to investigate efficacy of a computerized therapy programme for depression and anxiety, only 14 clients were recruited in a year by seven GPs, meaning that recruitment rate was two per therapist (Hetherton et al., 2004). Findings from another study suggest that providing brief GP training on patient recruitment skills could be helpful for a future cluster RCT (Foster et al., 2015). As mentioned earlier in this section, such training may help to increase recruitment rate per

[28] This information was given by David Ekers who was one of the researchers in the COBRA study via an email to the researcher.

therapist.

Fletcher et al. (2012) mentioned that clinicians in an RCT want their contribution to the trial to be acknowledged. In addition, a systematic review on barriers to participation in RCTs found that one was lack of reward and recognition (Ross et al., 1999). This finding and the increase in client recruitment after acknowledging therapists' contribution to the feasibility study on the University of Leeds website (see 5.1) suggest that therapists' contribution in a future trial should be acknowledged, to increase their engagement with the trial and clients' recruitment.

In a future trial, if client recruitment is lower than expected in the first three months, recruitment strategies could be improved based on findings from an investigation of the reasons for declining to take part in the trial among potential clients and reasons for low recruitment among therapists within the trial.

8.2.4 Retention of therapists and clients

One of the progression criteria was to retain 60% of BA-M clients for at least six sessions, which was achieved as about 80% of BA-M clients completed at least six sessions. The retention rate could be considered as good as about 79% of the therapists and 77% of the clients were retained, whereas, as mentioned in Section 7.3, only eight clients (42.1%) from the pilot study attended at least six sessions and only three therapists (30%) remained in the study. This shows that the retention rate was better among BA-M (TR) clients and therapists compared to BA-M (UK) ones, but it is important to consider that the settings and type of practitioner in these studies (see 7.5.3) were different. The retention rate among clients was also better compared to some other studies that implemented CAPs (Aguilera et al., 2018, Chowdhary et al., 2016, Hwang et al., 2015, Jesse et al., 2015).

One CBT client was categorised as dropped-out since she attended less than six sessions, although she recovered from depression. Clients should not be expected to attend at least six sessions when they have recovered from depression. In a future trial, the criterion regarding retention should be based on either attending at least six sessions or recovering from depression, as indicated by having PHQ-9<10.

BA-M clients were generally satisfied with the number of sessions that they attended except one who felt ending treatment was a sudden decision, despite it confirming that she had recovered. As the study was a feasibility study, during the training the therapists were asked what the maximum number of sessions was they provided for a depressed client in their normal

practice. There was not an agreed maximum number of sessions. Thus, it was decided not to limit the number of sessions, in order to assess how many would be sufficient, meaning that clients did not know how many sessions they would have. This might be the reason for the above client to feel it was a sudden decision to end the treatment. In a future trial, having an end point is necessary for both informing clients in advance to not to have expectations for more sessions and arranging treatment fees and therapists' time accordingly. Richards et al. (2016) planned to provide a minimum of eight sessions, and a maximum of 20 sessions over 16 weeks, with an additional four booster sessions if clients wanted them provided three months after the treatment.[29] Their results showed that the average number of sessions attended was 11.5 in the BA group and 12.5 in the CBT group, which is more than the average number of sessions attended (8.6 sessions in both groups) in the feasibility study. The authors did not mention how many of these were booster sessions. Considering that on average, 8.6 sessions were attended in the feasibility study and the BA-M manual suggests a maximum number of 12 sessions, a future trial should aim to provide the maximum 12 sessions.

Providing optional booster sessions should also be considered, as one of the clients suggested, and also booster sessions have been found to help in maintaining treatment gains from behavioural therapies and CBT interventions for longer, compared to treatments without booster sessions (Gearing et al., 2013, Whisman, 1990). According to a meta-analysis, CBT interventions that include booster sessions are more effective and have a longer-lasting effect than CBT interventions without booster sessions. As the measurements were collected before the start of the booster sessions in all reviewed studies, the authors suggested that clients knowing that there would be booster sessions may have an effect on treatment prior to them occuring (Gearing et al., 2013). NICE (2009) guidelines suggest providing three to four booster sessions over the following three to six months for all clients with depression. Similarly, a future trial may offer an optional four booster sessions and timing of them can be, for example, at week 4, 8, 12 and 24, after treatment ended. This should depend on the time frame of the trial because if it is conducted over a year, having a booster session after 24 weeks would require all clients to be recruited in the first three or four months, which may not be an easy target to reach.

[29] This information was given by David Ekers who was one of the researchers in the COBRA study, via an email to the researcher.

8.2.5 Assessment tools and their frequency

Findings from the feasibility study suggested that assessing clients' eligibility with SCL-90-R is probably feasible as they considered it practical and standardised. Findings also suggested that SCL-90-R may not be sufficient in some cases, and clinical interview could be used as either an alternative or in addition to it. According to Smith et al. (2010), rating scales, for example, SCL-90-R are informative and useful for some clinical situations and settings, but sometimes a more comprehensive psychological assessment might be needed. For successful clinical research, multimethod assessment (i.e., measuring clinical phenomena using a variety of techniques) is suggested (Burns and Haynes, 2006, Widiger, 2008) because relying on a single method can be subject to its limitations and systematic biases (Widiger, 2008). For example, a clinician's judgement can affect the outcome of clinical interviews whereas a client's poor reading skills or capacity for self-reflection can affect results of a self-report measurement such as SCL-90-R (Widiger, 2008). This suggests the use of both clinical interviews and SCL-90-R together might be more reliable, but this decision should be made based on the available resources – time, money, administrator, interviewer – in a future trial.

Quantitative data showed that all therapists used PHQ-9 at almost every session that the recruited clients attended (except two out of 125 sessions in the BA-M, and two out of 60 in the CBT group). This excludes data from the clients of two therapists: one BA-M therapist who recruited only one client, and one CBT therapist who recruited two clients but one of them was removed from the study due to not being Muslim. The qualitative data revealed that those two therapists misunderstood that they needed to use PHQ-9 at every session and used it at the beginning, middle, and end of treatment. As most therapists were able to use PHQ-9 at every session and the general view of both clients and therapists were positive about using it at every session – especially because of its brevity, this suggests that in a future trial this is likely to be feasible.

