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Culturally Adapted Treatment for Depression – development and evaluation

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Overview

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- **Rationale for culturally adapted depression therapy**
- **Therapy adaptation**
- **Pilot trial**
- **Randomised control trial**
- **Contribution to system change**
- **Future implementation and uptake**

Rationale

- **Culturally appropriate treatment** - promoted by World Health Organisation (2018), NICE (2009) and Department of Health (1999;2005)
- **Faith-sensitive therapies** – large body of evidence that these can reduce levels of depression and improve wellbeing (Anik et al 2022; Koenig et al 2001)
- **People from Muslim backgrounds** – religion a prime identity (Finney et al 2023; Nazroo 1997) more likely to use religious coping techniques for mental illness than other faith groups in the UK (Loewenthal, Cinnirella et al. 2001)
- **Behavioural Activation (BA)** - proven effective in clinical trials (Richards et al 2016; Ekers 2011). Focus on client values promising for adaptation to meet the needs of Muslim clients. BA-M feasible and acceptable in NHS primary care mental health/IAPT (Mir et al 2015)
- **Research Question:** Does culturally adapted behavioural activation reduce depression in adult Muslims in Bradford when delivered by;

  a) trained NHS primary care staff

  b) trained non-specialist staff in voluntary sector organisations?

Rationale

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Higher levels and more chronic depression for some in UK Muslim communities compared to general population

97% of Pakistani Muslim people continue to have depression after a year compared to 45% in the general population after six months (Spronston and Nazroo 2002)

Under referral of Muslim populations for psychological therapies, low levels of trust in mental health services among minority ethnic clients and widespread failure to accommodate spiritual needs in NHS care

National IAPT data analysis - under referral :

- **2% Muslim (5% nationally); 6 sites: 3.32% (8.39%)**

Poorer treatment outcomes

Suggests current treatment may be inappropriate

Mir et al 2019

Rationale

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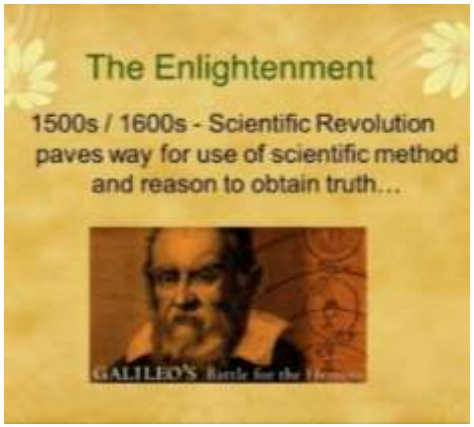
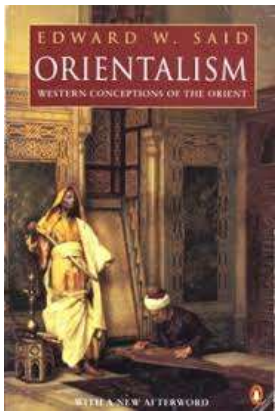
- **Lack of training** - poor engagement with religious values within therapy setting/lack of familiarity with Islamic values; potential to replicate social exclusion/Islamophobia in therapy settings
- **Social/historical context** –
  - negative perceptions of Islam/religion vs. accepting as a valid value framework
  - Attitudes towards religion/Islam in Western culture - a private matter, 'unprofessional', 'inferior, immoral, dangerous'
  - Racism in health policy and practice:
  - Overrepresentation of psychiatrists without religious beliefs in the UK and US (**Neeleman and King 1993; Whitely 2012**)





‘Privileging’ v reducing disadvantage

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Meeting unmet need

Socially included groups

Socially excluded groups

- **Under referral/lower use of services (access/stigma)**
- **More environmental stressors**
- **Higher levels of comorbidity**
- **Low representation amongst therapists**

(***Mir et al 2015***)

Development

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Medical Research Council guidelines for development of complex interventions):

PHASE 1: Systematic review of literature *(Walpole et al 2013)*

PHASE 2: Interviews with 29 key informants

PHASE 3: Synthesis and production of treatment manual – 3 Advisory Groups

PHASE 4: Piloting.

Mir et al 2015

Religion and depression

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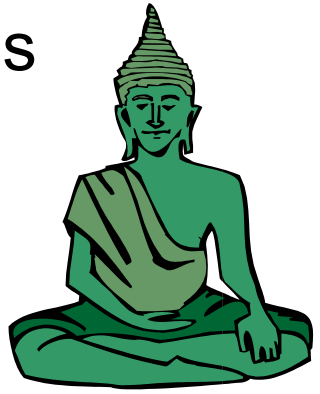
Existing evidence

- ❑Positive and negative religious coping
- ❑Effectiveness of faith-based interventions
- ❑Complementary not competing approaches

Key informant views

- ❑Need to address/engage on the client's terms
- ❑Influence on references and metaphors
- ❑Confidence to discuss all aspects of identity



Therapy adaptation

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RELIGION AND THERAPY

- Positive religious coping:
  resilience, hope, making sense of experience, increased self-esteem
- Negative religious coping: punishment, obsessive behaviour, guilt, despair, hopelessness (Pargament et al 2001)

encourage valued religious activity without inducing guilt

- "Islamic way of life" = good health;
- Islamic scriptures support healing and link values/beliefs with actions.

range of religious teachings a resource for improving health

ISLAM AND HEALTH

(Walpole et al 2013)

Therapy adaptation

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Spiritual understandings of depression in Islam/ Muslim communities

- Religious activity as potentially positive resource for health, **emphasis on acting upon beliefs** *eg 5 pillars of Islam*
- **Diversity amongst Muslims**: religion as central, marginal, struggling with identity
- **Intertwining of religious and other cultural influences** – need to differentiate
- Use of **faith healers/supernatural explanations** for depression

Results: BA/Islam parallels

sadness and grief are as normal responses to difficult life events

spend time on self

Discouraging self-criticism or low self-esteem

Resilience

being active

Active response to the risk of harm

don't just rely on God

not abnormal or 'mad'

Stigma unjustified

discourage extremism / obsessive behaviour

Reframe experience

Reframe relationships

congruence between beliefs and actions

positive outlook

refocusing thoughts

think positively about self

look after self physically.

