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Research report

Adapted behavioural activation for the treatment of depression in Muslims

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ABSTRACT

Background: Incorporating religious beliefs into mental health therapy is associated with positive treatment outcomes. However, evidence about faith-sensitive therapies for minority religious groups is limited.
Methods: Behavioural Activation (BA), an effective psychological therapy for depression emphasising client values, was adapted for Muslim patients using a robust process that retained core effective elements of BA. The adapted intervention built on evidence synthesised from a systematic review of the literature, qualitative interviews with 29 key informants and findings from a feasibility study involving 19 patients and 13 mental health practitioners.
Results: Core elements of the BA model were acceptable to Muslim patients. Religious teachings could potentially reinforce and enhance BA strategies and concepts were more familiar to patients and more valued than the standard approaches. Patients appreciated therapist professionalism and empathy more than shared religious identity but did expect therapist acceptance that Islamic teachings could be helpful. Patients were generally enthusiastic about the approach, which proved acceptable and feasible to most participants; however, therapists needed more support than anticipated to implement the intervention.
Limitations: The study did not re-explore effectiveness of the intervention within this specific population. Strategies to address implementation issues highlighted require further research.
Conclusions: The adapted intervention may be more appropriate for Muslim patients than standard therapies and is feasible in practice. Therapist comfort is an important issue for services wishing to introduce the adapted therapy. The fusion of conceptual frameworks within this approach provides increased choice to Muslim patients, in line with policy and research recommendations.

1. Background

Culturally appropriate treatments for depression are promoted by policy bodies internationally (NICE, 2011; APA, 2010; WHO, 2013) and evidence suggests that population specific treatments can improve outcomes for minority ethnic patients (van Loon et al., 2013). Globally, Muslims are the second largest faith community; in the UK some Muslims can experience higher prevalence of common mental disorders, which are more chronic than in the general population (Gater et al., 2010; Weich et al., 2004). This suggests a need to develop interventions, including culturally specific adaptations of existing treatments to improve their acceptability and relevance to Muslim populations (Smith et al., 2010).

A number of studies exploring and evaluating adaptations of psychological treatments for predominantly Pakistani Muslim populations have focused on broad aspects of culture such as language, acculturation, family dynamics and community networks, rather than specifically on religious identity (e.g., Gater et al., 2010; Naeem et al., 2015; Rahman, 2007; Rahman et al., 2008; Rathod and Kingdon, 2009). Religious identity is, however, an important focus for adapting therapy treatments to Muslim populations as this constitutes a prime identity for many individuals (Nazroo, 1997) and religious coping techniques are more commonly adopted than in other religious groups (Loewenthal et al., 2001). Faith-sensitive interventions can potentially reduce and prevent depression (Townsend et al., 2002) and improve quality of life (Lee et al., 2010) and are at least as effective as secular treatments. For Muslim patients, such approaches have resulted in earlier improvements in depressive symptoms (Hook, et al., 2010; Koenig et al., 2001) than those achieved by secular interventions.

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Several possible mechanisms have been suggested for the effectiveness of spiritually-focused therapy, including providing meaning (Gerwood, 2005), providing a sense of wellbeing (Hawkins et al., 1999), fostering social support (Scott, 2003) and through the act of surrendering control to a higher power (Cole, 2000). A distinction between 'negative religious coping' (feeling punished or abandoned by God or unsupported by one's religious community) and 'positive religious coping' (the use of an internalised spiritual belief system to provide strategies that promote hope and resilience) is, however, important (Pargament et al., 2001). The former is associated with increased depression and anxiety, whereas 'positive religious coping' is associated with reduced levels of depression (ibid; Koenig et al., 2001; Dew et al., 2008).

However, more evidence is needed about interventions for Muslim populations: reviews of clinical trials and faith-sensitive therapies provide insufficient evidence because there are too few studies involving minority religious groups (Townsend et al., 2002), methodological quality is often poor and detailed descriptions of the form and content of interventions for Muslim patients are not generally available (Walpole et al., 2013; Azhar and Varma, 1995; Anderson et al., 2015). Interventions may need to take account of ethnic diversity within minority Muslims populations as well as variations in understandings and personal relevance of Islamic teachings and practices that can be culturally influenced (Maynard, 2008; Haque, 2004).