The findings showed that Beck Depression Inventory (BDI) was one of the commonly used tool by the therapists to assess depressive symptoms, which may suggest to consider using BDI in addition to or instead of PHQ-9 in a future trial. A study that investigated psychometric properties of PHQ-9 and BDI-II during treatment for depression reported that both measures "demonstrated adequate reliability, convergent/discriminant validity, and similar responsiveness to change" but PHQ-9 had an advantage over BDI by being shorter (Titov et al., 2011). Thus, using PHQ-9 at every session could be more practical and since they have

similar responsiveness to change, there is no need to use BDI instead of or in addition to PHQ–9.

In order to investigate the potential moderators of treatment effect, some scales in addition to PHQ-9, i.e. BA for Depression Scale (BADS) and Ruminative Response Scale- (RRS) at baseline, session 4 and session 7, and six months after the treatment were used in the COBRA study(Richards et al., 2017). Since the findings of this study showed that there were some concerns about whether focusing on behaviour alone could be insufficient to some clients, BADS and RRS could be used in addition to PHQ-9 at different time points –such as baseline, session 6, and final session- in a future trial, as this could help to assess change in specific behaviours and ruminative responses in both groups.

As mentioned, completion of PHQ-9 at every session attended was good, and the progression criteria for the baseline of at least 80% of clients and at six weeks of at least 60% of the clients, were met. Progression criteria, however, were not met at 12 – at least 50% of clients – and 18 weeks – at least 40% of clients. Considering the number of sessions attended by each client, 12 and 18 weeks appeared to be a follow-up for most of them, and some clients had been in the study less than 12 or 18 weeks when the study ended. Although for one client who filled in PHQ-9 at the 12th session, it was not clear whether this was at the 12th week, which was supposed to be during the treatment; thus, the data from the 12th week was dealt with as not reported. This shows that there was confusion about the 12th session and 12th week as for some clients the 12th week was the 12th session, but for others, it was not. In addition, for some, it was follow-up, but for others, it was not, which made data from both weeks 12 and 18 a little bit complicated. This issue could be a potential barrier that confused therapists regarding data collection time points. In a future trial, clearer guidance on time points for data collection is needed to improve data collection. For example, PHQ-9 would be used at every session and six and 12 weeks after treatment ended, if booster sessions are offered at these time points. As mentioned above, arranging booster sessions might help to maintain treatment outcomes and increase follow-up data collection. Six-month follow-up data from 65% of clients in the COBRA study was collected (Richards et al., 2016). This might be due to offering four optional booster sessions of treatment, suggesting that offering booster sessions in a future trial might help to collect follow-up data.

As finance was a motivational factor for some clients to participate in the study, offering monetary incentives in a future trial may help increase the collection of follow-up data.

Dirmaier et al. (2007) undertook a randomised trial to see if minor monetary incentives and a shorter questionnaire helped enhance postal response rates in a one-year follow-up survey for mental health patients who had received inpatient psychotherapy treatment. The findings showed that providing financial incentives helped collect follow-up data (Dirmaier et al., 2007). Although using financial incentives – together with reminders – was supported by a review by Gillies et al. (2021), the authors mentioned that overall certainty about this finding was not high and further studies are needed to evaluate whether monetary incentives increase retention to follow-up. Thus, offering monetary incentives and sending reminders about data collection might be an option for increasing data collection in a future trial. Furthermore, offering optional booster sessions in addition may help increase follow-up data collection if the treatment is offered for free in a future trial.

In Section 8.2.3, providing training on RCT methodology and recruitment techniques is suggested to increase community awareness in RCTs, which will subsequently help increase recruitment. Providing such training may also help address two potential data collection issues mentioned in qualitative findings: therapists' performance anxiety and clients' concerns about affecting their therapists' performance ratings. It can help reduce therapists' performance anxiety as they will be aware that a blinding procedure will be applied, and the main interest in the trial is not therapists' performance, but it is treatment effect in general, so it may help to increase recruitment and data collection. It may also help to reduce clients' concerns that if they score badly that will affect therapists badly, as therapists will have more information about the methodology of RCT, which can help them explain to clients more clearly that their scores on measures will not affect therapists, but will be valuable for assessing the therapy.

As inclusion of clients with anxiety is suggested in Section 8.2.3, measuring anxiety symptoms will be required in a future trial. The therapists mentioned using the Beck Anxiety Inventory (BAI) in their usual practice, which consists of 21 items and measures anxiety symptoms (Beck et al., 1988). The Turkish version of BAI was found to be a reliable and valid measure of anxiety for patients in Turkey (Ulusoy et al., 1998). Considering the length of BAI, Generalised Anxiety Disorder (GAD)-7 is shorter than BAI so might be a better option to assess anxiety symptoms in a future trial. Similar to BAI, GAD-7 was translated in Turkish and was found to have a high validity and reliability in a clinical sample and was considered to be a useful screening tool (Konkan et al., 2013).

8.2.6 Treatment settings

Most therapists in the feasibility study were working in the private sector so the findings could not be extended to the public health sector in Turkey. For the private sector, therapists' autonomy appeared to have an important role in clients' recruitment. Some therapists had financial concerns about losing clients which would not be an issue in the public sector as therapists have fixed salaries which do not depend on number of sessions that they delivered.

There were only two therapists who worked in the public sector. Reasons mentioned for their clients taking part in the study were related to altruism, wishing to help and treatment being in line with their values, whereas for the clients seen in the private sector, this was more related to finance – free or discounted treatment-, being in need and being recommended by a trusted person. Thus, motivational factors for taking part could be different in different sectors, and this suggests that future trials should consider these differences.

If a future trial is conducted in the private sector, paying on behalf of clients and obtaining approval from therapy team members (see Section 8.2.3) will potentially be important facilitators for clients' recruitment. On the other hand, if a future trial is conducted in the public sector where treatment is offered for free, paying on behalf of a client cannot be a facilitator for clients' recruitment, but reimbursing therapists' time for each client could help clients' recruitment as this was effective in another clustered RCT (Foster et al., 2015), and clients may also need to receive incentives, such as reimbursement for travel costs –as it is done by Oladeji et al. (2015)(for the details of study see 3.3) and offering booster sessions if it is not provided in normal practice, in order to encourage them to take part in the trial.