Develop meaning in life

Reduce isolation

Hope

feel less alone

small changes can have a major influence

positive ways of thinking

encourage interaction with others

Adaptation: Client Self Help Booklet

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- Collection of teachings from the Qur'an/Prophetic teachings(*Sunnah*).
- Familiar and valued framework.
- Resource for both the therapist and the client:
  - means of developing own knowledge for therapists
  - don't have to believe the teachings, just that they can help the client.

- Teachings linked to positive religious coping and principles of BA.
- Content guided by clinical psychologist qualified in Islamic jurisprudence.
- Booklet includes action points and space for reflection.

Examples of therapy adaptation

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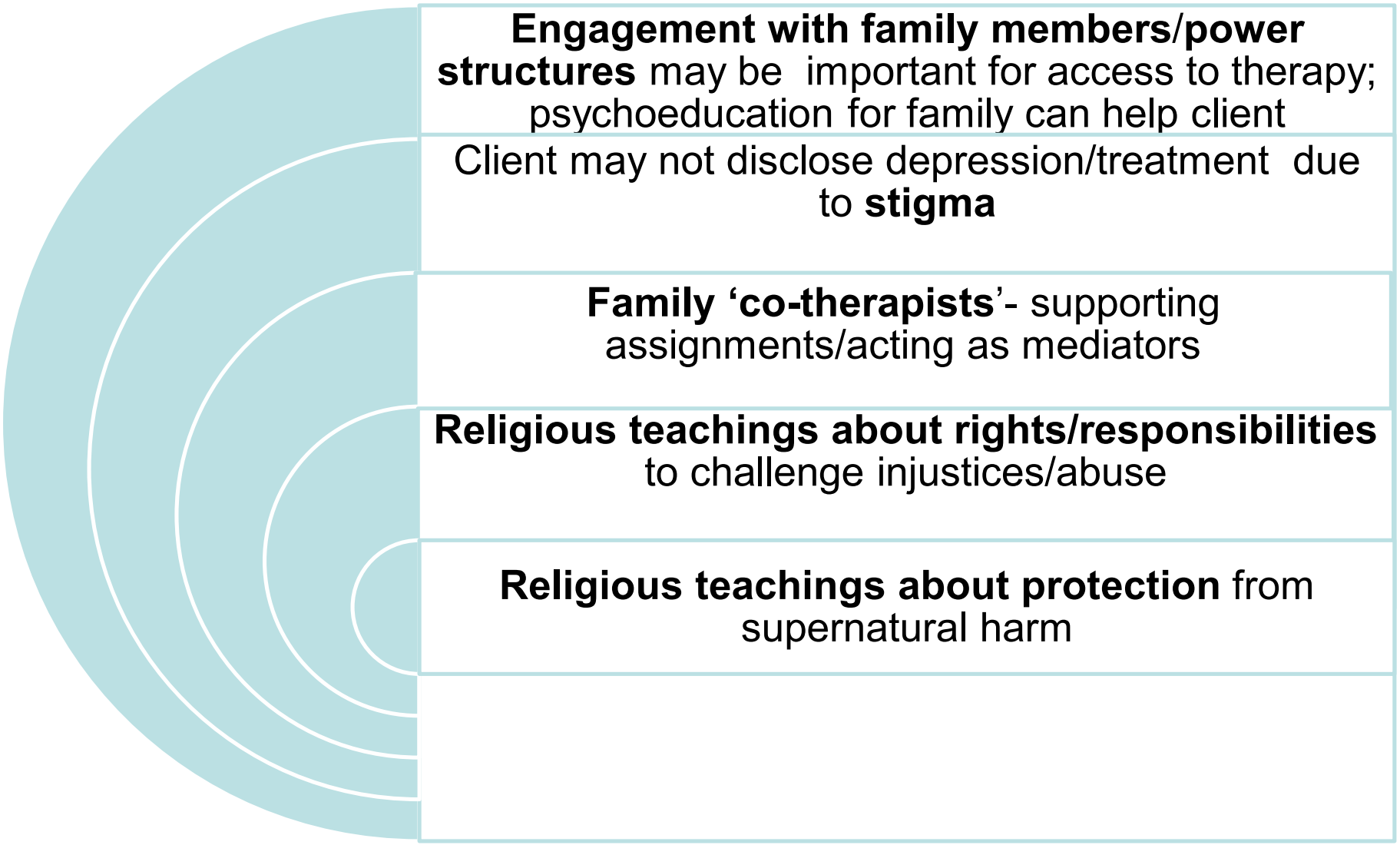

Therapy adaptation

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- **Social exclusion** of Muslim identity in UK society – racism, discrimination in key areas of social life (Runnymede Trust 2017; 2004; Whitaker 2002)

- Therapists consequently need to:
  - Give a message of **social inclusion**
  - Be **reflexive** about attitudes towards religion/Islam
  - Avoid stereotyping/prejudice and **accept legitimacy** of Islam as a value framework
  - Target adverse social circumstances/unhelpful beliefs through **activation assignments**
  - **Collaborate** with those who have relevant expertise when possible

