BA-M Treatment Manual

Addressing Depression in Muslim Communities

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Acknowledgements

Contents

1. Development of this manual

This intervention has been developed in response to a number of policy statements and guidelines that promote the use of culturally appropriate treatment for service users from minority ethnic and faith groups (NICE 2009; Department of Health 1999; Department of Health 2005). Reviews of clinical trials and interventions provide little evidence about minority religious groups (Townsend et al 2001), and detailed descriptions of the form and content of interventions for Muslim clients are not generally available (Azhar and Varma 1995). More evidence is therefore needed about the effectiveness of culture-sensitive models of therapy and treatment outcome data is needed to assess whether these yield better results with specific religious groups than standard therapies (Hook, Worthington Jr et al. 2010).

This project focuses on people from Muslim backgrounds because there is evidence that some people within Muslim communities experience higher levels of depression which are more chronic in nature than in the general population (Spronston and Nazroo 2002). Muslim clients are also more likely to use religious coping techniques than individuals from most other religious groups in the UK (Loewenthal, Cinnirella et al. 2001) and this is therefore a potentially important focus for culturally appropriate mental health treatments. There is a significant body of literature which shows that religion may influence wellbeing through pathways that are behavioural, psychological, social and physiological (Koenig, McCullough et al. 2001). This literature identifies a distinction between 'negative religious coping' ie feeling abandoned or punished by God or unsupported by one's religious community and 'positive religious coping'. The former can increase depression and anxiety (Dew, Daniel et al. 2008) and pain severity for people with physical illnesses (Cole 2000). 'Positive religious coping', on the other hand, is associated with reduced levels of depression and the use of an internalised spiritual belief system to provide strategies that promote hope and resilience (Pargament, Tarakeshwar et al. 2001;Koenig, McCullough et al. 2001). Religious beliefs and practices that encourage a proactive approach to dealing with problems, rather than relying on divine intervention, are also more likely to help people overcome depression (Uchendu 2006).

Interventions that draw on faith can be effective in addressing and preventing depression (Lipsker and Oordt 1990; Kumar 2006; Barron 2008) and improving quality of life (Lee (Lee, Czaja et al. 2010). Religious coping strategies for depression have been integrated into cognitive behavioural therapy (Lipsker and Oordt 1990; Propst, Ostrom et al. 1992; Satterfield 2002; Scott 2003; Randall 2004; Barron 2008; Paukert, Phillips et al. 2009), counselling (Chandrashekar 2007; Glueckauf, Davis et al. 2009), acceptance and commitment therapy (Hayes 2004), energy psychology approaches (Brockman 2006) as well as treatment of depression in cancer and terminally-ill patients (Cole 2000; Reyes 2003), and those who have experienced trauma (Kelly 2007) and torture (Leaman 2009).

Reviews of religious and spiritual therapies for depression have shown that studies incorporating religious components into therapy can have positive results and that adapted therapies can be at least as effective as existing secular therapies. For Muslim clients such therapies have also resulted in earlier improvements in depressive symptoms (Hook, Worthington Jr et al. 2010; Koenig, McCullough et al. 2001; Worthington Jr and Sandage 2001; O. Harrison 2001 et al 2001).

Psychotherapy and religious teachings can therefore be seen as complementary rather than competing approaches to overcoming depression (Wright and Basco 2001). It is suggested that the effectiveness of spiritually focused therapy is achieved through its ability to provide meaning (Gerwood 2005), a sense of wellbeing (Hawkins, Tan et al. 1999), social support and the use of positive self-talk (Scott 2003) as well as to the act of surrendering control to a higher power (Cole 2000).

Given that practitioners without religious beliefs are overrepresented in the NHS (Neeleman and King 1993), approaches that can potentially be delivered by therapists from a range of religious and non-religious backgrounds are desirable. In this context, a secular therapy with the capacity to incorporate spirituality – a concept understood in both secular and religious contexts (Speck 2004) - may provide an important bridging model and there is evidence that therapies adapted in this way can be effectively delivered by non-religious therapists (Worthington Jr and Sandage 2001; Hook, Worthington Jr et al. 2010).

The research partnership that was formed to develop this manual was multidisciplinary (health service practitioners, community based service providers and academic researchers) and multicultural, including people from Muslim and other backgrounds. Research partners felt that Behavioural Activation (BA), with its focus on client values (Kanter, Manos et al. 2010), was a therapy that could be adapted to meet the needs of Muslim service users. Behavioural therapy supports religious teachings that certain types of activity can increase a sense of meaning in life, the loss of which may be a cause of depression (Andreasen 1972).

The methods used for adapting BA involved synthesizing evidence from existing literature and interviews with 'key informants', individuals with experience of mental health in Muslim communities. The research partners also took advice from three expert advisory groups, one involving professionals and service users, another exclusively made up of Muslim service users and a third virtual group involving academics and practitioners. We piloted this manual with a range of Muslim service users in Bradford and made further revisions based on feedback from the clients, therapists, supervisors and managers involved. The pilot study showed that the therapy is acceptable and feasible to deliver within standard NHS settings and appears to impact positively on activity for many clients.

The aim of the synthesis was to identify the adaptations needed to BA therapy and mechanisms by which these can influence outcomes. The manual produced builds on earlier BA manuals (Kanter 2010; Ekers, Richards et al. (2008)) which had in turn built upon work by Lejuez, Hopko et al. (2001) and Martell, Addis et al. (2001). Manualising the guiding principles and effective methods of a therapy helps develop consistency and promote best practice amongst practitioners (Pote, Stratton et al. 2003). Common patterns identified from our various data sources aim to provide a prescriptive base, from which therapists may develop their own creative components. We hope that broad and flexible approaches to therapy are developed from these guiding principles that are widely acceptable and allow a co-construction of therapy between therapists and patients (ibid).

We found no existing faith-based adaptations of BA, although an adaptation to meet the needs of an ethnic group has been developed and forms one of the foundations for this manual (Kanter 2010). The manual has been further revised following the pilot treatment phase of the study, in which it was used with 19 Muslim clients with depression.

Client considerations

This manual has been developed to be appropriate for Muslim clients who meet criteria for depression. It is also suitable for clients with other clinical depressive disorders and those who have significant depressed mood along with another diagnosis. It is not designed to be used with clients who (a) have bipolar depression, (b) are psychotic, (c) 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) have primary substance abuse or dependence. Once BA has begun or been completed, therapists should follow their normal practice for stepping clients up to higher intensity interventions if this is appropriate, bearing in mind that BA has been found to be effective for severe depression (Dimidjian et al 2006) and is used for addressing relationship problems (Kanter 2010).

The manual is intended for use with all Muslim clients including: those who would benefit from BA with a strong intertwining of Muslim faith teachings, those for whom faith is not a major consideration in terms of their values and those who have an ambivalent or unsettled view on the role they want faith to play in their treatment.

The flexibility of the manual is demonstrated in the picture below: the BA approach will remain constant in therapy no matter what the religious inclination of the client. The focus on Islamic teachings within this manual, however, will vary for different people from Muslim backgrounds. For some clients the focus on Islamic teachings will not be very relevant as this is not an important part of their identity or value framework. For others, these teachings will be somewhat relevant or they may feel ambivalent about their relationship with God. For some clients, religious teachings will be central to their identity and the most important aspect of their value framework.

Manual flexibility

BA-focus

Intervention will always be 100% BA

Islam-focus

For some people will not be very relevant

For some it will be somewhat relevant/they may feel ambivalent towards religion

For others it will be very relevant
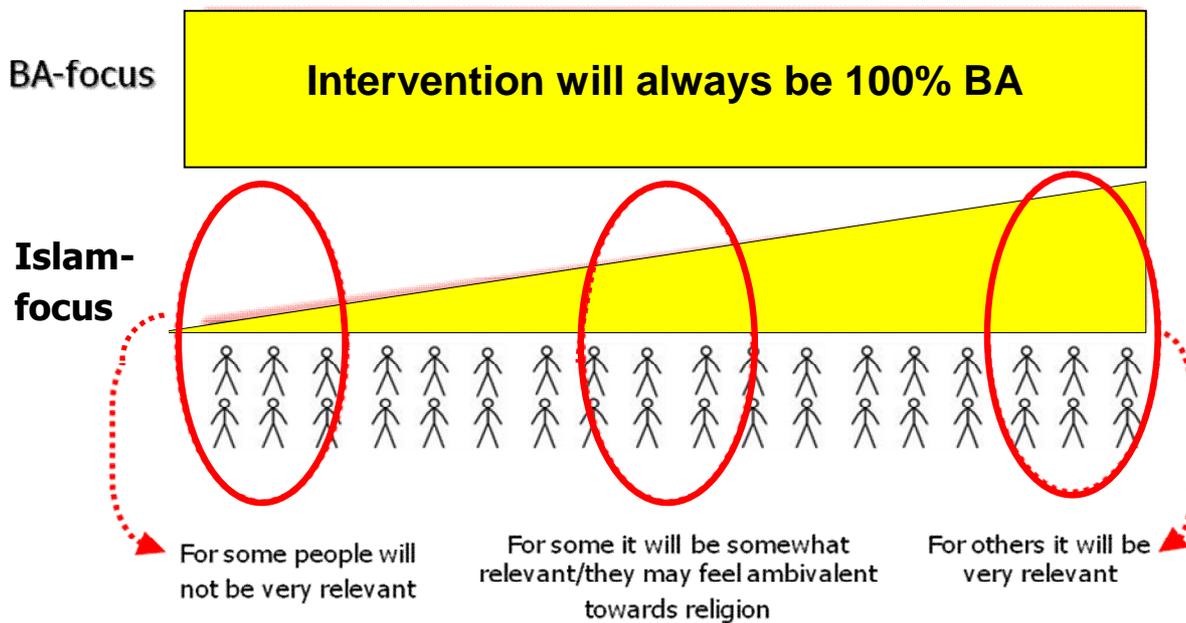
Therapist considerations/supervision

To use this adapted therapy, therapists must have graduate-level training in psychology, psychiatry, psychiatric social work or nursing, or counselling. Therapists should have access to clinical backup and supervision and/or consultation from licensed mental health professionals (Kanter 2010). Therapists will also need to be open to approaches outlined in the section of this manual entitled Treating Muslim Clients with Depression in order to work with Muslim clients effectively.