Psychological practitioners in UK and US health services have been found less likely to hold religious beliefs than the general population (Neeleman and King, 1993; Whitely, 2012); interventions that can potentially be delivered by both non-religious and religious therapists are therefore desirable. Secular therapies do have the capacity to incorporate spiritual values and such modified therapies can be effectively delivered by non-religious therapists (Worthington Jr and Sandage, 2001; Hook et al. 2010), providing an important bridging model for clients for whom spiritual practice is important.

A good candidate for faith-sensitive adaptation for Muslim populations in the UK is Behavioural Activation (BA) – an effective therapy for depression (Ekers et al., 2014) that has shown improved clinical outcomes linked to increased religious activity (Armento et al., 2012). BA involves supporting and motivating patients to engage in rewarding activities based on their own personal values and goals (Kanter et al., 2009). This suggests potential suitability for population-specific adaptation, including the sensitive incorporation of religious practices and identity. BA has also been identified as a therapeutic model that is parsimonious and relatively easy to train and disseminate, especially to minority and other populations with cultural belief systems outside the Western medical norm (Kanter et al., 2012). Furthermore, the treatment has previously been modified for Latino populations in the US, based on a similar logic, with promising results (Kanter et al., 2010, 2015).

Using the modification of BA for U.S. Latinos as a framework (Kanter et al., 2010), we conducted a two-part mixed-method study to (1) develop a faith-sensitive adaptation of BA for Muslim patients and (2) test the feasibility and acceptability of the adapted intervention. Because incorporating the specific themes and teachings of a minority religion (Islam) into a mainstream, evidence-based psychotherapy approach was somewhat novel, we describe the process of developing the adapted intervention (Study 1) and the qualitative feedback we received from patients, therapists and administrators associated with testing the feasibility and acceptability of the intervention (Study 2). Our goal was to develop a concrete set of adaptations to the existing BA manual; we anticipated that the adaptation would both help to facilitate effective relationships between therapists and Muslim patients and support therapists to engage patients with respect to their religious identity. We aimed to achieve this without compromising the core mechanisms and interventions of an evidence-based psychotherapy approach that was developed without such considerations in mind.

Ethical approval for both studies was granted by the Yorkshire and Humber Research Ethics Committee.

2. Study 1: development of the adapted intervention

2.1. Method

2.1.1. Participants

Participants were 22 local and 7 national key informants, recruited purposively because of their known interest and experience in mental health work in ethnically-diverse communities, Islamic understandings of depression or delivering BA in NHS practice. The final sample comprised 9 community mental health workers, 6 BA/intercultural therapy academics, 5 clinical psychologists, 4 Muslim service users, 3 service managers and 2 GPs.

2.1.2. Qualitative interview and procedure

Interviews were conducted by GM in person and lasted approximately 90 minutes; all interviews were audio-recorded for later transcription and coding. Interviewers did not follow a structured protocol but followed a topic guide which identified the following themes to discuss: therapy interventions/adaptations involving religion or spirituality and mechanisms by which these influenced outcomes; influences on Muslim patients' mental health and on seeking or receiving healthcare; faith-based coping strategies; strategies for engaging Muslim patients; similarities/differences with other social groups and within Muslim communities.

2.1.3. Data analysis

Interview data were coded using NVivo 9 software, with 20% double-coding by two researchers, and synthesised as per Pope et al. (2007). We used organising themes derived from initial analyses and from our systematic review of the literature on faith-sensitive adaptations of BA, other faith-sensitive therapies for depression, and interventions targeting Muslim patients with depression (Walpole et al., 2013; Wright et al., 2014). The key informant interviews and systematic review both informed adaptation of the therapy manual. Where themes derived from the qualitative analyses were consistent with or could be elaborated by findings from our review, these citations and elaborations have, therefore, been included in our results.

2.2. Results

The findings are discussed in relation to four primary themes identified in the analysis: relevance of the BA model, social context, patient–therapist matching, and religion and therapy. After presenting these themes, we describe how they informed the adaptations to the existing BA manual.

2.2.1. Relevance of the BA model

A primary theme was that much of the BA model was considered appropriate and a potentially good fit without significant adaptation. This was largely because key informants felt the model's straightforward behavioural focus linked to patient values resonated with Islamic teachings and religious practice (see supporting quotes in Table 1). Other aspects of the existing model that were determined to be appropriate included the procedures for supervising therapists, use of homework activities, strategies to encourage session attendance and prevent early withdrawal and strategies to take account of limited literacy and environmental pressures.