In order to include the Turkish public health service sector in future, there would be a need to explore what kind of procedures need to be followed in order to get permission for conducting an RCT within public organisations, how many therapists have training in CBT and whether organisations will be willing to take part. For such permission, it might be beneficial to consult with scholars, such as Prof Hakan Türkçapar, Dr Elif Çelebi and Dr Volkan Koç, who have experience working in these organisations.

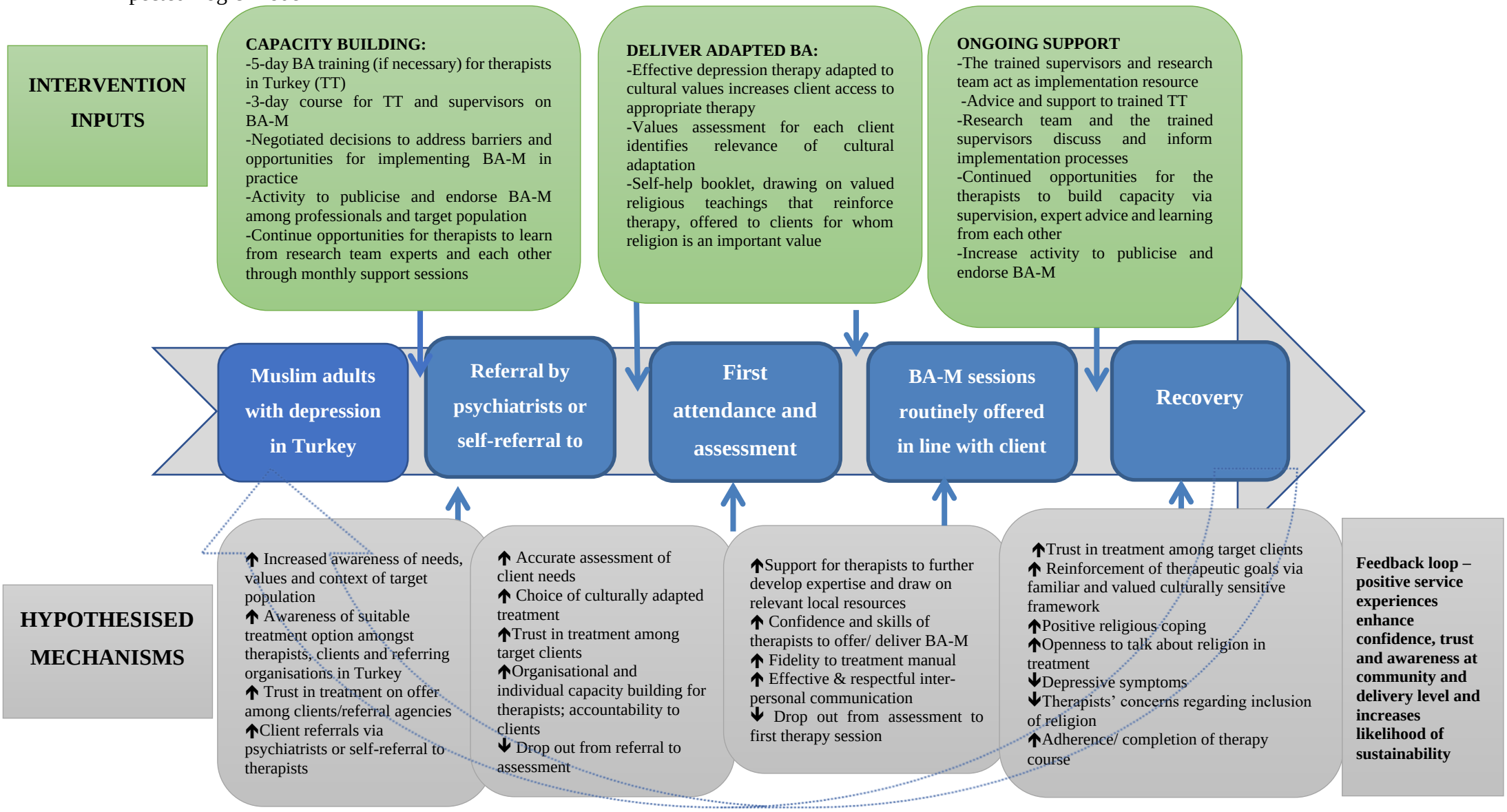
8.3 IMPLICATIONS OF THE STUDY

The aim of this study was to explore feasibility of a full RCT of BA-M, considering the perceived benefits (see 6.3.1), potential efficacy (see 8.1.4) of BA-M and evidence regarding its acceptability, it will be useful to explore this intervention further. If the trial shows that BA-

M is not worse than CBT in practice, more therapists could be trained in BA-M. One advantage of BA-M is that training takes less time than CBT (Ekers et al., 2011), thus, more therapists can be trained in a shorter time frame, and so more clients with depression could have access to treatment. Treating more clients can have both personal and public health benefits, since depression can be the cause of substantial impairment in social and in occupational functioning and is one of the leading causes of years lived with the disability in the world (see 1.1). According to one study, only 14% of those who had mental health disorders sought/accessed mental health treatment, which shows that millions of people were not treated in Turkey (Kılıç, 2017). A longitudinal study with 4101 participants conducted in Izmir, the third-largest metropolitan area in Turkey, reported that the estimated 12-month prevalence of major depressive disorders (MDD) was 8.2% and although 43% of clients with MDD sought help, including 30% who used mental health services, only 25% got minimally sufficient treatment in the same 12-month period (Topuzoğlu et al., 2015). Therefore, having BA-M as another approach to use in clinical practice would mean that clients would have more treatment options. Therapists would potentially feel more confident to include religion in the treatment if religion is a value for their clients, as BA-M provides a more systematic way for its inclusion.