Supervision

As with integrating any new techniques into one's therapeutic repertoire, it is recommended that those wishing to become proficient in the practice of BA-M receive feedback and guidance from a supervisor. The necessary qualifications of the supervisor will depend on the attributes of the therapist. Therapists who have practiced BA, but are unfamiliar with Islam or Muslim communities should enlist supervision from someone sensitive to Islamic teachings. Therapists who have experience of treating Muslim clients should seek out supervision from an experienced BA therapist. Our pilot study highlighted the value of a group of people delivering the intervention at the same site to facilitate helpful discussion and peer supervision. It was also helpful for therapists to have access to a range of colleagues with expertise in BA and/or Islam to whom they could refer for advice on either area when necessary.

A list of questions that could be used for self-reflection and by supervisors with therapists is provided at Appendix 9.

2. Overview of Behavioural Activation

BA has a long history dating back to the 1970s. It evolved out of a behavioural model of depression and all variants of BA have maintained a primary focus on using behavioural techniques to schedule new activities (Kanter, Manos et al. 2010). As BA has evolved, the focus of activity scheduling has shifted from simple pleasant and enjoyable events to activities that are consistent with a client's life goals and values, active problem solving, functional alternatives to avoidance and rumination, activities that bring a sense of mastery or accomplishment, and other activities that do not necessarily bring about feelings of pleasure or enjoyment but are still functionally important to the client. Over the years, BA has received a wealth of empirical support, documented in three meta-analyses (Cuijpers, Steunenberg et al. 2007; Ekers, Richards et al. 2008; Mazzucchelli, Kane et al. 2009). In a systematic review of randomised trials, BA was comparable to Cognitive Behaviour Therapy in reducing symptoms of depression at post-treatment and follow-up (Ekers, Richards et al. 2008). Most evidence of effectiveness has been developed in populations that have not been diverse in terms of faith identity or ethnic background. However, this manual has been piloted with Muslim clients and the pilot study provided evidence that a focus on behaviour is also acceptable and perceived as helpful within this population (Meer et al 2012).

As presented to clients, BA has a very straightforward rationale: People are more likely to become depressed when there are more difficult events in their lives. Difficult life events may be major losses like the end of a relationship, the loss of a job, or a move to a new city. Difficult events may be interpersonal difficulties including a lack of friends, or conflicts with friends or family members. Difficult events may be daily hassles arising from a promotion that leads to too many responsibilities , inability to pay the bills, confusion about how to use public transportation, and experiences of racism or discrimination.

The more difficult events one experiences in one's life, the more likely one is to become depressed. When a client becomes depressed, he or she gives up, gets stuck, becomes hopeless, becomes passive and inactive in life. He or she stops putting in real effort to solve problems, and stops doing activities that used to be pleasant, meaningful and enjoyable. Individuals may even stop taking care of themselves, showering and brushing teeth, or getting out of bed. All of these changes may result in the depression getting worse, which starts a vicious cycle of depression. BA focuses on the difficult events that cause people to get depressed in the first place, and on helping people get active again in life to break the cycle of depression. BA uses behavioural techniques to activate clients to solve problems, not giving up in the face of seemingly overwhelming obstacles, experience pleasure and mastery in what one does, and stay committed to active lifestyles in support of one's life goals and values.

Presenting BA-M's Model

The Session 1 outline below presents specific language for use in the first session when presenting the treatment rationale. Here we discuss the general idea behind this rationale, presented typically as the "2 circles" model. This is taken from a model of BA that has previously been culturally adapted (Kanter 2010) and was found to be acceptable for use with Muslim clients in our own pilot study (Meer et al 2012) .

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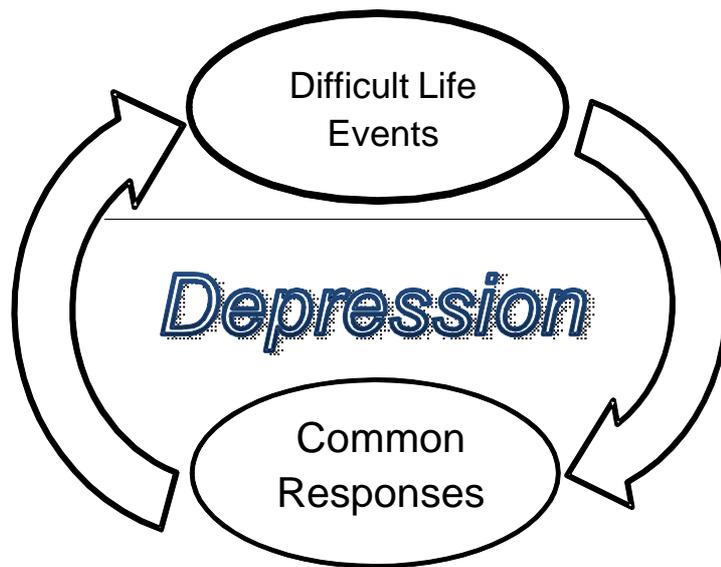
Circle 1: Difficult Life Events

Clients may present in therapy with a variety of difficult life events, problems, daily hassles, stressors, and the like. Our fieldwork and existing studies showed that within Muslim communities these *difficult life events* may be influenced by:

- high rates of disability, long-term illness and infant deaths (National Statistics 2004; Department of Health 2008)

- high rates of poverty, unemployment and poor social mobility (Platt 2005; 2007)

- financial problems (Chew-Graham, Bashir et al. 2002; Klainin and Arthur 2009)

- discrimination in a wide range of areas that affect health, such as employment, housing and education (Richardson and Stone 2004)

- media representation that promotes hostile and stereotypical images of Islam and those who follow its teachings (Al-Issa 2000; Whitaker 2002)

- for migrants, difficulties in acculturation (the process of adapting to the cultural norms of the host country) when norms conflict with those of their cultural background (Askari 2003). The social change can involve experiences of discrimination (Al-Issa 2000) and role conflict, particularly where migration is involuntary as in the case of refugees (Aziz 1999; Askari 2003). In one study older adult migrants were more likely to be depressed than younger adult migrants (Ebrahimian 2006).

- family problems, isolation, or limited English, all of which, for example, affect women who experience maternal depression, particularly if they have migrated for marriage (Small, Lumley et al. 2003). Living within an extended family can be a stressor for daughters-in-law (Fazil and Cochrane 2003) but beneficial for the mental health of children and grandparents (Sonuga-Barke and Mistry 2000). Family and community pressures relating to reputation or family honour may also contribute to stress, particularly for women (Al-Issa 2000).

- dependence on *khat*, a culturally specific drug, is associated with depression in some African and Middle Eastern Muslim communities (Awas, Kebede et al. 1999).

In short, there are a wide range of potential stressors for people living within Muslim communities in the UK. The first stage of BA involves determining collaboratively with the client the specific nature of the problems and stressors causing low mood. Some clients may report just one or two discrete problems or losses, such as death in the family, divorce, or recent unemployment. Others will report on the accrual of multiple smaller hassles and stressors. Others will have been living in chronically stressful and deprived environments for so long that they will at first have no losses to report on, because nothing new has happened or changed in quite some time. Regardless, undoubtedly there will be problems, and it is the job of the BA therapist to emphasize that many of the symptoms of depression make sense given these problems.

In the first session of BA-M, the therapist should develop a list of these difficult life events, write them down and share them with the client. The therapist may call them "difficult life events" and draw a circle around them.

Circle 2: Common Responses

It is a natural human response, when bad things happen (either major events, the accrual of smaller events, or a combination of these), to feel bad and to become passive. In BA, these are called *common responses* to emphasize that they are common and that the client isn't weak, unusual or mad for having them. The client will feel sad, down or depressed. The client may cry more frequently or experience increased irritation. The client may feel tired, lethargic, lacking in energy. The client may feel that nothing is fun anymore. The important point for the BA therapist to stress is that these responses are common and make sense. Anyone would feel this way given the client's situation. Some common emotional responses include:

- Sadness
- Feeling down
- Crying more
- Feeling depressed
- Experiencing less pleasure in things
- Grief reactions
- Fear
- Stress
- Physical symptoms
- Fatigue

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- Anger, irritability
- Guilt
- Shame
- Despair
- Hopelessness

The client may also demonstrate a range of behavioural common responses to difficult life events. These include:

- Passivity
- Avoidance
- Not wanting to go out any more
- Staying in bed
- Sleeping too much
- Calling in sick to work
- Withdrawing from friends/family
- Stopping religious activities such as prayer, going to the mosque or reciting the Qur'an
- Stopping housework
- Stopping looking for work or pretending to look for work
- Smoking, using drugs, overusing prescription meds
- Filling every minute of the day to avoid facing problems
- Watching television
- Lashing out at others including family and children
- Eating too much junk food
- Trying to kill oneself
- Acting like life is already over

It is the therapist's task in BA to understand the client's common responses to the difficult life events, whatever they are, and validate and normalize them. If it becomes clear that religion is important to the client, it can be helpful to explore the degree to which the client sees this way of thinking about depression as compatible with their faith. The client's understanding of how Muslims are encouraged to respond to difficulties may be helpful for this discussion and some relevant Islamic teachings are contained in the Client Booklet that accompanies this manual. Some ways in which the manual can be used to draw parallels between the BA approach and Islamic teachings are described later in this manual. For example, drawing on a religious framework may be an effective way to help some clients feel that it is normal to feel sad when difficult life events happen.