BA-M

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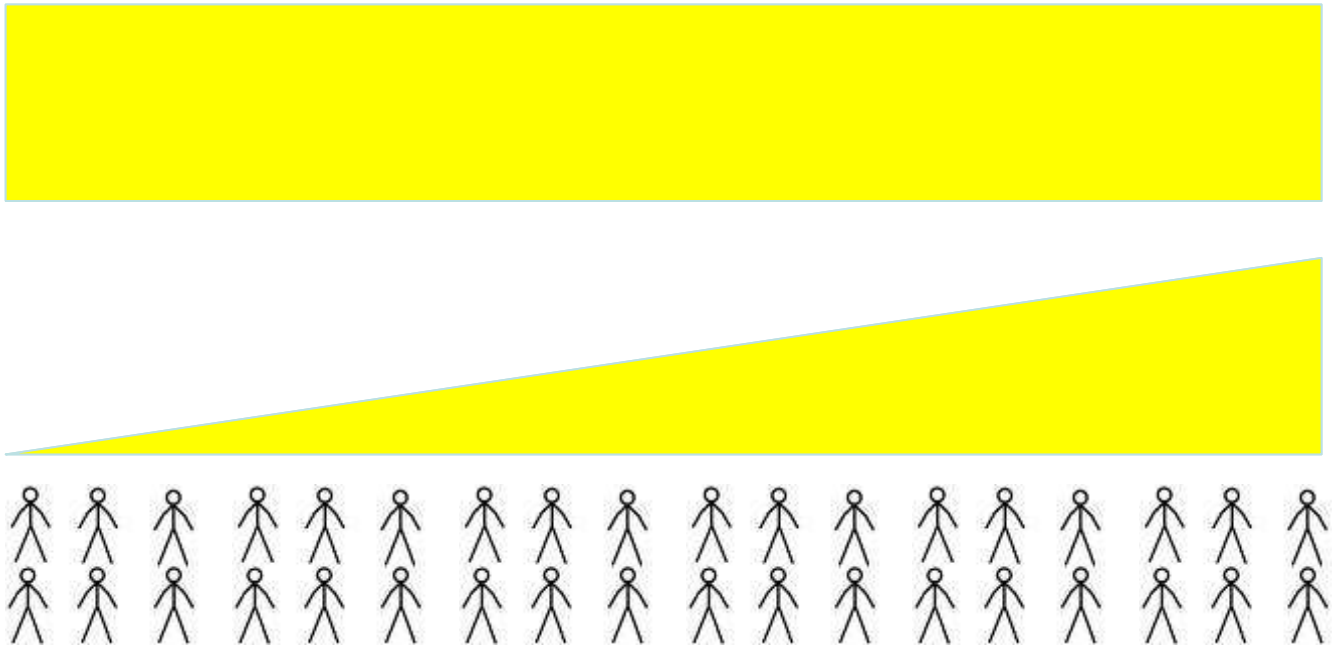
BA-focus

Islam-focus



Intervention will always be 100% BA

BA-M

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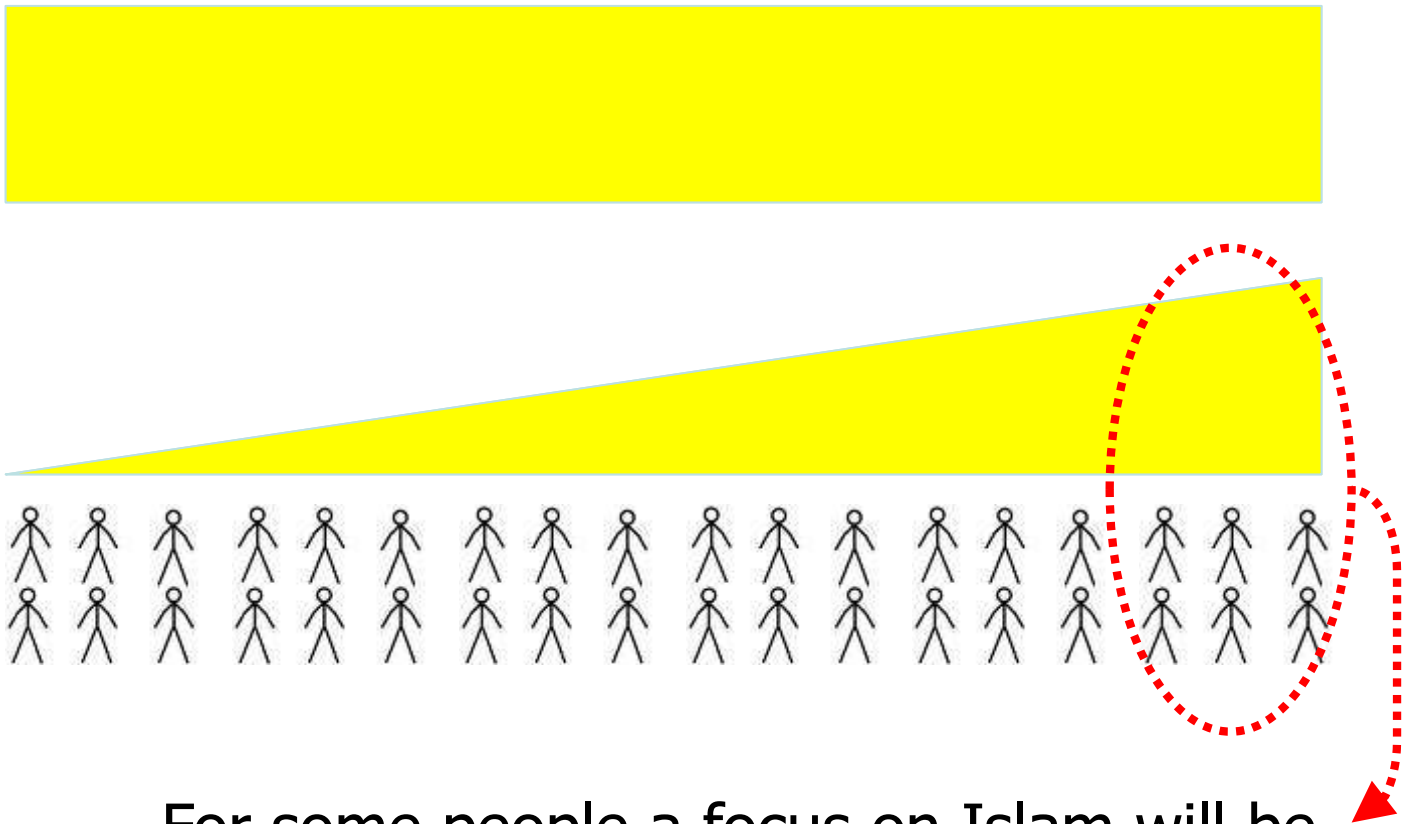
BA-focus