Findings from this study provided some evidence for the acceptability of BA-M and feasibility of conducting a full RCT of BA-M for depressed adults in Turkey. As the feasibility study showed partial success (5.5), the reasons for not meeting some progression criteria were explored via qualitative findings in 6.2 and suggestions have been made for a future trial to address the issues raised (6.4). These suggestions were further explored in the light of literature in this chapter. By making suggested changes, it will potentially be feasible to conduct a full RCT of BA-M for depressed adults in Turkey. The logic model below shows the expected mechanism for how BA-M will work in practice in Turkey.

Expected Logic Model



A recent study by Akan (2020), which explored the understandings and experiences of common mental health difficulties of Turkish-speaking people in the UK, reported that religion was a source of support for more than half of the sample. These individuals indicated how concrete religious rituals like *salah* (the daily ritual prayer performed by Muslims) and *dua* (calling upon Allah) served to reduce, if not eliminate, their distress. For personal growth and resilience, others mentioned using spiritual aspects of their faith, such as the Islamic concepts of *sabr* (patience), *şükür* (thankfulness), and *tevekkül* (trusting in God's plan). The client booklet includes these concepts. Considering the potential benefit of BA-M for depressed clients in Turkey and that religion in general and these concepts specifically were considered as a source of healing by Turkish speaking immigrants in the UK, the Turkish version of BA-M may have potential to be used for Turkish speaking immigrants in the UK and other countries.

8.4 LIMITATIONS

Most of the recruited therapists had five or more years of experience and none had less than three, and most worked in private sector. Therapists with less experience and who work in the public sector could have different experience, and their clients could have a different demographic. Therapists who did not have good English skills were excluded from the study. Excluding them was unavoidable because of lack of resources, as having an interpreter for the three days of training and in all the support meetings would have been costly. This may cause bias because therapists with good English skills are likely to be from richer and more educated backgrounds compared to the other therapists. Their clients' profiles and concerns might also be somewhat different from other therapists. Having a more educated background may have influenced their views about the training, the manual and the booklet, and the way they perceived BA-M and delivered it. It might be considered that their clients' profiles may not be representative of general population, causing concerns about whether the clients in the feasibility study were really different from the general population. However, since most of the clients paid a reduced fee or had treatment for free and mentioned this was a facilitator to take part in the study, this suggests they were probably from a range of different financial backgrounds.

The treatment sessions were not recorded although this was suggested to the therapists. The therapists thought that it would be harder to recruit clients, so it was decided not to record sessions. Thus, it was not possible to assess therapist adherence to the manual.

Not being able to interview participants who dropped out could be a source of bias in the study. Attempts were made but the two therapists did not return emails and text messages. One BA-M client who was categorised as having dropped out because of attending only four sessions was interviewed but two others were not, since their therapists could not reach them.

Some clients were interviewed a few months after their treatment ended so they might have forgotten how their treatment experiences were. Therefore, it would be better if they were interviewed right after their treatment ended.

One of the limitations of this project is the lack of Patient and Public Involvement and Engagement (PPIE). Public involvement in research is defined as "research being carried out 'with' or 'by' members of the public rather than 'to', 'about' or 'for' them" by National Institute for Health and Care Research (NIHR, 2021a). PPIE is promoted as a vital part of research since it gives members of the public the opportunity and right to have a say in research and improve the quality of research by, for example, ensuring that research focuses on questions and outcomes that are important to the public. As explained in Methods, Phase 1 – Translation and modification of *the Manual* and *booklet* – of the study included Translation Development Group (TDG) meetings with mental health professionals. The relevant audience for the Manual was therapists and they were involved in the translation and modification process. Although clients were the relevant audience for the booklet, they were not involved in Phase 1, which is a weakness of this study. In order to discuss the content and language of the booklet, focus group meetings with people who were from different ethnic, socio-economic and educational backgrounds and had previous experience of depression could have been conducted. These meetings would have been helpful in exploring whether the content was culturally appropriate, how the language could have been improved and whether it was understandable. If any refinements were suggested, the booklet could have been refined in line with these suggestions before the therapist training. This could have helped to further improve the acceptability of the treatment. Although interviews with the clients and the therapists at the end of the study provided information about acceptability of the treatment and feasibility of a future trial, PPIE at the design stage of a future trial would be helpful to further improve acceptability of the treatment and feasibility of the trial. It would also be helpful to improve the quality of a future trial by ensuring that the trial focused on questions and outcomes that are important to the public. In a future trial, some clients who took part in this study, people who were or are caregiver for a person with depression, and mental health professionals who

were in the TDG could be invited to help design the trial. In order to ensure good public involvement in a future trial, the UK Standards for Public Involvement in research (NIHR, 2021b) would be followed by, for example, providing inclusive and equal opportunities to PPIE participants, being flexible, working together with respect, offering support and learning opportunities that build confidence and skills in public involvement and recognising their contributions. PPIE requires time and resources, which were not available during this PhD project, thus, adequate time and resources would need to be allocated to ensure good public involvement in a future trial.

8.5 SUGGESTIONS FOR FURTHER STUDY

Based on the findings from the meta-analysis (see 3.3.5), more studies are required to explore the efficacy of CAPs compared directly to an evidence-based psychotherapy for the treatment of depressed adults and why they are more effective for majority ethnic groups compared to minorities. Although findings showed that there was a potential for BA-M to be effective, it is not possible to measure it by a feasibility study. Thus, an RCT of BA-M is required to assess the efficacy of BA-M for depressed adults in Turkey.