Some clients may not report any feelings in response to the events. For example, in response to the question, "How are you feeling in response to all this?" the client may say, "I can't do anything anymore.". This is fine and the therapist does not have to help the client understand or report on her feelings. In this case the therapist may just focus on the client's behaviour.

In the first session, the therapist may develop a list of the client's common responses, write them down, and label them "common responses." The therapist may circle the list and draw an arrow from

the difficult life events to the common responses to show that they are an understandable response to the events.

Putting it All Together

When clients respond to difficult life events with hopelessness and passivity, it makes problems worse and starts the cycle of depression. It is important for clients to see this pattern. The therapist may ask the client:

- When you respond this way, what happens?
- What does your sitting and watching television all day do about these problems?
- How has your relationship with your wife changed since you stopped communicating with her?

Clients are usually very aware that their responses are making problems worse, and it is the therapist's job to gently and compassionately point this out to the client. To make the point, the therapist may draw an arrow back from the "common responses" circle to the "difficult life events" circle as in the figure.

When the client understands this cycle, the therapist can then discuss what they are going to do about it. Specifically, BA directly targets how the client has become stuck, passive, and inactive. The goal is to help the client activate behaviours that proactively address the initial difficult life events. Stay active. Solve problems. Get out of bed and apply for jobs. Start praying or going to the mosque. Force oneself to interact with others. Call the friend with whom one had an argument. Do the dishes that have piled up in the sink. The therapist's job is to collaborate with the client to identify the difficult life events and the common responses and then collaboratively design activation assignments that are attempts to solve the initial problems rather than the common responses. Activation assignments will be formulated in the context of what is important to the client and there should be early discussion of the clients values so that these can be built into the goals that are designed as part of the therapy. The therapist should explain that activation will be very focused on the things that the client has been avoiding doing, the things that are hard to do on one's own and one would continue to avoid if left by oneself, and the things that the client would find helpful to increase their own resilience and positive outlook.

Examples of the 2 Circles Model

Relationship problems. Some families may have specific expectations about the roles that family members should fulfil and these can clash with what individuals feel capable of or want for themselves, leading to tension and the breakdown of relationships. For example, elder sons may be expected to take responsibility for their parents and other family members and respond to their needs at all times. Young people may be expected to conform to their parents' wishes about who and when they should marry. These expectations may also exist at a community level so that people find it hard to speak to anyone about their difficulties.

Tensions between family members or the breakdown of marital relationships may lead to isolation, stigma and high levels of emotional pressure. The expectations of others may be framed in terms of family responsibility or religious duty leading clients to feel angry, guilty or confused about how they should respond and helpless to change the pressure they feel under. Marital breakdown, relationship difficulties and stigma are "difficult life events" to which feelings of helplessness and withdrawing from others are common responses.

Acculturation Issues. Some Muslims have migrated to the UK, particularly older people, young people who came for marriage and refugees or asylum seekers. Low income, limited ability in English and recent migration can all contribute to problems with acculturation (see Difficult Life Events above). Clients may be fearful of mainstream society and/or of being forced to acculturate in ways that are inconsistent with their values, beliefs, skills, and knowledge. In addition, clients may be being paid very low wages for working extended hours.

Migration, pressure to acculturate, low wages, and social exclusion are all seen as "difficult life events" in this model. Fear of mainstream society and of authority are seen as common responses. Many clients simply do not know how to solve these problems, do not have the necessary skills, and do not recognize the time commitment involved. Failure to successfully acculturate and overcome these multi-faceted problems leads to frustration which turns into hopelessness as the length of time in the U.K. without solving these problems continues. Thus, passivity and hopelessness also are seen as common responses.

Discrimination. Client reports of discrimination occur all too frequently and discrimination often leads to avoidance. For example, suppose the client is repeatedly discriminated against at work (e.g., being looked over for promotion, made to work undesirable shifts and complete undesirable tasks). Frequently, clients in these types of situation speak up, but over time if nothing in the environment changes or the environment becomes increasingly punishing, the client will be shaped into passive avoidance. By remaining passive the client will experience a reduction in the difficult emotions related to trying to change the environment. However, this does not address the long-term problem, being discriminated against in the workplace, and may actually increase the likelihood that the client will continue to experience discrimination in the work place. In this specific example, the discrimination is seen as the difficult life event and the common response is passivity and avoidance.

Modifying the Model to Focus on Avoidance of Bad Feelings.

In some cases the therapist may observe that the client is very focused on *not feeling bad,* and many of the common responses are attempts to avoid the bad feelings. Feeling bad is hard and it is natural to not want to feel this way. The question is, what does one do to not feel this way? It is natural to do things to avoid feeling bad, even if these things have a cost. When feeling upset we go to sleep. When feeling like crying we avoid going to places where crying is likely. We may avoid social situations entirely or attend passively and without spirit. When feeling badly enough, it is easy to give up, become hopeless and passive. According to BA, it is often this secondary response, of

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avoidance and passivity, which we may call *getting stuck,* to the initial common response that causes a spiral into depression.

Another way of thinking about *getting stuck* is that clients may be focused on *short term solutions* to problems, which are about just feeling better as soon as possible, versus *long term solutions* to problems. The therapist should explain that activation will be very focused on the things that the client has been avoiding doing, the things that are hard to do on one's own and one would continue to avoid if left by one's self. In addition activities that will help the client feel more positive and resilient will also be a focus of activation.

In these cases it may be helpful to distinguish common emotional responses from common behavioural responses in the model, resulting in 3 circles, with the emotional responses labeled "common responses" and the behavioural responses labeled "getting stuck."
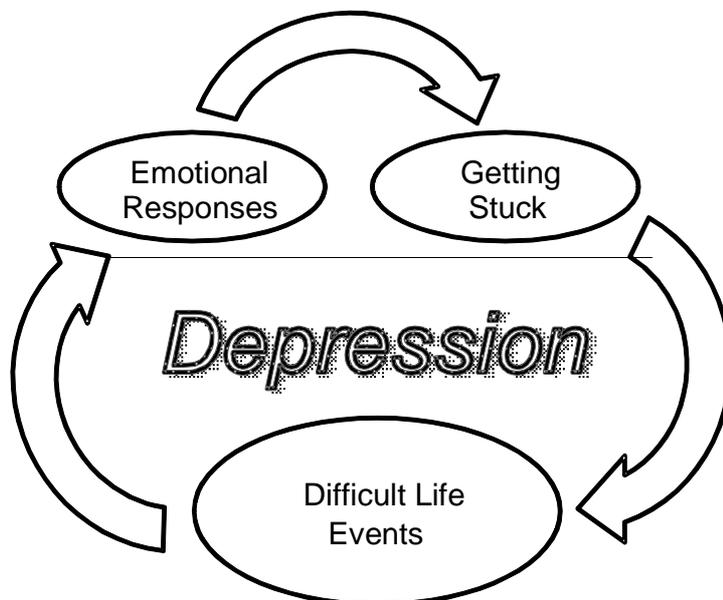
As another example of the 3 circles model, consider a client whose primary response is anger and irritability. This is a common response and the key here is how the client responds behaviourally to feeling angry. What does the client do? For example, arguing with his wife would be a behavioural response that would go in the "getting stuck" circle. The client could be asked, "When you argue with your wife, does it help the problem or make it worse?" and the therapist and client would work at developing more positive responses to anger that help solve problems rather than make them worse.

Examples of 3 Circles Model

	Difficult Life Event	Emotional Response	Getting Stuck
1	Unemployed and needs to look for work	Overwhelmed and anxious	Watch television, stop looking for work
2	Argument with sister	Guilt, frustration	Not pick up phone, not call sister back
3	No friends	Tired, bored	Stay in bed all day

3 Structure of this manual

The following session plans for delivering BA-M therapy include references to sections later in the manual that the therapist will need to read and understand in order to engage appropriately with Muslim clients, particularly those for whom religion is important.

These later sections cover understandings of depression within Muslim communities, the therapeutic relationship promoted in this therapy, how to discuss religion, how to schedule activation assignments and use the Client Booklet , and how to involve family members and make use of community resources.

4. Session Plans for BA-M

Session 1

- **Before the session read the sections of the manual about Discussing Depression, Treating Muslim Clients with Depression and General Issues when Conduct BA-M** to prepare yourself for issues that may arise. The development of a relationship on the client's terms is an important first step for engagement and trying to impose a specific model or therapy framework on interaction too soon will hamper this. Initial sessions should therefore focus on understanding what is important to the client and establishing a good relationship. Ensure the therapy room will be comfortable for the client.

- **Language:** Ask the client what language he or she would like to speak in, if necessary. Ask in the language the client has been using.

- **Review screening measures:**
  Screening measures used in this therapy are the Values and Goals Assessment (see Appendix), which is used at the beginning of therapy and PHQ9, GAD7, which are completed before each session and which were seen as acceptable to Muslim clients during our pilot study of this manual along with the Behavioural Activation for Depression Scale (see Appendix 1). The purpose of the measures should be explained to clients and therapists should check that the client understands how to answer questions and provide support where necessary.

  Our initial fieldwork indicated that some clients may feel offended about being asked questions relating to suicide, because this is forbidden in Islam. However, feedback from the pilot study showed that clients accepted this was a reasonable question. It is routine in the PHQ-9 screening questionnaire used with this manual and therapists we spoke to dealt with any negative reactions by acknowledging that, whilst in most religions suicide is a sin, having suicidal thoughts is normal and this would not make someone a bad person. The therapist can highlight that these are questions that everybody is asked, regardless of their religious beliefs, so that if there are any suicidal thoughts, they can talk about these. Check for suicide risk.