Islam-focus



For some people a focus on Islam will be very relevant

BA-M

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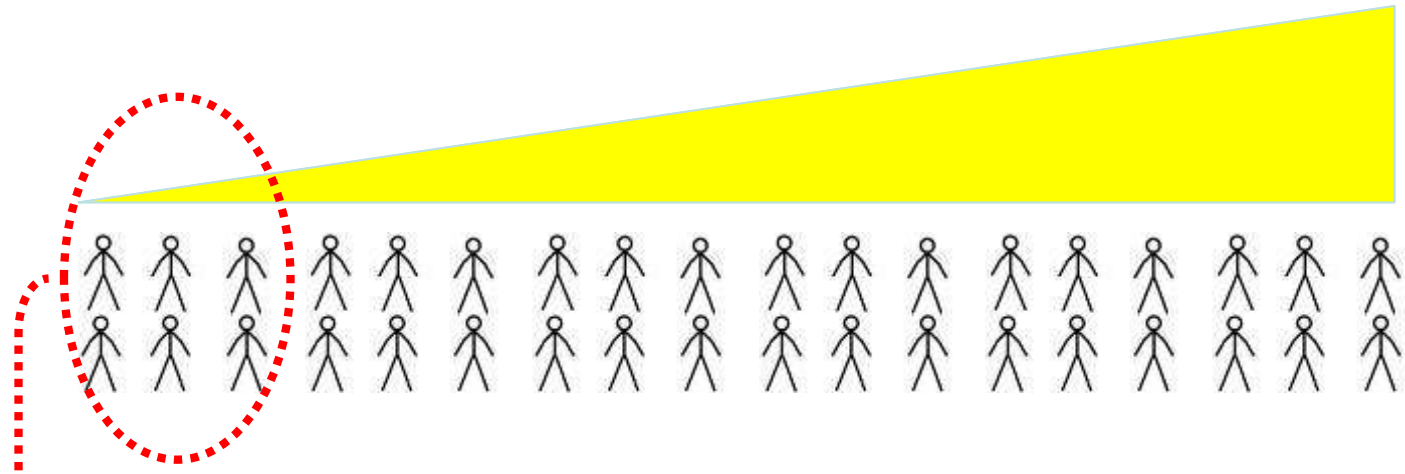
BA-focus

Islam-focus



For others it will not be relevant

BA-M

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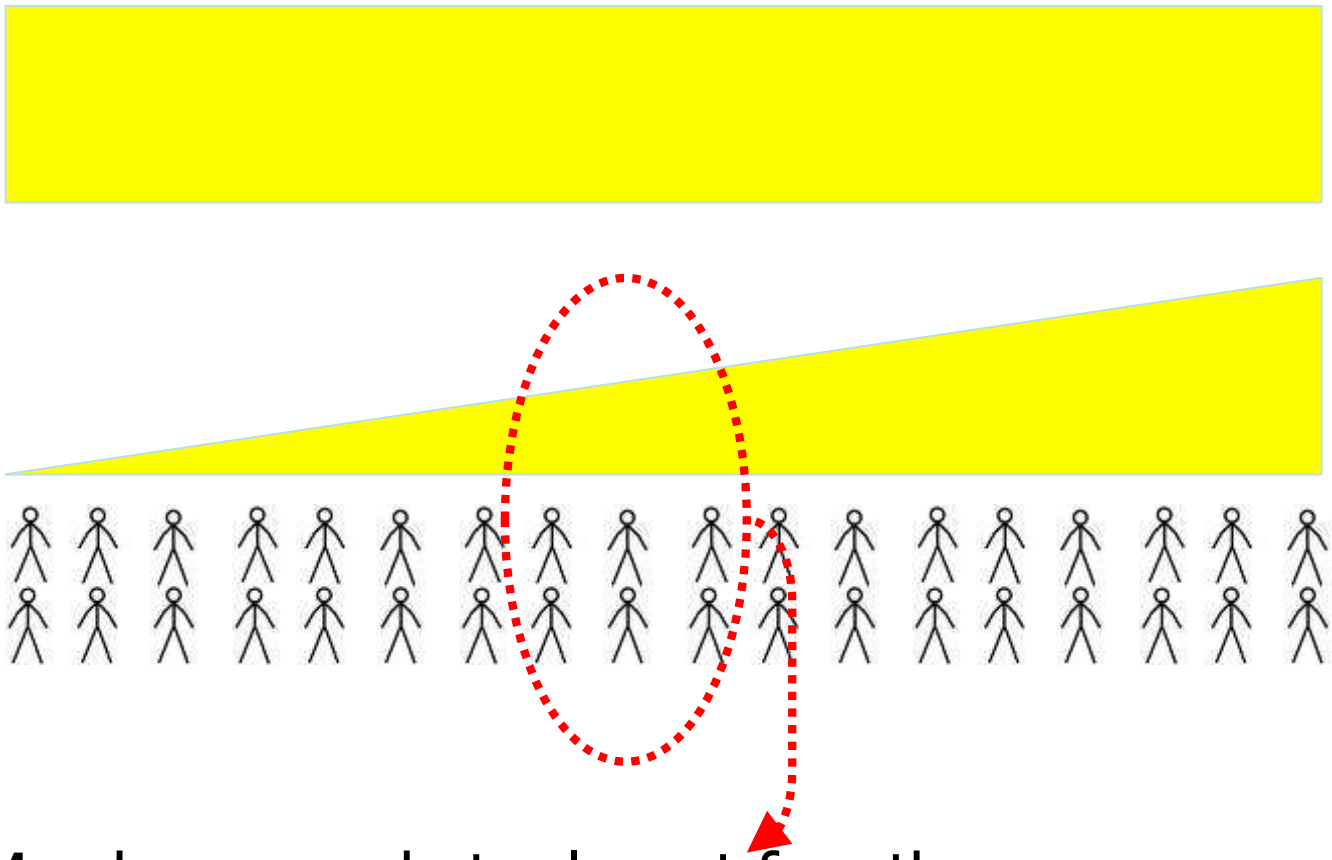
BA-focus