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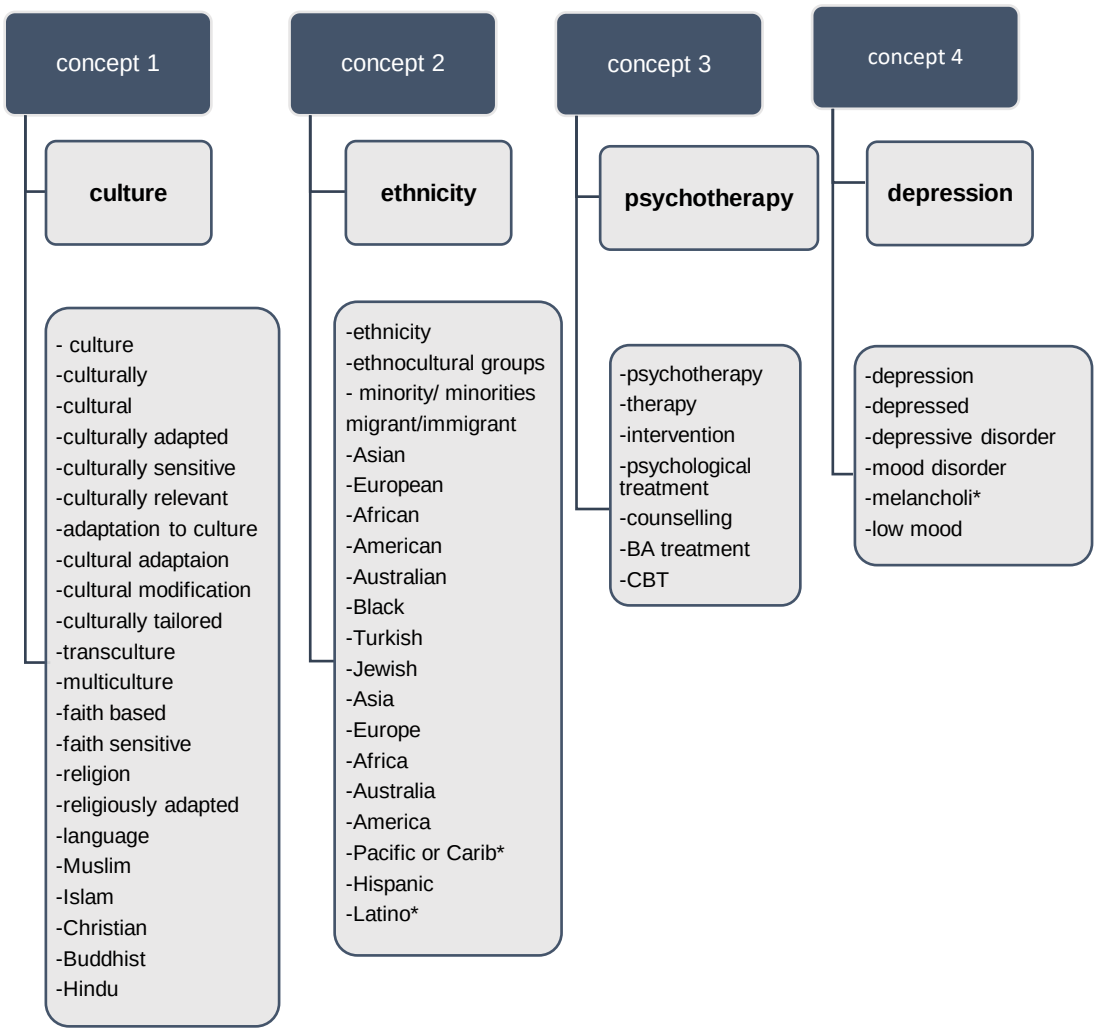
APPENDIX A

SUPLEMENTARY DOCUMENTS FOR THE SYSTEMATIC REVIEW

Appendix A1 Concept of search Terms



Appendix A2 Search terms used

Table 1: EMBASE

Database: Embase <1996 to 2018 Week 31>
Search Strategy:
---

1 exp cultural anthropology/ (39336)
2 culture.tw. (493758)
3 exp transcultural care/ (3994)
4 (cultur* adj4 (adapt* or sensitive or appropriate or relevan* or modif* or tailored)).tw. (29804)
5 transcultur*.tw. (1746)
6 multicultur*.tw. (3227)
7 (faith adj4 (adapt* or sensitive or appropriate or relevan* or modif* or tailored)).tw. (70)
8 (religio* adj4 (adapt* or sensitive or appropriate or relevan* or modif* or tailored)).tw. (375)
9 "religio* sensitiv*".tw. (36)
10 "religion based".tw. (50)
11 "religio* adapt*".tw.(4)
12 exp religion/ (50348)
13 Islam.tw. (1139)
14 muslim.tw. (3536)
15 Christian*.tw. (6564)
16 Buddhi*.tw. (1460)
17 Hindu*.tw. (1783)
18 (Judaism or Jewish).tw. (7387)
19 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 (604811)
20 exp ethnic group/ (105403)
21 ethnicity.tw. (78536)
22 exp minority group/ (10948)
23 minorit*.tw. (68406)
24 ethnocultural group*.tw. (95)
25 exp ancestry group/ (239173)
26 Asia*.tw. (170767)
27 Europe*.tw. (403620)
28 Africa*.tw. (217723)
29 America*.tw. (1135919)
30 Australia*.tw. (142958)
31 Caribbean.tw. (12790)
32 "Hispanic americans".tw. (679)
33 Latino*.tw. (12728)
34 Blacks.tw. (16583)
35 Turkey.tw. (39062)
36 Turkish.tw. (22617)
37 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 (2171678)
38 19 or 37 (2690893)
39 exp depression/ (355000)
40 depress*.tw. (417916)
41 "low mood".tw. (1009)
42 melancholia.tw. (814)
43 39 or 40 or 41 or 42 (540717)
44 38 and 43 (72140)
45 exp psychotherapy/ (166764)
46 psychotherapy.tw. (28180)
47 CBT.tw. (13015)
48 exp counseling/ (123097)
49 (psycholog* adj3 (therap* or treatment* or intervention*)).tw. (20454)
50 (Cognit* adj2 (therap* or treatment* or intervention*)).tw. (33607)
51 (Behav* adj2 (therap* or treatment* or intervention*)).tw. (49070)
52 45 or 46 or 47 or 48 or 49 or 50 or 51 (318322)
53 44 and 52 (7511)
54 effectiv*.tw. (1877240)
55 53 and 54 (2124)
56 limit 55 to (human and yr="2012 -Current" and adult <18 to 64 years>) (556)