- **Talking about client's life story:**

  - Begin the session by getting to know the client, the client's life, the client's story.
  - For some clients it may be helpful to suggest that the client does not have to give away family secrets or divulge what he/she does not want to.
  - As you listen to and ask about the client's story:
    - be warm, validating and responsive (see The Therapeutic Relationship).
    - try to obtain information to guide future activation assignments and think about potential activation assignments that can be given to the client at the end of the first session
    - collect information so you will be able to link the client's story to the "2 circles" model later in the session
    - discuss what the client sees as the cause of the depression/feeling the way he/she does (see "Discussing Depression").

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Difficult life events:

o Learn about the difficulties that have been occurring in his/her life, both currently and historically. Take your time with this and try to cover all the important past and present issues. Write these issues down as a list to show the client later in the session. Call them "Difficult life events."

o Consider the list of difficult life events highlighted in Presenting BA-M's Model of Depression above

Common responses:

o Listen to and ask the client about his/her responses to the life events. How has the client been feeling or responding? Listen for and ask about ways the client has become stuck.

o Take your time with this and write the responses down to show the client later. Call this list "common responses" or something like that.

o Consider the list of common responses presented in Presenting BA-M's Model of Depression above.

o The important point is that when people have these difficult life events, they naturally feel this way.

o The way the client is feeling is not an illness or a weakness. It is an understandable response to life's difficulties.

o Really emphasize how the responses make sense given the client's difficult life events. THIS POINT CAN BE STATED REPEATEDLY. If there is one thing we want the client to get from this session, this is it.

o You can say that depression does not mean the client is going mad, or that there is something wrong in the client's head. It is understandable.

- **Summary of model:**
    o Show the client the 2 circles with the lists you have made. Do this to explain the model but also to express compassion and give the client the sense that you have been listening deeply and empathically to the client's life story.
    o Express to the client that this treatment is about getting active in life again. It is about taking action steps to solve problems, rather than avoiding, feeling overwhelmed, and shutting down to avoid feeling so terrible. The focus of the treatment is on coming up with action plans and taking action, to help the client start doing things that he/she used to do before he/she became depressed, and things that the client doesn't have the energy to do. The goal is to get the client back on track in life.
    o Tell the client this is an active treatment, it will require work. The key is to do things differently in life. Treatment will be about figuring out what needs to change and how to change it. This will be done by the therapist listening very carefully to the client's story and then the client and therapist together will come up with plans for what to do differently during the week. For clients who have indicated that religion is important to them it may be helpful to draw on the parallels between BA's focus on activity and the amount of activity contained in the five pillars of Islam (see Client Booklet).
    o It is key to the model that activation will lead to improved mood and that the client cannot afford to wait until he or she feels better to start solving their problems.

- **Ask for feedback about the model**:

    o Discuss with the client what he/she likes and doesn't like about the approach.
    o Discuss with the client what makes sense about it.
    o You may ask the client to state in his/her own words what they are understanding.

- Carry out a Values Assessment using the forms/picture at Appendix 2. The therapist should use this form as a starting point for assessing what is important to the client. The assessment is a key part of the therapy and should not be rushed. Filling in the form can be a homework assignment if time is running short and you feel the client would be able to fill in the form on their own. Many clients in our pilot study preferred an oral discussion of the issues contained in the form but a written/picture version of their assessment should also be provided to take away at the end of the session as a reminder of what they are aiming to achieve through therapy (Appendix 2).

    o Tell the client that his or her own values and goals are extremely important in deciding what kind of activities will help. Check that he or she understands the purpose of the assessment and how it will influence therapy. The therapist should use the values identified by the client to move very rapidly to goals that can be scheduled as concrete actions. Avoid a vague, unstructured discussion of the client's values that is not linked to specific actions.
    o It is extremely important to accept the client's values, including religious beliefs, in a non-criticial way, in order to develop trust and open discussion. Therapists who are from a Muslim background themselves should try their best to create a safe space for clients to say that religion is not important to them, if this is the case.
    o Evidence of 'negative religious coping' or ambivalent/ hostile views of God will also need to be addressed in therapy if they play a part in maintaining depression. Strategies for how to do this are included in section 6b on Discussing Religion.

    Whilst religion is not a central aspect of identity for every Muslim person, Islam will have formed part of the upbringing of most Muslims. A client's relationship with God is, therefore, likely to feature in some way for the majority of people, including people who are struggling to make sense of their identity and people who do not appear to be overtly religious.   In our pilot study this assessment was found helpful by people who were and were not practising Muslims.

- **Set an initial activation assignment:**

    o It is always a good idea to give the client an initial activation assignment or two at the very first session, to set the tone and get the client moving quickly. As you were listening to the client's story and discussing their values and goals, ideas for activation assignments may have occurred to you. If they did, discuss them with the client.

    Discuss these initial assignments as you would any activation assignment in BA (see the section 6d on "Scheduling Activation Assignments").

- **Discuss coming to the second session:**
  - o Tell the client how long the treatment will last (our research was based on up to 12 sessions of 50 minutes but some clients may need more or less than this). Tell the client that you expect that he or she will have started to feel better well before the end of therapy but the goal of treatment is not just to feel better. You will be teaching the client a new skill—the skill of learning how to respond to difficult life events and to feeling bad with action steps so s/he does not get stuck. It takes time to learn this skill so <u>ask the client to commit to at least 6 sessions</u> even if they start to feel better immediately.
  - o Tell the client that it is very important to come to sessions, and ask how they feel about coming weekly.
  - o Discuss the next session time. Ask if there are things that will get in the way of the client coming to next session? Problem solve barriers to coming to the next session.
  - o Let the client know how s/he can get in touch with you if necessary in between sessions.

- **Session review:**
  - o Make sure you leave time to review the session. This should not be rushed, especially in the first session.
  - o Ask client for feedback about today's session. What do you think about our approach? Are there things you think will be particularly helpful? Unhelpful? Does the approach fit with the client's beliefs and values?
  - o Address and problem-solve any negative reactions the client might be having.

Conducting the first session when you are short of time

The most important elements of Session 1 are: listening to the client's story, explaining the BA model and setting a homework assignment. If there is no time to do more than this then other parts of Session 1 can be carried over to the following session.

The essential elements of the first session can be covered by breaking the session up into three parts – first, ask the client 'What brought you here today?'. This will cover the first circle (of the 2 circle model). Then follow this by asking how the client responded to the situation/problems that resulted in them seeking therapy – this covers the 2nd circle. And finally acknowledge that you haven't been able to cover everything, but based on what you have learnt about the client try to set one or two simple activation assignments.

Optional Issues for Session 1:

- **Initial activation assignments:**
  - o Where the Values Assessment has shown that religion is important to the client, religious behaviours should be treated like any other to be activated in BA and the therapist should think about issues of shaping, scheduling and structuring the behaviour. It will be useful to discuss early on how much clients would value building religious activities into their assignments and what they would consider an achievable level of religious practice.

- o The Client Booklet is intended to be a resource for clients who wish to draw on their faith as a support and includes Islamic teachings that they may find helpful. The booklet should not be offered immediately to clients but can be suggested to those who have referred positively to religion in relation to their values, beliefs or activities. The therapist might say 'I wonder if you would find this booklet of any interest? It's a collection of quotes from the Qur'an and Hadith that some people have found useful. You may or may not find it helpful and we could perhaps discuss what you think about it next time we meet'. The Booklet contains space for clients to add their own quotations and any teachings they have found especially helpful and clients should be encouraged to note down their responses to the teachings.
- o For clients using 'negative religious coping', who may have ambivalent or hostile views of God, the therapist could explain that positive ways of thinking about one's relationship with God can help people overcome depression. Depending on whether the therapist thinks it would be useful, the Booklet could be introduced as an alternative way of drawing on religious beliefs and the therapist could explore the client's response to reading the Booklet as an activation assignment.
- o If clients need to learn how to do a particular activity (eg prayer) help them identify an individual or group they can approach for support. See the Useful Resources at Appendix 9 for examples of the kinds of organisations that could be helpful to clients.

- **Activity monitoring:**
  - o Explain the activity chart (Appendix 3) as a way to get a sense of what the client's daily activities look like, so we can begin to figure out what needs to change.
  - o Explain that clients should complete the chart at the end of each day.
  - o *Depending on the client, you can also ask the client to rate his/her mood during the activities (using a scale of 0-10), or mastery/pleasure during the activities, or anything else that you think would be useful to know.*
  - o Ask clients if they will be able to complete the chart? What might get in the way?
  - o Try to come up with solutions to potential barriers. Be creative. For example:
    - ▪ Individuals without literacy skills can use pictures or work with a friend or family member to record their activities and the rating they give verbally.
    - ▪ If there are many other demands on the client's time suggest again that a friend or family member be asked to help remind or encourage the client to fill in the chart at the end of each day
  - o *Discuss where clients are going to keep the chart (on nightstand, on refrigerator, by tv, etc.).*
  - o *Discuss telling another family member about the assignment.*
    Possibly discuss rewarding self for completing the assignment (can they do the chart and then watch tv, versus putting on the tv immediately?).

  - o Phone call activity monitoring:
    - ▪ One possibility is to have the client call you and report the activities over the phone.
    - ▪ This could be done twice a week.
    - ▪ Ask the client to call at different times so there is a good sampling and representation of important time periods.
    - ▪ The client needs to make the call, not his/her spouse or son or daughter, etc.

- It may be a good idea to tell a family member that the client will be making the call.

- **If the client has been prescribed medication, or is scheduled to see the psychiatrist:**
  o Explain to the client that taking medication may be helpful but people are more likely to relapse if they stop taking it.
  o Discuss any concerns about medication, for example, clients may have concerns about side effects or whether the ingredients in medication are *halal* ie from sources that are allowed by religious rulings. Medicines that contain gelatine, glycerine and other animal-based ingredients or alcohol can be seen as *haraam* ie forbidden and not taken as a result (Sattar, Ahmed et al. 2004). It will be helpful to discuss whether any alternative medication can be prescribed and what to do if this is not available[1].
  o Explain that the important thing is to work out how to take action and take concrete steps to help deal with depression, and get started solving problems in addition to taking medication.