Islam-focus



May be somewhat relevant for others
Yet others may feel ambivalent towards religion

Values Assessment

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Existing tool – no pressure to select religion

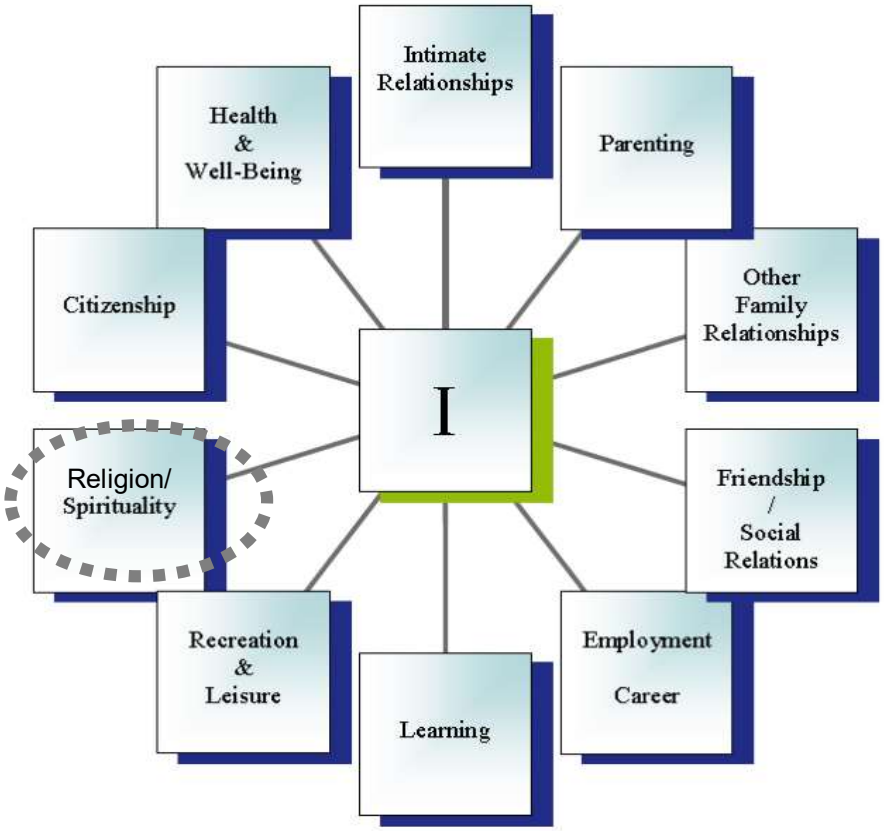
What's important to a person, what gives life meaning

Very individual

No right or wrong values

Crucially for BA:

"Value-consistent behaviours"



Pilot study

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- **Therapist training** in engagement with Muslim clients and delivery of BA-M
- **Monthly peer supervision sessions** – facilitated by global expert in BA via weblink
- **Routine supervision** in IAPT
- **19 participants recruited**; 14♀ 5♂, aged between 23-56, mainly British Pakistani backgrounds, 9 received therapy in English and 10 in other languages
- **Mixed methods data** - depression measures and qualitative interviews

Pilot study

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- **Intervention acceptable** to most clients and therapists **and feasible in practice**
- **Comfort zone and confidence** issues for therapists eg script for introducing religion/booklet
  - Whole team approach likely to be more successful than delivery by individual therapists
- **Therapist training** needed on values assessments, working with families and working with community organisations
- **Community settings** help decrease stigma and improve access to services.