Table 2: Ovid Medline

Database: Ovid MEDLINE(R) <1996 to July Week 3 2018>
Search Strategy:
---

1 exp culture/ (104696)
2 culture.tw. (331370)
3 exp Culturally Competent Care/ (774)
4 (cultur* adj4 (adapt* or sensitive or appropriate or relevan* or modif* or tailored)).tw. (19920)
5 transcultur*.tw. (1213)
6 multicultur*.tw. (2175)
7 (faith adj4 (adapt* or sensitive or appropriate or relevan* or modif* or tailored)).tw. (50)
8 (religio* adj4 (adapt* or sensitive or appropriate or relevan* or modif* or tailored)).tw. (237)
9 "religio* sensitiv*".tw. (20)
10 "religion based".tw. (32)
11 "religio* adapt*".tw. (3)
12 exp "religion and psychology"/ (11541)
13 exp Religion/ (35982)
14 Islam.tw. (640)
15 Muslim.tw. (2254)
16 Christian*.tw. (4124)
17 Buddhi*.tw. (808)
18 Hindu*.tw. (907)
19 (Judaism or Jewish).tw. (5161)
20 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 (472235)
21 ethnicity.tw. (45277)
22 exp Minority Groups/ (9304)
23 minorit*.tw. (43089)
24 ethnocultural group*.tw. (77)
25 exp Continental Population Groups/ (151352)
26 Asia*.tw. (90615)
27 europe*.tw. (187550)
28 Africa*.tw. (141655)
29 America*.tw. (245929)
30 australia*.tw. (87360)
31 caribbean.tw. (8589)
32 "Hispanic americans".tw. (484)
33 Latino*.tw. (8198)
34 blacks.tw. (10996)
35 turkey.tw. (22270)
36 turkish.tw. (11661)
37 exp Ethnic Groups/ (98021)
38 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 (826070)
39 20 or 38 (1239875)
40 exp Depressive Disorder/ (73284)
41 depress*.tw. (261018)
42 exp DEPRESSION/ (77971)
43 "low mood".tw. (465)
44 melancholia.tw. (628)
45 40 or 41 or 42 or 43 or 44 (283847)
46 39 and 45 (30242)
47 exp PSYCHOTHERAPY/ (98772)
48 psychotherapy.tw. (14994)
49 CBT.tw. (6988)
50 exp Counseling/ (26430)
51 (psycholog* adj3 (therap* or treatment* or intervention*)).tw. (10657)
52 (Cognit* adj2 (therap* or treatment* or intervention*)).tw. (18812)
53 (Behav* adj2 (therap* or treatment* or intervention*)).tw. (29445)
54 47 or 48 or 49 or 50 or 51 or 52 or 53 (148705)
55 46 and 54 (2511)
56 effectiv*.tw. (1161349)
57 55 and 56 (826)
58 limit 57 to (humans and yr="2012 -Current" and "all adult (19 plus years)") (324)

Appendix A3 Tables for the quality assessment of included studies

Table 3 Risk of bias summary: Review authors' judgements about each risk of bias item for each included uncontrolled study based on the Newcastle-Ottowa Scale

	Score (max 6)	***Selection 1***	***Selection2***	***Selection3***	***Selection4***	***Comparability 1***	***Outcome 1***	***Outcome 2***	***Outcome 3***
Aguilera et al. (2018)	**4**	b*	NA	a*	a*	NA	b*	b	d
Bennett et al. (2014)	**5**	a*	NA	a*	a*	NA	c	a*	b*
Ward and Brown (2015)	**5**	b*	NA	a*	a*	NA	c	a*	b*

NA= not assessed; *= one point for each star

Table 4 Risk of bias summary: review authors' judgements based on the ROBINS I Scale about each risk of bias item for each included non-RCT study

	Bias due to confounding	Bias in selection of participants into the study	Bias in classification of interventions	Bias due to deviations from intended interventions	Bias due to missing data	Bias in measurement of outcome	Bias in selection of the reported result	Overall bias
Leung et al. (2013)	L	L	M	NI	M	M	M	M
Roland (2014)	S	L	M	L	S	S	S	S

L: Low, M: Moderate. S: Serious, NI: No information

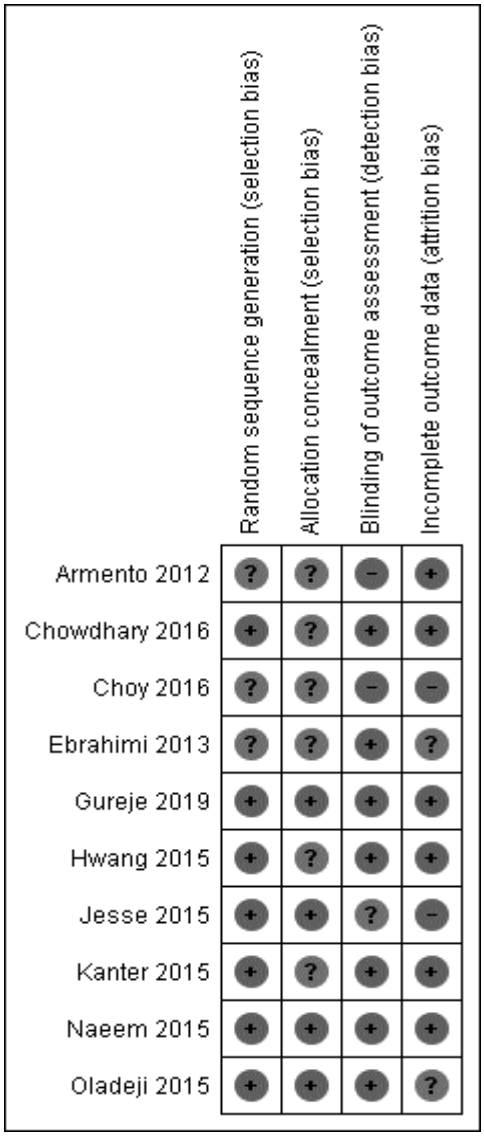


Figure 1 Risk of bias summary: Review authors' judgements about each risk of bias item for each included RCT study.