- **Family involvement:**
  o Tell the client that it is up to him/her how much family can be involved but that it may help the client take action.
  o Tell the client that family members can be invited in to sessions. Ask the client how he/she feels about inviting family members to attend future sessions.
  o If it is important to get a family member on board to ensure a client's continuation with therapy, the therapist should get the client's permission and call the family member him or herself rather than relying on the client. The therapist should really try to sell the treatment, convincing the person to come: "Would you be willing to come to our session next week? It would be so important for you to come to a session and learn about what we are doing."
  o **If the client is interested in bringing a family member in to treatment:**
    - Discuss with the client his/her relationship with this family member. Is this person supportive or part of the problem?
    - If this person is clearly supportive, schedule to bring the family member in as soon as possible. **Try to get the family member in for the next session.**
    - If this person is not supportive, tell the client that you will need to figure out how to get the family member to be helpful, and it may be an important aspect of treatment.

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[1] A helpful publication about this issue is available from the NHS National Prescribing Centre
http://www.npci.org.uk/therapeutics/cardio/diabetes1/resources/library_other_publications_drugs_of_porcine_origin.pdf

Session 2 - if family present

- **Review the sections of the manual on Family and Community Involvement and, if the client has listed religion as a value, the section about the Client Booklet**

- **Overall purpose:** To learn how the client interacts with the family and work out ways for the family to assist with treatment

- Ask the client to complete PHQ9, GAD7 and BADS-SF measures

- **Meet individually with the client:**
    - Try to meet with the client individually for a short time before bringing in the family. This will allow you to determine any information that should not be shared and particular family members that may or may not be helpful collaborators. However, be flexible (you may have to do the whole meeting with the family members present).
    - Describe the purpose of the meeting
    - Review the previous session
    - This time will also allow you to review the activity chart and any other homework assignments from the previous session (often the client will not complete the first assignment and may feel embarrassed if this is discussed in front of family members).
        - From the activities listed in the chart, you may be able to gauge how important religious activities are to the client, for example, if a person begins the day by observing the pre-dawn prayer or tries to remain in a state of purity by performing ablution this will indicate an important position for religion in their life.
        - If the Client Booklet has been given to the client, discuss their reaction to this and any teachings they have found helpful.
    - It is very important that it is the client's choice how involved the family is. Make this clear while meeting alone and ask the client if there are particular areas in which he or she does not want the family to be involved.

- **Discuss treatment with the family:**
    - Describe the purpose of this meeting
    - Review the model of depression with family. Focus on common responses (2nd circle) to make sure the family understands that what the client is feeling makes sense.
    - Make it clear that we do not think the client is mad and emphasise that feeling depressed following difficult life events is understandable.
    - Emphasize that it is good that the client is in therapy.
    - Let the family know that treatment takes time (so be patient) and enlist the help of the family in encouraging the client to come to session every week, even if they are feeling depressed. Let the family know that they can be a big part in helping the client get better.

- **Use the families inside knowledge to assist in your assessment**
    - Ask the family what the client was like and what he/she enjoyed doing before becoming depressed. It is possible that the client will overlook important areas for activation.
    - Ask the family in what situations the client seems most depressed and least depressed.

- **Enlist the family's help in treatment**
  - o Give the family a rationale for and enlist their help in encouraging the client to be active (even in very small ways) while feeling depressed or not having the energy
  - o Let the family know that the loving response is not always the response that will help the client. For example, taking over all of the client's household chores may function to maintain depression.
  - o Use the information gathered in this session and Session 1 to suggest interventions for family members
  - o It may be particularly useful to involve supportive family members in the completion of homework assignments. For example, you could ask a family member to discuss the homework for the week with the client each week after the session and provide reminders, encouragement, and facilitation (e.g., transportation).
    - ▪ Make sure the family does not badger or criticize the client. Get permission from the client for the family to ask about completion of homework and provide reminders.
    - ▪ Schedule family member's asking about homework to avoid badgering (e.g., Wednesday evening the family can check in with client).

- **Give homework:**
  - o Activity monitoring.
  - o Activation assignment (involve family if appropriate). It is often helpful to provide the client with a small calendar or day planner to facilitate scheduling activities.
    - ▪ The techniques and tools of BA may be specifically used to help clients integrate any teachings from the Client Booklet they have found helpful with the treatment.for depression. For example, the five or ten teachings clients think are most important can become "activation assignments" and the therapist can work with the client to get him or her active in these ways.
    - ▪ The extent to which religious activities are suggested as a resource for dealing with depression will need to match the client's level of religiosity to avoid inducing guilt at not being able to fulfill assignments. However, the absence of religious activity may be a consequence of feeling depressed and it should not be assumed that clients who do not mention religious activity would not be interested in these. Again, it will be useful to discuss how much clients would value building religious activities into their assignments and an achievable level of religious practice. Some script for possible ways of raising this is given in Section 6b) Discussing Religion. Feelings of guilt about not fulfilling religious practice can be discussed in terms of helpful behaviours to address this (Andreasen 1972).
    - ▪ If a client has an ambivalent or hostile view of their relationship with God and did not find the Client Booklet helpful, the therapist may need to consider other resources that could help. For example, the therapist could collaborate with someone from within the Muslim community who has the religious authority to provide alternatives to unhelpful beliefs (see Appendix 11).

- **Discuss barriers to completion of homework:**
  - o Ask client if they will be able to do their homework assignments? What might get in the way?

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- o Try to come up with solutions to potential barriers. Be creative.
- o Discuss family members' role in helping with completion

- **Coming to the next session:**
    - o Remind the client and family members of the importance of coming to sessions.
    - o Are there things that will get in the way of the client coming to next session?
    - o Problem-solve barriers to coming to session.
    - o Involve the family where necessary

- **Finish session alone with client to review session:**
    - o Make sure you leave time to review the session.
    - o You need time to address and problem-solve any negative reactions the client might be having, especially reactions to having the family in the room.
    - o Ask client for feedback about today's session. What do you think about our approach? Are there things you think will be particularly helpful? Unhelpful?
    - o If religion appears important or helpful to the client, ask whether he or she would be interested in continuing with the Client Booklet and discussing this with you in the following session.

Session 2 - if family not present

Before this session, review the section of the manual about General Issues when conducting BA-M and, if the client has listed religion as a value, the section about the Client Booklet

- **Overall purpose:**
  - To further explain the model to the client
  - To devise and assign functional activation assignments.

- **Ask the client to complete PHQ9, GAD7 and BADS-SF measures**

- **Review the previous session**
  - Elicit client reactions to specific aspects of the previous session

- **Review the model and explain how you will apply it to the activity chart / outside events review**

- **Review homework**
  - Review the client's activity chart. Depending on the client it may be appropriate to review the mood that accompanied each activity or each day. Watch out for examples of activation and avoidance. Fit these into the model. ***If possible, point out how activation leads to better moods, problem solving, and task completion, while avoidance leads to feeling OK, but bigger problems in the future.***
  - From the activities listed in the chart, you may be able to gauge how important religious activities are to the client, for example, if a person begins the day by observing the pre-dawn prayer or tries to remain in a state of purity by performing ablution this will indicate an important position for religion in their life.

    - The extent to which religious activities are suggested as a resource for dealing with depression will need to match the client's level of religiosity to avoid inducing guilt at not being able to fulfill assignments. However, the absence of religious activity may be a consequence of feeling depressed and it should not be assumed that clients who do not mention religious activity would not be interested in this. Feelings of guilt about not fulfilling religious practice can be discussed in terms of helpful behaviours to address this (Andreasen 1972). Again it will be useful to discuss how much clients would value building religious activities into their assignments and an achievable level of religious practice.
    - If the Client Booklet has been given to the client, discuss any teachings they have found especially helpful. The techniques and tools of BA may be specifically used to help clients integrate any teachings from the Booklet they have found helpful with the treatment.for depression. For example, the five or ten teachings clients think are most important can become "activation assignments" and the therapist can work with the client to get him or her active in these ways.
    - If a client has an ambivalent or hostile view of their relationship with God and did not find the Client Booklet helpful, the therapist may need to consider other resources that could help. For example, the therapist could collaborate with

> someone from within the Muslim community who has the religious authority to provide alternatives to unhelpful beliefs (see Appendix 11).

  o If the client did not complete the homework. First, assess the barriers to completing the homework, problem-solve barriers creatively, and stress the importance of completing future assignments. Reconstruct the basic activities of each day focusing on possible activation and avoidance examples and then follow the above instructions.

- **If appropriate, review possibility of later family / friend involvement**
  - o Family involvement does not need to involve attending sessions. Again, creativity is encouraged.

- **Assign activity chart and give activation assignment:**
  - o Add mood during the activities (0-10), or mastery/pleasure during the activities, or anything else that you think would be useful to know to the activity chart if appropriate. Only do this if the client successfully completed the activity chart the first time. If not save it for later (BA assignments should always be graded).
  - o Devise activation assignments that have a good chance of being accomplished, but will still be meaningful for the individual client. For client A this might mean going for grocery shopping and a 30-min jog and for client B this might mean simply leaving the house and walking around the block.

- **Discuss barriers to completion of assignments:**
  - o Ask client if they will be able to complete this chart? What might get in the way? Try to come up with solutions to potential barriers. Be creative.
  - o Discuss where they are going to keep the chart (on nightstand, on refrigerator, by television, etc.).
  - o Discus barriers to completing the activation assignment
  - o For both assignments, ask, "What can we do that will make it more likely that you will be successful?" Then do it.
  - o Discuss telling another family member about the assignment.
  - o Possibly discuss rewarding self for completing the assignment (can they do the chart and then watch TV, versus putting on the TV immediately?).