Randomised control trial

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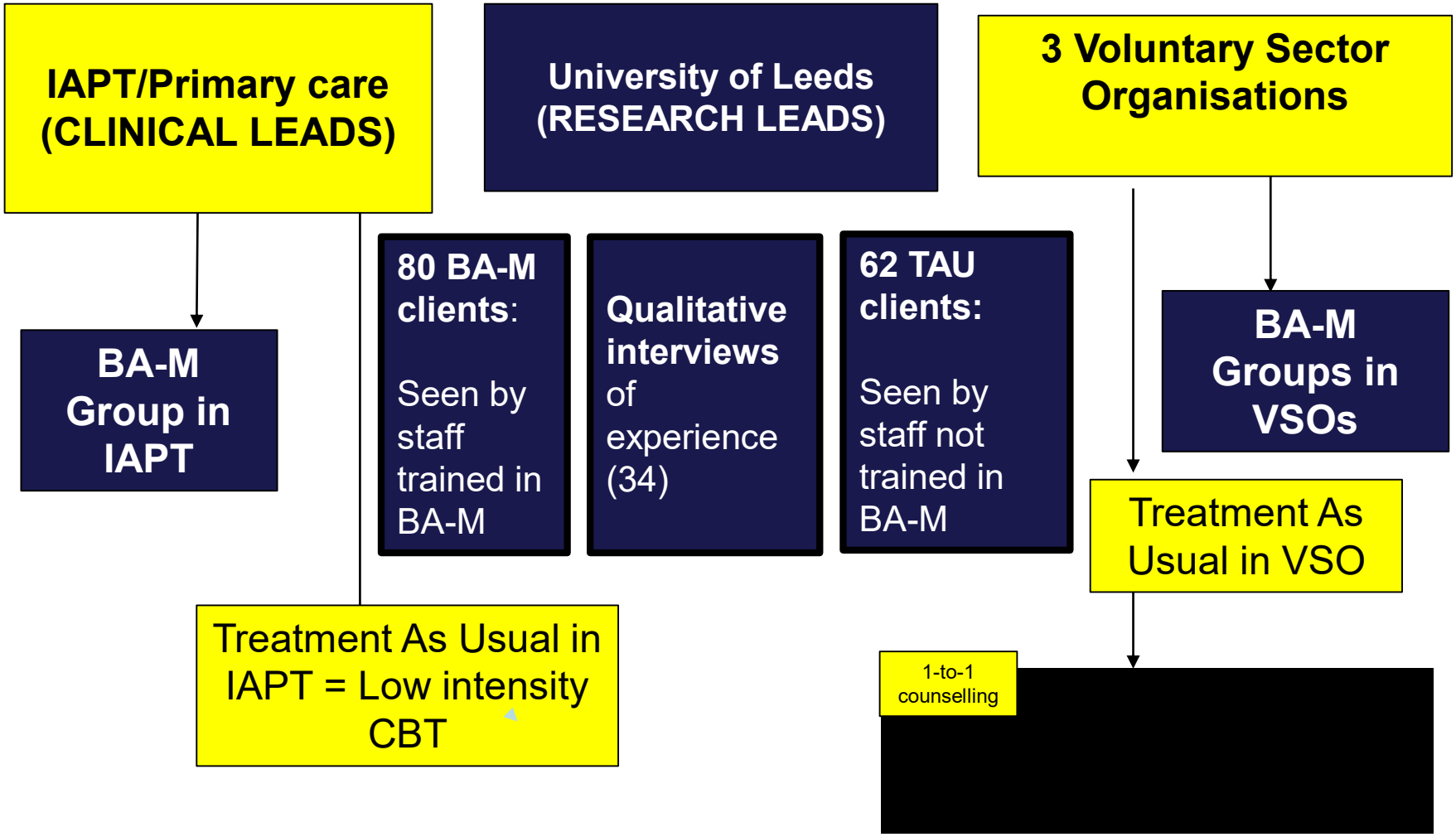

Trial participants

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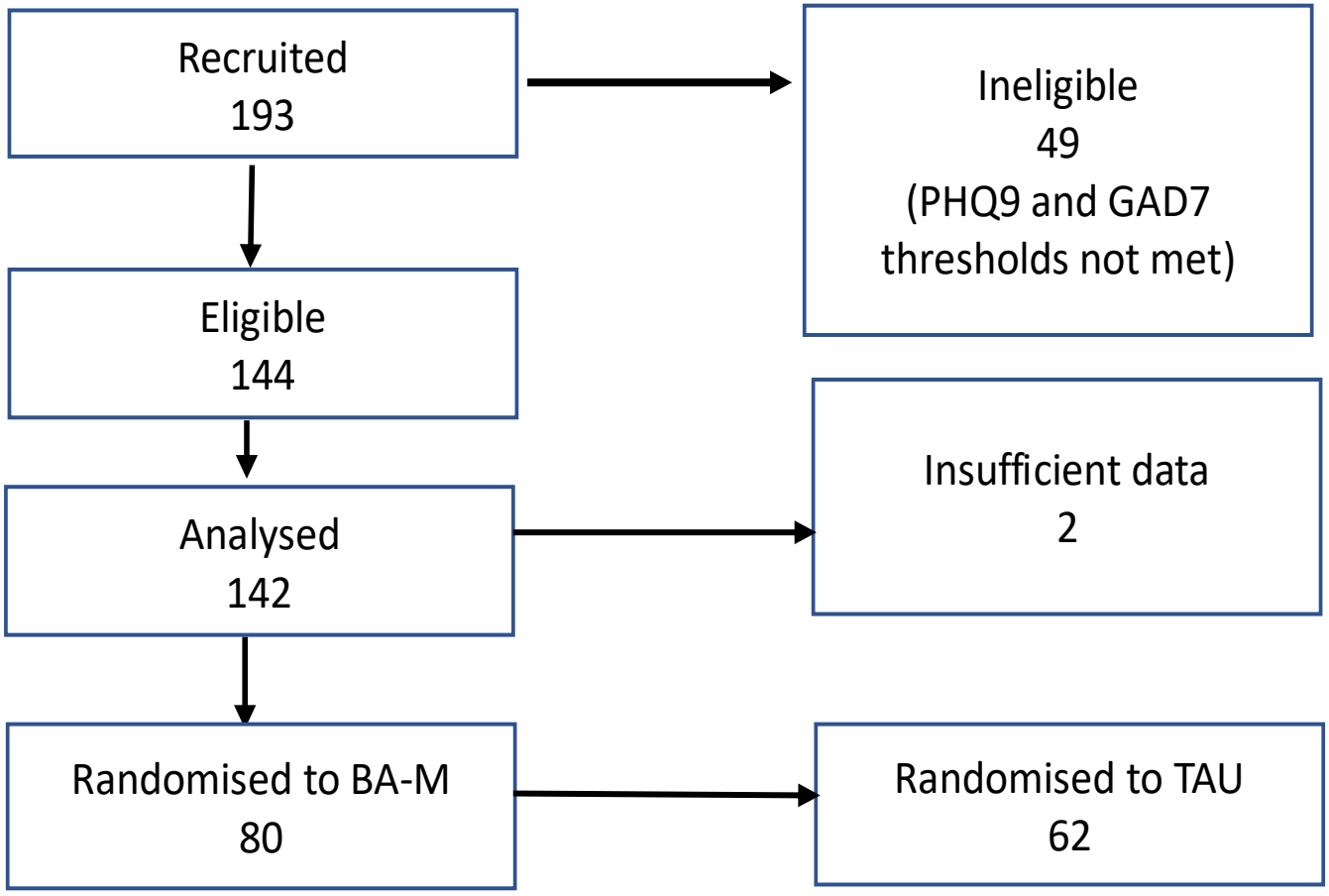

34 qualitative participants

18 BA-M service users (6 who dropped out)

9 BA-M therapists

7 managers and supervisors

Figure 1: CONSORT flow diagram

RCT findings

- **Better outcomes -** statistically significant and clinically important improvement for BA-M therapy compared to CBT and social interventions (TAU).