APPENDIX B

TRAINING PROGRAMME FOR THERAPISTS

	Friday 7th December	Saturday 8th December	Sunday 9th December
Morning 9:00-9:30	Refreshments and Registration		
Morning 9:30-12:30 **Break at 11ish**	9:30-10:00 Introduction by Evrim and then Host (Elif Celebi) to introduce trainers David – Introduction to training Introduction to Behavioural Activation Theoretical model Evidence base of BA/BT for depression	David -Introduction to day Technique 3: activity scheduling Avoidance and depression Rumination and BA Discussion and summary What we are expecting from therapists in the study (Evrim)	9.30 Introduction to day (Evrim) 9.40 Role play for Values assessment tool and case study (Gul) 10.20 Pt 2: Manual – family (Ghazala) 10.40 BREAK 11.00 Case Study and Role play: Family and Community (Gul) 12.00 Reflexive exercise and feedback (Gul) 12.40 Using the Client Booklet (Ghazala: Manual based)
Lunch on Friday 12:30-2		**Lunch 1-2pm**	**Lunch 1-2pm**
Afternoon 2 - 5:00 **Break at 3ish**	(David) Giving the rationale Technique 1: self-monitoring Self-monitoring homework Homework review Technique 2: functional analysis; ABC and TRAP/TRAC	2.00 Background to the training (Evrim) 2.10 Background to the research project (Ghazala) 2.40 Reflexive exercise (Gul) 3.15 BREAK 3.45 Pt 1 Manual (Ghazala/ interactive*) 4.15 Values Assessment Tool 4.50 Q&A	2.00 Gul: practice experience, mini role play with volunteer; 10 mins Q and A 2.30 GM – pilot/Pt 3: Manual 3.00 BREAK 3.20 Gul - Scheduling activation assignments; using the client booklet/activity monitoring/ community involvement – collaboration eg Grand Mosque resources 10 mins questions 3.40 Case study and role play (Gul) 4.20 Final issues/concs/Supervision/ reciprocal supervision /(Ghazala) 4.45 Q&A 4.55 Evaluation forms/end

APPENDIX C

TURKISH VERSION OF PHQ-9

HASTA SAĞLIK ANKETİ-9 (PHQ-9)

Son 2 hafta içerisinde, aşağıdaki sorunlardan herhangi biri sizi ne sıklıkla rahatsız etti? *(Cevabınızı "✔" işaretiyle gösteriniz)*	**Hiçbir zaman**	**Bazı günler**	**Günlerin yarıdan fazlasında**	**Hemen hemen her gün**
1. Bir şeyleri yapmaya az ilgi veya zevk duymak	0	1	2	3
2. Üzgün, depresif veya umutsuz hissetmek	0	1	2	3
3. Uykuya dalmada veya uyumaya devam etmekte zorluk, veya çok fazla uyumak	0	1	2	3
4. Yorgun hissetmek veya enerjinizin az olması	0	1	2	3
5. İştahsızlık veya çok fazla yemek	0	1	2	3
6. Kendinizi kötü hissetmeniz — veya kendinizi başarısız ya da kendinizi veya ailenizi hayal kırıklığına uğrattığınızı düşünmeniz	0	1	2	3
7. Gazete okumak veya televizyon seyretmek gibi faaliyetlerde dikkatinizi toplamakta güçlük çekmeniz	0	1	2	3
8. Başkalarının fark edebileceği kadar yavaş hareket etmeniz veya konuşmanız? Veya tam aksine— normalden çok daha fazla hareket edecek kadar kıpır kıpır veya huzursuz olmanız	0	1	2	3
9. Ölmüş olsanız daha iyi olacağınız veya bir şekilde kendinize zarar verme düşünceleri	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

Bu sorunlardan herhangi birini işaretlediyseniz, bu sorunlar işinizi yapmanızda, evinizle ilgili işleri halletmenizde veya diğer insanlarla olan ilişkilerinizde ne kadar zorluk yarattı?

Hiç zorluk yaratmadı	**Oldukça zorluk yarattı**	**Çok zorluk yarattı**	**Aşırı derecede zorluk yarattı**
☐	☐	☐	☐

APPENDIX D

INTERVIEW TOPIC GUIDE FOR CLIENTS

Thank you for making the time to meet with me today

1. How did you come to take part in the research?
    - What were your feelings about taking part?
2. How much information did you have about the study before taking part?
    - Was there any information that would have been useful to know beforehand?
    - Were there any aspects of the process that were not clear before starting therapy?
3. Did you think the way you were approached about the study was an appropriate way to identify and recruit you to the research?
    - Where would be a good place to recruit people from? /Where would be a better place to approach people?
    - Do you have any suggestions about how we might recruit participants in future research
4. How did you feel about being asked to take part in the study?
    - What would have made you feel reassured/comfortable?
5. Am I right in saying you had……. sessions?
    - ***If client completed therapy***: Did you feel the number of sessions were right for you?
    - ***If client did not complete therapy***: Why did you finish early?
      What would have encouraged you to continue?

***For all clients*:**

- Did you ever miss/cancel sessions?
- How did the therapist deal with that?

6. How was your relationship with your therapist?

Was the therapist from the similar background to you? What about in terms of religion

- How important was it is to you to have a therapist that was from the similar religious background as you? Why?
- Do you feel the therapist understood what you were going through?
- Did the therapist give you instructions sometimes? Did the therapist explore what was important to you sometimes? Did you feel there was enough of a balance between the two?
- Did you prefer having instructions or did you prefer the exploration?

7. Were you asked to complete some questionnaires at the beginning of the session?
    - Did you mind having to complete them at the beginning of each session and at two different time points after completion of your treatment
    - Did you always fill them in or did you ever refuse to?
    - What did you think of the questions asked?
    - Was the function of the questionnaires explained to you?
    - Did you think the questions asked were appropriate?
8. Did you have any views about using an approach that was focussed on behaviour?
    - Did these views change over the course of the therapy? How?

SHOW 2 CIRCLES MODEL

- Was the 2 circles model explained to you?
- What did you think about the 2 circles model?
- Did you find it useful to concentrate on behaviour and getting active to help you feel better? Why/ why not?
- ***If 'no',*** what would you have found more useful?

9. Were you asked to complete a values assessment?
    - What did you think about this? Was it useful?
    - Do you think it was helpful to the therapist to know about your values? and what was important to you?
    - How important would you say religion is to you?
10. Was religion brought up during your therapy? How?