- **Homework:**
  - o Activity monitoring.
  - o Activation assignment

- **Session review:**
  - o Make sure you leave time to review the session.
  - o You need time to address and problem-solve any difficult reactions the client might be having.
  - o Ask client for feedback about today's session. What do you think about our approach? Are there things you think will be particularly helpful? Unhelpful?
  - o If religion appears important or helpful to the client, ask whether he or she would be interested in continuing with the Client Booklet and discussing this with you in the following session.

- **Coming to next session** (see General Issues when Conducting BA-M)**:**
  - Tell the client that it is very important to come to sessions.
  - Are there things that will get in the way of the client coming to next session?
  - Problem-solve barriers to coming to session.

Session 3-11

Sessions 3-11 should follow the basic structure of BA, which is:

1. Review screening measures
2. Set agenda
3. Review homework and activity level since last session
4. Develop new activation assignments as homework
5. Other agenda topics
6. Session feedback including client review and questions

The heart of the session is items 3 and 4. Reviewing and assigning homework is crucial; without it the session is not BA. Our pilot showed that many clients struggled with written forms of homework so verbal reports and agreements on practical assignments may be more appropriate in such cases. Our pilot showed that clients were often motivated by their relationship with the therapist, or through encouragement by family members, to complete homework that they found difficult to do. The therapist should make sure homework is reviewed each week and assign new homework based on the client's goals each week. Therapists should collaboratively work with clients to schedule activities to block avoidance and solve problems as well as to simply produce more pleasure and fun in the client's life.

Activity charts or calenders may be used to track and schedule activities and the Activity Hierarchy (Appendix 4) and Activation Homework Sheet (Appendix 5) may be used. Therapists should pay attention to the level of difficulty of the tasks to be assigned, and how avoidant/scared of the task the client is, and collaboratively work with the client to schedule tasks that are graded in terms of difficulty and fear level. The important thing in earlier sessions is that the client experiences some mastery and success with the tasks, so they should not be too difficult. It is also important for the therapist to save a few minutes at the end of the session to review the session and ask for client feedback about what was useful and not useful.

If the client has been offered but not taken up the option to involve family members, this should be raised again in a later session. Our research showed that some clients who would have found this helpful did not realise or remember they could include family members in therapy and would have valued a reminder that this was possible.

Final Session

Before session: Review ALL progress notes on the client.

- **Overall purpose:** Review progress and complete "Staying Active Guide."

- **Review PHQ9, GAD7 and BADS-SF:** In addition, it may be useful to graph the client's scores from over the course of therapy to highlight gains.

- **Set Agenda**

- **Review homework:** As in all sessions, this session should begin with a review of the previous week's activation assignments.

- **Review progress**
  - The therapist and client should review the client's progress. Clients often do not remember how depressed they were at the beginning of treatment and how much progress they have made. It may be helpful for the therapist to review all the progress notes before the session, so the therapist will be able to remind the client of details from the past. Focus on how learning to take action has resulted in a better life.

- **Complete "Staying Active Guide"**
  - Complete the form at Appendix 6 collaboratively with the client. Ask the client the questions on the form but help shape the responses to be as appropriate as possible.
  - The form is for the client to keep in an important place and review weekly.
  - Make a copy of the form at the end of the session. This will be helpful if the client calls for help in the future, or if the client loses the form the client can call you for another copy.
  - You may want to add a personal note to the end of the form with your name and phone number.

- **Self-therapy**
  - The therapist could encourage the client to schedule "self-therapy" sessions once a week. In these sessions, the client would continue the work of looking at his/her avoidance and activity, and schedule new activities, including religious activities if these have been helpful. Then, the next week the client should review the previous assignments. In other words, the self-therapy sessions should mimic the real therapy that is now ending.

5. Discussing Depression

Muslim clients will vary considerably with respect to knowledge about depression and familiarity with psychiatric terms such as "symptoms" and "diagnosis." In BA-M, it is *not* important that the therapist educate the client about depression or the symptoms of depression. The BA-M therapist does not have to use the word "depression" while working with clients. Instead, the therapist should learn the client's language and descriptors of their problems, and fit the BA model to the client's language. The therapist should provide a good rationale for treatment that links the treatment techniques to whatever problems the client presents with.

For example, explanations for depression amongst people from non-European backgrounds may be expressed somatically or linked to environmental causes and this holistic understanding of body, mind, and social environment will need to be taken into account during diagnosis, assessment and therapy (Pfeiffer 1996; Valiante 2003). Generalized bodily pain and physical symptoms are strongly associated with depression in many studies of Muslim populations from diverse ethnic groups (Al-Krenawi, Maoz et al. 1994; Azhar and Varma 2000; El-Islam 2000; Bilal and Ahmed 2001) and clients may deny being depressed. This is not a problem and the client does not need to be convinced to talk in emotional terms. Treatment does not need to shift in this way. The therapist should use the client's language and terminology for how they are describing their experience, and use the somatic symptoms directly in the model. Usually these somatic symptoms can be seen as "common responses" and the therapist will want to focus on activating the client to maintain healthy lifestyles in the presence of these symptoms.

A physical expression of depression may not apply to all individuals within Muslim populations, however, and we found evidence both within our fieldwork and existing studies that terms such as 'depression' and 'stress' are used by Muslims in the UK as well as in other countries as a result of exposure to such terminology and to Western models for understanding depression (Greenwood, Hussain et al. 2000; Halliburton 2000),

Service users also highlighted the stigma that could be attached to depression, which could be perceived as being 'mad' or failing to draw on Islamic teachings or turn to God as an appropriate response to sadness or distress. This perception may be a factor in Muslim clients' reluctance to admit to depression (Fonte and Horton-Deutsch 2005). Such perceptions are not inevitable, however, and in the UK context a study of predominantly Muslim South Asian inpatients found little evidence of excessive stigma associated with receiving mental health treatment (Greenwood, Hussain et al. 2000).

Our fieldwork also confirmed that depression may be linked by some Muslims to Islamic teachings about the existence of supernatural forces (Azhar and Varma 2000) and the existence of magic or 'evil eye' (Amer and Khan 2005). Belief in possession or the influence of *jinn* (supernatural beings which may be either good or evil) as a reason for mental illness is accepted as possible in rare situations by Muslim scholars (Philips 1995). Key informants said that the connection between mental illness and supernatural causes is often made when clients self-harm, hear voices, have unexplained pain or have suicidal thoughts. The context in which clients may describe such

experiences can also often involve family conflicts and the therapist can explore this by asking what the client thinks is the reason for supernatural forces to affect him or her.

> *"…I found this both in UK Muslims and in Pakistan - their explanations are biological, psychological, social but also spiritual and paranormal. So I think rather than this bio-psycho-social model there are two more [aspects]: spiritual and paranormal…"*
>
> Psychiatrist

Within Muslim societies, possession has historically been perceived both as a test of faith, with the consequence of supportive treatment, or a punishment for sins, in which case individuals are considered to bear more responsibility, and therefore isolated and stigmatised. Both interpretations may exist in modern Islamic societies (Al-Baldawi 2005), but Islamic teachings promote supportive practices such as encouraging people to protect themselves through recitation of the Qur'an and prayers, and exorcism by a knowledgeable and devout person (Philips 1995). Where a client believes supernatural forces are involved in causing his or her depression, explain that therapy can still be helpful alongside other actions that might be needed to counter these forces. Exploring with the client the possibility of collaboration with, or referral to, religious leaders may also be effective in supporting people in this situation (Shaikh and Hatcher 2005) and the client may already be taking such advice (Dein, Alexander et al. 2008). The list of resources at the back of this manual includes organisations that can provide advice and support for this.

Shame and stigma may be reasons for not accessing professional help and lead to some Muslim clients preferring private coping strategies (Cinnirella and Loewenthal 1999). These factors can be linked to cultural taboos about disclosing personal or family problems to outsiders and the potential adverse impact this may have, for example on future marriage prospects (Youssef and Deane 2006). However, there is also evidence that the tolerance for mental illness can be very high in Muslim populations, provided the illness can be understood within a culturally acceptable framework. For example, depression resulting from a marital problem would be perceived as understandable and not stigmatised, whereas depression that is isolated from its cause and explained in biological terms or in ways that indicate deficiency within the individual would be associated with stigma (Coker 2005). The psychological model promoted by services is therefore important in terms of how the service will be perceived and BA emphasizes that depression is an understandable response to the context in which it occurs. An emphasis upon action, rather than on understanding the pathology of depression is considered to be more in line with the values of people from Muslim communities (Valiante 2003).

The therapist should explain that therapy will be completely confidential and is not about working with some problem inside the person but is about helping people solve the problems they think are important. The therapist may say, "Listen, my goal is to help you solve the problems in your life and get moving again so you feel like life is working better for you. I can help you with that. I can understand why you feel the way you do and I would like to help you."

6. Treating Muslim clients with depression

a) The Therapeutic Relationship

BA therapists display a genuine concern and compassion for their clients. The therapist should accurately reflect what the client is saying, and the therapist should continuously reflect that the details of the client's life and how the client feels make sense and are understandable. The therapist should always maintain hope and optimism about change.

The therapist should be collaborative and open to the client's influence. The therapist should recognize that he or she is not always right and that he/she and the client are working together as a team. The therapist is an expert, has studied the situation, and can offer guidance, advice and support. But the client has access to the details of his or her environment and behaviour that the therapist does not have. Activation assignments should be determined collaboratively, using feedback from the client on what the client feels would be a graded improvement, what the client feels his or her environment will respond positively to, and what the client feels will be an accomplishment. Likewise, the therapist should not guarantee the outcome of an activation assignment. Activation assignments should be presented as experiments, things to try, and the outcomes should be discussed and decided on collaboratively.