- **Explained by improved retention** – BA-M clients typically attended 3 more sessions that TAU clients. Depression scores improved by just over one PHQ9 unit per session attended.

- **In line with existing evidence** - on better outcomes for culturally adapted depression therapies/BA-M (Anik et al 2022; Dawood et al 2023).

PHQ9 trajectories

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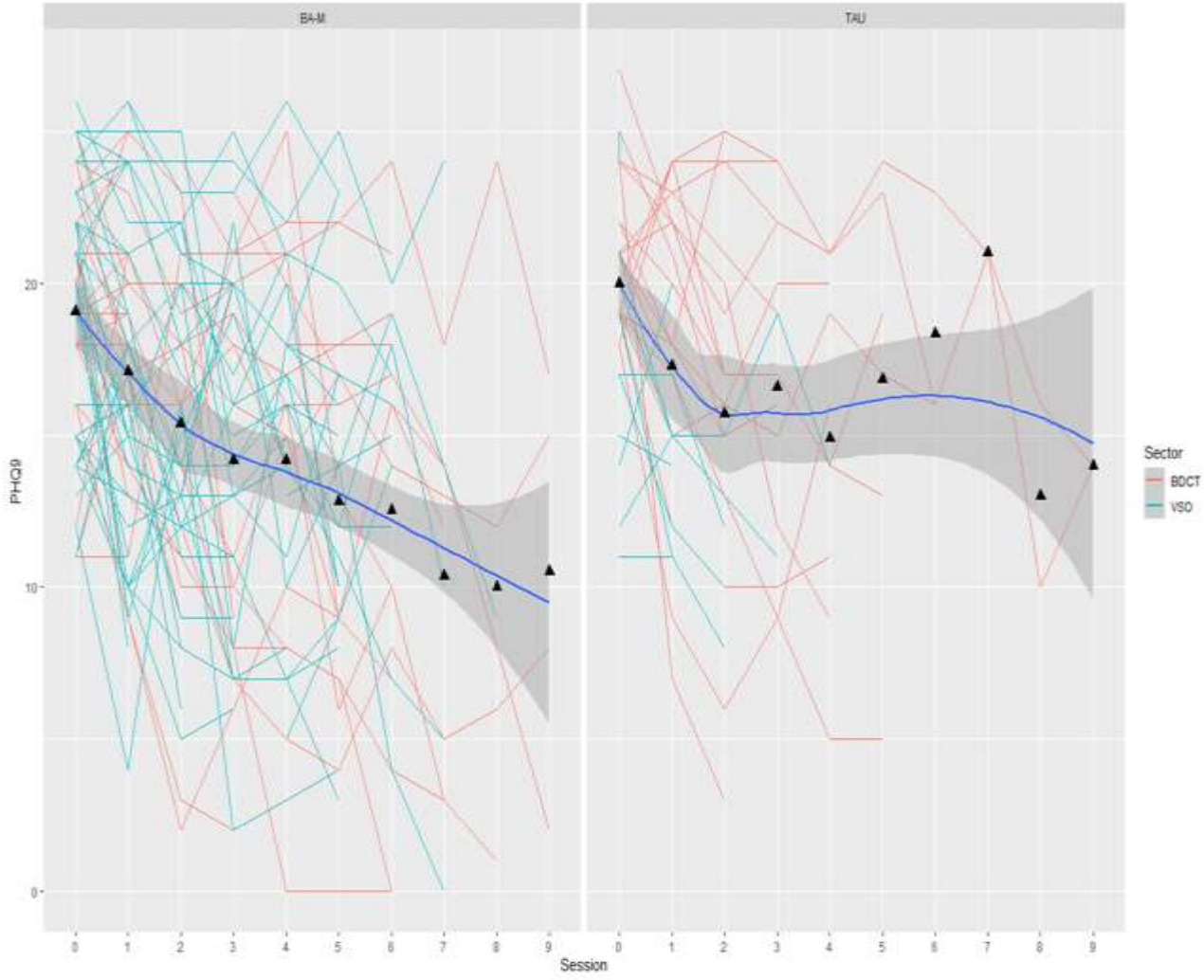

PHQ9 scores: TAU arm on average scoring 3.5 units higher on PHQ9 than BA-M arm ie BA-M clients report fewer symptoms and the result is highly significant both clinically and statistically ($p<0.001$)

Comparison by site: VSO performance a little worse (1 PHQ9 unit worse than IAPT), however, there is little evidence ($p > 0.05$) that the type of organisation is associated with a significant effect.