***If yes*:** Did this make you think that the therapist was being sensitive to your beliefs or stereotyping you?

- Some people feel that they want to include their religious beliefs in therapy, and some people do not want it to be brought up – how did you feel?
- Was discussing religion useful or relevant to you?
- Were you happy with the way it was brought up – by you or the therapist?
- How easy was it for you to talk about your religious beliefs – if you wanted to?
- Did you feel that the therapist was open to talking about your religious beliefs? Why? Why not?
- Can you give me some examples of how religion was used in the therapy?
  Did you find these useful or not? Why/why not?
- Did these feelings change over the course of your therapy? Why/why not?

***In no*:** why do you think it was not discussed?
Were you happy with the fact that religion was not discussed?

- Would you have felt comfortable or uncomfortable in drawing on religious beliefs and teachings during therapy?
- Did these feelings change over the course of your therapy? Why/why not?
- Is there anything that would have made it easier or made you feel more comfortable to be able to?

11. Were you given the client booklet?
    - Was it relevant to you?
    - Was its function explained to you?
    - Did you think it was given at a relevant time?
    - Did you find it useful?
    - ***If 'yes***, is there anything that could be done to improve it?
    - ***If 'no'***, what would have been more useful? Would you have preferred not to have it?

12. Did you understand the homework tasks that were set?
    - What did you think about the activities that were suggested?
    - Were they linked to your goals and values?
    - How easy was it to complete the tasks?
    - What made it difficult/easier?
13. Were your family or friends included in your therapy at all?
    - ***If 'yes'***, were you happy for them to be included? Was it helpful to you?
    - ***If 'no'***, did you choose not to have them included? Would you have preferred them to be? Would it have been helpful to you?
    - Did your therapist suggest you contact any community e.g., imams or social groups?
    - ***If 'Yes':*** did you find this useful?
    - ***If 'no'***: Would you have found it useful if any community were suggested by the therapist?
14. How did you feel at the end of therapy?
    - Do you think the therapy helped you?

    ***If yes*:** How has it helped?
    - What changes in your depression/circumstances did it bring for you?

    If no: Did it make you feel worse? How?

- Can you give me some examples of what you mean?

15. Do you think we should make some changes to the therapy you received?
16. Have you had any other support to deal with your depression in the past?

    If yes:

    - In your experience how did you think this therapy compared to the other support that you have been given before?
    - Which do you think was most relevant to you as a somebody from Muslim background?
    - Which approach do you think best took account of your values and worldview?
    - How important was that to you?

17. Is there anything else that you would like to add?

APPENDIX E

INTERVIEW TOPIC GUIDE FOR THERAPISTS[30]

Thanks for your involvement in this research study and making time to see me today. This interview will cover your views on the adapted therapy that we've been working on it and your experience of being involved in this study.

1. How did you come to take part in the research?
    - What were your feelings about taking part?
2. How did you feel about randomization?
3. How would you describe your normal therapy style to treat depression?
    - What are the differences and similarities between BA and your normal style?
    - Before the training and study did you have any views about using an approach that was focused on BA?
    - Did these change over the course of the study? Why/why not?
4. Did the training prepare you for delivering the intervention? How did you feel about the training being in English?
    - Were there any areas that you think should have been covered in more detail?
    - Were the suggested examples and exercises in the training and manual relevant and useful?
    - Were there any aspects of the process that were not covered by the training that you would have found useful?
    - What did you think of the 2 circles model? How useful did you find it?
5. Before the training and study did you have any views about using an approach that incorporated religion?
    - As a therapist how relevant did you feel a religiously informed intervention was to your work?
6. Did your views and feelings about using an approach that incorporated religion change over the course of the study? Why/why not?
    - How did you respond if a client talked about their religious beliefs during the sessions?
    - How do you feel about supporting clients to draw on religious beliefs and teachings to support their recovery?
7. Can you give any examples of when you drew on religious beliefs or teachings when delivering the therapy?
    - How did you feel about doing this?
    - What was the client's response?
    - How helpful did you feel it was to draw on this belief/teaching?
8. Have you offered the Client Self-help Booklet to your clients?
    - If yes, did they choose to use it? If yes, what do you think about its usefulness?
    - If no, why?
9. How does the adapted BA therapy compare with the way you normally deliver therapy to clients?

[30] The questions specific to BA and BA-M approach were not asked to the therapists in the CBT group

- Which approach do you think is most relevant to Muslim clients? Why?
- Which approach do you think best takes account of the client's values and worldview? Why?
- Which approach do you think is better at engaging with Muslim clients? Why?
- Do you think this approach fits with Turkish culture?

10. How did you recruit clients to the study? What methods did you use for recruitment of the clients?
    - To how many clients you have approached for inviting to the study?
    - How many of them accepted to take part in the study?
    - What things made it easy or difficult for you to recruit clients?
    - Do you have any suggestions as to how we might recruit participants in future research?
11. If you had any clients who declined to take part, why do you think this is? Did they give any reason?
    - Did the fact that that the therapy was part of a research study influence people's decisions to take part/not take part?
    - Did the focus on religion in the study influence people's decisions to take part or not?
    - Did the extent to which they were coping or the severity of their depression influence their decision?
    - What do you think could have been done to resolve/address this?
12. How did you feel about using the measures? Did you think that using SCL-90-R to identify eligible clients and ask them to take part in the study was an appropriate way of recruiting to the study?
13. What is your usual practice for asking clients to complete depression measures
    - Did you ask clients to complete depression PHQ-9 at baseline, at the beginning of each session and 12 and 18 weeks after the first session?
    - What kind of response did you get from clients when you asked them to fill in the measures? Did they mind having to complete them at the specified times?
    - What helped with getting clients to fill in the questionnaires and what got in the way?
    - Did they always fill them in or did they ever refuse to? Why do you think this is?
14. How did you feel about engaging with the research?
    - Why?
    - How motivated were you to stay involving with the study? Why?
    - What do you think would help to keep therapists engaged in a future research study?
15. Will you continue to use BA-M? Why?
16. Do you have any other thoughts or comments about the adapted therapy or about using religion to support therapy more generally?
17. Is there anything else that you would like to add?