Some studies present Asian Muslim clients as likely to view the therapist as someone with a great deal of authority from whom they expect instructions rather than discussion about how to overcome depression (Naeem, Gobbi et al. 2009; Rathod and Kingdon 2009). Our fieldwork did not highlight this as an issue for Muslim clients in the UK, although they sometimes wanted concrete suggestions or advice from therapists which they could then decide to adopt or not. An approach developed within the Latino community suggests that if such expectations become apparent therapists can use this authority in early sessions to maximize compliance with homework assignments and with session attendance. However, over time, reliance on authority and relegation of decision making to authorities may come to be seen as an avoidance pattern for certain clients. In these cases it will be important to work toward less therapeutic authority but still maintain a confident and respectful therapeutic stance (Kanter 2010).

The pilot study for this manual revealed a high level of acceptance by most therapists but some potential anxieties about dealing with the religious framework that clients might bring. Therapists may, for example, be uncomfortable with a religious framework because their training has not prepared them for dealing with this. The manual aims to address this gap in training and we would encourage therapists to try the approaches we are promoting and see how effective they are. There have been similar anxieties for other new approaches that have been developed – for example, when BA was being tested therapists were sometimes reluctant and felt the approach was likely to be unhelpful but in practice found that it was actually not too difficult and worked (Ekers et al 2008).

Therapists may also be uncomfortable with the religious material in the manual because they are not experts in, or knowledgeable about, Islam. This could be handled by the therapist being completely honest about his or her training and expertise and saying something like: "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." A discussion about how the client feels about the therapist's religious background, that does not exaggerate or try to minimise differences, will also be helpful (Gorkin 1986).

Finally, there may be some therapists who – perhaps because of their own beliefs or previous training - are so uncomfortable that they are not prepared to work with a client who wishes to draw on his or her religious framework in the way promoted by this manual. Client preference is an important consideration for decisions about whether to incorporate religious components into therapy (Hook et al 2009; Worthington 2001) so in this case we suggest the therapist should not choose to deliver the intervention we have developed.

b) Discussing Religion

Muslims formed almost 3% of the UK population at the time of the 2001 Census and the second largest faith community (National Statistics 2004). In contrast to most other religious groups, religious identity is prioritised over ethnicity by Muslims (Modood et al 1997), and can act as a significant resource for patients coping with depression and other long term illness (Cinnirella and Loewenthal 1999; Mir and Sheikh 2010).

Religious values and practices can, nevertheless, be an area which both health professionals and Muslim service users lack the confidence to discuss (Mir and Sheikh 2010). Our fieldwork revealed that practitioners had different approaches to exploring the issue of religious beliefs and practices with Muslim clients. Enabling the client to identify important values was seen as a key part of therapy by our key informants and by clients taking part in our pilot study, but was not always addressed sufficiently by therapists (Meer et al 2012). Therapists need to build up their confidence to ask whether faith is important to clients as part of understanding the person and the context in which they live and in order to work with clients more effectively. The training of health professionals and their perceptions of professional boundaries can prevent the development of confidence and ability in dealing with this issue:

> *"… I mean I have to say my psychotherapy training didn't prepare me for asking questions about religion and spirituality at all……"*
>
> *"... psychotherapy, I mean you have to remember, politically is a discipline that tries to distance itself from religion. …….. because a lot of people in the profession come from a more secularist point of view….."*
>
> **Family Therapist**

Training that increases therapist confidence to make space to discuss religion or support clients to draw on religious beliefs as a resource is, therefore, helpful. Therapists involved in our pilot study said

that confidence also increased with practice of delivering the intervention and through developing their own knowledge of Islam.

Strong arguments were made by a number of people taking part in our research that the framework in which therapy is practised should be adapted to include religion if it is important to the client. Spiritual aspects of depression, for example, the impact of not being able to keep up with religious observances, can be just as important as physical, psychological and behavioural aspects. Service users for whom religion was important confirmed that this aspect of the therapy was very important to them and gave the message that talking about their faith was acceptable. Some service users felt that such discussions could be easier with a sympathetic third party than with family and friends.

> *"…of all the different ways of helping people, psychological therapy should be able to include anything that somebody brings along……we can adapt, you know the content is shaped as much by what people bring as by what we bring….all we have to be is open enough to take that on face value and have an open discussion about it."*
>
> Secondary Care Manager

Evidence from both fieldwork and the literature indicated that the relationship between client and practitioner was key to the therapeutic process. Access issues for clients included confidentiality (Youssef and Deane 2006), and non-critical acceptance of their religious beliefs (Koenig et al 2001; Paukert, Phillips et al. 2009), both of which supported trust and open discussion, and both of which may be tested by clients. Practitioners from Muslim communities who were visible in community contexts could also be conscious of client judgements that were developed outside treatment settings.

> *"…we think that we are assessing the patients - the patients are assessing us: 'Who is the person opposite to me [..], how much does he or she understand?' "*
>
> **Clinical Psychologist**

Initial sessions should include assessment of values and goals, including religious values (see Appendix 2). Discussion of homework activity can also be used to explore the significance of religion to clients (see Session 2 outline).

Our key informants pointed out that religion is not a central aspect of identity for every Muslim person and there is evidence that for some its influence can be similar to that of family and friends (Mir and Sheikh 2010). However, because Islam is likely to have formed part of the upbringing of most Muslims, a client's relationship with God is likely to feature in some way for the majority of people, including when they are struggling to make sense of their identity. Our research showed that people did not feel under pressure to incorporate religion when offered this therapy. Many individuals who were not overtly religious did consider Islam to be important and were familiar with Islamic concepts that are relevant to therapy. The express prohibition of suicide in Islam, for example, can act as a

powerful deterrent when clients can see no other reason to go on living. Service users told us that when they felt extremely depressed, their faith could be the last thing to which they held on and the only thing to which they were able to respond.

It should also not be assumed that clients who usually draw on religion positively will always do this - our pilot showed that sometimes such clients could focus on negative feelings such as sinfulness or guilt, that could increase or maintain depression. Therapists should ask whether clients sometimes have such feelings and encourage them to find out about religious teachings that help them frame their experience more positively. Many such teachings are contained in the Client Booklet described in the next section and this could be a helpful resource for such clients.

Clients should be specifically asked how/how much they would like to include attention to religion in their therapy. It should not be assumed that clients with strong religious values, for example, will feel that religious activity is relevant to their therapy, particularly if they are already active in practicing their religion. Similarly clients for whom religion is not a central value may nevertheless appreciate assignments that help them increase their practice of Islam.

 Where religious advice/knowledge is very important to the client, the therapist should discuss involving someone with in-depth knowledge of Islam. This can be important in motivating clients who want to practice Islam more but are finding this difficult. The client may already know someone he or she could approach but therapists should also try to build up their own professional contacts to ensure the quality of advice given is high (see Community Resources below).

Some suggestions for how to talk to clients about drawing on religion in therapy are given below:

This treatment is about you and what is important to you and you have mentioned that spirituality is an important value for you. How would you like us to pay attention to spiritual activity during therapy? How much would you like this to be a focus of your therapy?

I am not an expert in Islam but I have had some training to develop my knowledge about the links between Islamic teachings and this therapy in order to be as helpful to you as possible. How do you feel about my supporting you to use your religious beliefs during therapy?

Do you ever feel guilty or sinful or angry because of your religious beliefs? Do you know of any Islamic teachings that might help you think about your experience in a way that is more helpful to you? How could you find out more about positive Islamic teachings?

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

The Client Booklet
A booklet bringing together various Islamic teachings that may help clients use 'positive religious coping' (Pargament 2001; Koenig et al 2001) accompanies this manual. The booklet was developed as a result of feedback from other research on mental health in Muslim communities (Maan 2010) as

well as advice from our project management and service user advisory groups. Many clients involved in our research and our Service User Advisory Group appreciated the integration of religious activities and teachings into the treatment and wanted to see a clear link between the therapy and the Islamic teachings in the booklet. Others felt they already knew what was in the booklet and did not read it much but were nevertheless positive about it. Some therapists also felt positive about using the client's value framework to promote what the therapy is trying to achieve, whilst others felt unsure about how to use it. It is important to remember, that the booklet is intended to be a resource for clients who wish to draw on their faith as a support as well as a means for therapists to increase their knowledge of Islamic teachings that clients may find helpful. Therapists are not required to believe in the teachings themselves but should be familiar with the content of the booklet. It is very important to assess the client's degree of religiosity and not make assumptions about whether he or she would find the booklet helpful; it should not be offered immediately to clients, or before therapy has even begun, but can be suggested to those who have referred positively to religion in relation to their values, beliefs or activities. The booklet does not rule out more open discussions about what Islam might teach on specific issues that are important to the client.

The suggestions below are designed to support therapists to introduce and discuss the booklet with clients who have clearly indicated they wish to draw on their religious beliefs during therapy:

> The people who developed this therapy have produced a self-help booklet for clients which contains Islamic teachings that you might find helpful. I wondered if you would be interested in looking at this for your homework this week?
>
> How helpful do you think the self-help book is? Were there any parts of it that you thought could support the goals you want to achieve?
>
> How would you feel about my supporting you to work through the booklet when we meet and think about how it could help you become more active?
>
> Would it be helpful to involve someone with in-depth religious knowledge to support you to work through the booklet?

The booklet should be used to draw parallels between BA and Islamic teachings, placing the therapy within a framework that the client values and is already likely to understand. As such it enhances BA approaches, rather than acting as a substitute for these. The table below shows how teachings included in the booklet relate to the underlying concepts of BA and the idea of 'positive religious coping'.