Explaining better engagement

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NHS

Religion a prime identity for majority of Muslims :

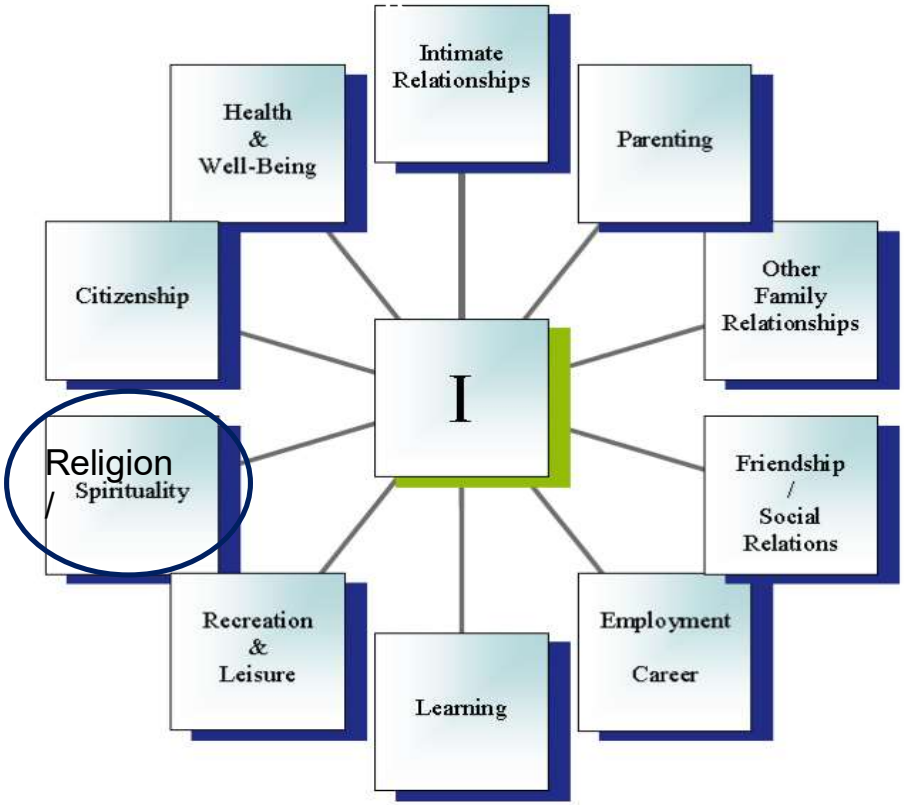
'very important'

'core of my identity'

'110%'

'more than everything'

'I wouldn't be here'



but also important to recognize diversity and support choice

'I went to Jum'a [...] but I don't believe on these mullahs

They might say, 'no religion is our personal thing, we don't want to talk about it'.

Explaining better engagement

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Religious teachings reinforcing BA

*a lot of the five pillars that are also behaviours [...] So like **bringing the two together was really helpful***

NHS Therapist

Positive religious coping v negative religious coping

*with a few clients, they did say **they felt kind of punished by God** for having these issues and then [...] let's bring in what religion says about people going through difficulties with mental health issues. Let's look up what patience brings, what the rewards are and what they're exempt from such as fasting and what the rewards are of having the intention to pray. So [...] **bringing in those positive aspects***

VSO Therapist

Meaningful activities/motivation

*I enjoyed [the activities], I thought they were **very meaningful***

VSO Service User

System change for Muslim patients

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Services that replicate social exclusion:

- **Poor access and engagement**
- **Lack of early intervention/low recovery/low trust** in services
- **Stereotyping, Islamophobia**, use of PREVENT - add to environmental stressors
- **No engagement with Muslim value frameworks** or community resources

Social inclusion achieved through BA-M **via better engagement** by institutions and therapists:

- Promotes **reflexive** attitudes towards religion/Islam
- Avoids stereotyping/prejudice and promotes **legitimacy of Islam** as a value framework: i**ncreased motivation, inclusion, trust, engagement; decreased stigma,**
- **Target adverse social circumstances**/ unhelpful beheviours and beliefs through activation assignments
- **Collaborate** with those who have relevant expertise

Service-level findings

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- **Collaboration between IAPT and VSOs supported capacity building** across both sectors - increased knowledge and skills that significantly improved engagement with Muslim service users.
- **Policy and resource gaps** are a barrier to the development of inclusive mental health services.
  - The demands of meeting **IAPT targets are a disincentive**: unfair resource allocation, time pressures on practitioners and lack of priority for culturally adapted therapies
  - VSOs could only continue delivering the approach with **adequate resource and clinical supervision**

Implementation and uptake

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Funding to be continued by ICB next year. Potential funding for research to explore implementation of trial recommendations:

- **BA-M should be adopted as a routine therapy choice** for Muslim services users within both IAPT services and voluntary sector organisations
- **Funding and monitoring** of mental health services should **incentivise and resource inclusive provision.**
- Mental health services should **continue to promote a message of social inclusion** to Muslim populations and support effective engagement through
  - promoting **reflexive attitudes** towards religion/Islam and **legitimacy of religion as a value framework**
  - Challenging **racism and stereotypes affecting Muslim service** users
- Care pathways for Muslim clients should facilitate **continued collaboration between NHS and voluntary sector organisations** to support service development in both sectors

Publications

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Mir, G., Meer, S., Cottrell, D., McMillan, D., House, A. and Kanter, J.W., 2015. Adapted behavioural activation for the treatment of depression in Muslims. Journal of affective disorders, 180, pp.190-199.

Dawood, S., Mir, G. and West, R.M., 2023. Randomized control trial of a culturally adapted behavioral activation therapy for Muslim patients with depression in Pakistan. World Journal of Psychiatry, 13(8), p.551.

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Mir, G., Ghani, R., Meer, S. and Hussain, G., 2019. Delivering a culturally adapted therapy for Muslim clients with depression. The Cognitive Behaviour Therapist, 12, p.e26.

Walpole, S.C., McMillan, D., House, A., Cottrell, D. and Mir, G., 2013. Interventions for treating depression in Muslim patients: A systematic review. Journal of affective disorders, 145(1), pp.11-20.

Further details

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Website/resources

http://medhealth.leeds.ac.uk/info/615/research/327/addressing_depression_in_muslim_communities

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