Section of Client Booklet	Parallels with BA/psychological benefit
Dealing with difficulties	As in BA, sadness and grief are seen as normal responses to difficult life events from an Islamic perspective. This section can be used to help clients feel they are not abnormal or 'mad' and that any stigma they have encountered is unjustified.
Staying Active: **Mercy to yourself** **Hope**	These sections support 'positive religious coping' by encouraging clients to think positively about themselves and discouraging them from being too self-critical or harsh on themselves. The teachings can help clients reframe their relationship with God, give them hope,and help them feel less alone.
Core beliefs **Practical steps to wellbeing**	These sections can again be used to show that the BA approach is similar to an Islamic framework. They highlight that being active is key to following Islam and is encouraged through small daily acts of worship that are likely to be achievable for most people. For example, it may be helpful to discuss how much activity is involved in observing the five pillars of Islam. For clients who say religion is important to them, these small actions will contribute towards developing congruence between their beliefs and their daily actions. They can also support clients to spend time on themselves rather than focusing only on others and to begin to look after themselves physically.
Tie your camel	This teaching similarly highlights a parallel with BA, encouraging clients to take action themselves and not just rely on God to provide a solution.
One step at a time:	This teaching conveys to the client that being active is encouraged in Islam and highlights parallels between Islamic teachings and therapy that focuses on action (Valiente 2003). From both perspectives even small changes in behaviour can have a major influence on one's situation, no matter how complex and difficult this may be. The Hadith also discourages extremism which may be useful to counter obsessive behaviour.
Remembering God **Connecting with the Qur'an** **Calling on Allah**	All these sections support 'positive religious coping' by encouraging clients to think positively about themselves and discouraging them from being too self-critical or harsh on themselves. The teachings can help clients reframe their relationship with God, give them hope,and help them feel less alone. They can also help clients reframe their understanding of their experience and develop a sense of meaning in their lives. This in turn can promote a positive outlook and the resilience to deal with difficult situations. The teachings can help counter feelings of helplessness, for example the therapist

Names of Allah	could ask whether the client believes God has the power to help and if so what the client can do to receive that help. For example, the therapist can introduce a discussion about some of the Names of Allah (eg Most Merciful and Most Compassionate) to help clients who think they are beyond forgiveness or who have a concept of God as punishing to consider more positive ways of thinking about God. Clients who may feel guilty about past actions could be asked what Islam teaches them to do when they have done something wrong. Where clients have an ambivalent attitude towards God or think of Him in ways that increase hopelessness or guilt, it may be helpful to suggest they reflect on the Names of Allah and explore whether they have any experience relating to the positive ways in which God describes Himself in the Qur'an. Certain ways of remembering God, such as the 'Remembrance for Morning and Evening' prayers can also be helpful for clients who may feel fearful or exposed to harm from others. For example if a client feels threatened by supernatural forces, these teachings provide an Islamic response to the risk of harm.
Dealing with unhelpful thoughts: **God's mercy/ forgiveness** *Sabr* **Developing** *Ihsan*	As above these teachings can support an active approach and positive religious coping linked to an improved relationship with God. The therapist may also explore with the client their response to key concepts in the Qur'an that can help positive religious coping: for example, that illness is a test that has meaning and that times of difficulty are followed by times of ease. Islamic teachings about *Ihsan* describe this state as the highest level of faith, achieved by focusing intensely on God during acts of worship. This is similar to the concept of mindfulness, in which a person's focus and perception is altered by intense concentration. For clients who constantly ruminate, an activation experiment to develop *ihsan,* for example during their daily prayers or during other acts of worship, may be helpful in refocusing thoughts.
Be part of your community	These teachings support BA approaches by encouraging interaction with others in ways that can reduce a client's sense of isolation. A number of social activities are recommended by Islamic teachings that can be drawn on for activation assignments,

The booklet contains space for clients to add their own quotations and any teachings they have found especially helpful. The techniques and tools of BA may be specifically used to help clients integrate the teachings they find most helpful with the treatment for depression. For example, the five or ten teachings clients think are most important can become "activation" assignments and the therapist can work with the client to get him or her active in these ways.

Therapists should be careful to keep the booklet in a place that indicates the contents are being treated respectfully. Some members of our Service User Advisory Group told us they had felt

offended by seeing copies of the Qur'an stored in cleaning cupboards in some clinical settings. Keep the booklet on a high shelf if possible and not under a pile of other material.

Religious background of the therapist

Whilst some Muslim clients may request a therapist of the same faith and/or gender, others specifically ask for a therapist from a different background. Some clients involved in our research felt that therapists from a similar background were are more likely to understand clients' cultural references and metaphors and explain the religious elements of this therapy. Clients may also feel relieved they do not have to explain or justify their beliefs, particularly when the experience of depression is affecting their ability to express themselves. However, this common understanding should not lead to therapists crossing professional boundaries or giving advice on areas in which they lack expertise. For example, one service user complained that his GP advised him to get married as a solution to depression and felt he was being treated less professionally because of their shared background.

Clients may prefer a therapist from a different religious background if they have concerns about confidentiality or have had previous unhelpful experiences with professionals from their own faith community. Concerns about confidentiality can relate to not wishing to disclose their experience to someone from a Muslim background or worrying that someone from their community will find out about their mental health problems. Clients who are ambivalent about religion or feel embarrassed to disclose a lack of religious observance may also prefer a therapist who is not from the same faith background. Such embarrassment may also prevent disclosure to family members and friends and clients can feel more able to discuss these issues with someone outside their religious community. Trust, empathy and compassion as well as openness to understanding religious beliefs were felt to be the most important issues for clients with therapists from any background. Professionalism is highly valued and clients understandably do not wish to feel they are 'being judged' by therapists of any background who are supposed to be helping them.

Ideally a choice of Muslim or non-Muslim therapist should be offered for this intervention. There are advantages and disadvantages of having a shared and non-shared background and clients involved in our research often felt that any concerns about difference, including the age of the therapist, were overcome through the positive relationship they developed.

Therapy can involve complex dynamics and when therapists and clients have a shared understanding of their faith their reactions to each other may inform the development of their relationship with God (Peteet 2009). In intercultural therapy establishing trust and empathy may be more difficult however. Gorkin (1986) highlights conflict-based reactions in both clients and therapists that draw on the prejudices and stereotypes each holds of the other. For therapists working with Muslim patients this can result in a perception that individuals from this faith group are not psychologically-minded enough to benefit from therapy or that their beliefs and practices are from an inferior culture. Alternatively, a wish to use sessions to learn about the client's culture (rather than focus on the client's needs) or premature discussions of difference before a rapport has been

developed, can similarly interfere with the process of establishing a helpful therapeutic relationship (Gorkin 1986).

Some level of religious and cultural knowledge was seen as necessary by our key informants to facilitate helpful engagement. For example, awareness of common stereotypes and how religion may shape individuals' lives and beliefs, as well as familiarity with cultural metaphors that people may use to express themselves, was important for developing a shared understanding. Therapists from non-Muslim backgrounds should explicitly express an openness and desire to talk about such issues with clients.

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

Knowledge of Islam can also sensitise therapists to issues that might cause difficulties or discomfort for clients, such as appointments that clash with Friday prayers or mixed gender activities. Evidence of interest in Islam, such as having a copy of the Qur'an and referring to this during therapy sessions, also gives an important message of acceptance to clients (Nielsen 2004). Some of our key informants used verses from the Qur'an, for example, to promote the idea of hope, or drew on a Hadith about how to behave when angry to promote understanding of the link between emotions and behaviour.   Ahmed et al (2007) found that Muslim service users in Pakistan valued being treated by health professionals who expressed religious sentiments and an inclination towards God. Some of our key informants from Muslim backgrounds felt that once they had developed a relationship of trust with a client such expressions could also be appropriate in the UK context.

Our research showed that clients did not feel it was offensive for either Muslim or non-Muslim therapists to suggest religious activities as long as the therapist genuinely felt this would be helpful. However, a sensitive balance is needed between encouragement for valued religious activity and making the client feel guilty for not being active in this way already.

Whilst training about Islamic teachings is seen as necessary and useful, key informants warned about the risk of presenting Muslim communities as homogenous. They emphasised an awareness of diversity and the fact that training could not cover everything. It was felt that therapists should have undergone a process of self reflection about their own culture, beliefs and biases, both to give them confidence about exploring these issues with clients and become aware of their own preconceived ideas. Training could also provide an opportunity to share expertise and experience and show organisational support for addressing the specific needs of Muslim communities.

> *"…They need to have explored their own relationship to faith because otherwise if they haven't they can't help someone else do that".*
>
> **Family therapist**

c) Spiritual understandings of depression in Islam/Muslim communities

Our fieldwork and Service Users Advisory Group confirmed evidence from existing studies that the overwhelming majority of Muslim people with depression equate an "Islamic way of life" with good health and believe that following Islamic teachings supports healing (Ahmed, Choudhry et al. 2007; Coker 2005; Shoeb, Weinstein, et al. 2007; Tehran, Heidari, et al. 2009). Our key informants highlighted that not acting on one's beliefs can contribute to depression through guilt and self-criticism. Supporting the development of congruence between beliefs and actions is promoted both by BA practitoners (Kanter et al 2010, Veale 2008) and by Islamic scriptures (eg Qur'an 2:177; 3:114).

> *"Initially it was 'How could I call myself a Muslim if I am not praying?' because there is… obviously the difference between a Muslim and a non-Muslim is the prayer and so…but it was how I felt after I had prayed because I felt good I wanted to do it again. …. it was the lack of the anxiety and I thought 'Well I am happy with this' and I think it was the incentive for me to want to do it again and carry it on."*
>
> Service User

Islamic teachings about dealing with stress, promote reliance on God's mercy and support as well as acts of worship, without which the human need for spirituality is seen as unfulfilled (Esfahani 1995). Religious beliefs and practices are therefore perceived as a resource for improving health and key informants suggested a range of religious teachings that could be drawn on during therapy for clients who would find this helpful. For example, teachings that illness and loss are a test, that God rewards patience and perseverance and can provide relief from difficulties or distress and a cure for illness (Mubasshar 2000). Similarly stories of different prophets in the Qur'an can promote hope and encourage recovery as they involve persevering through difficulties and relying on God's help to resolve these. Many of these teachings are contained in the Client Booklet that accompanies this manual and others can be accessed through the resource list at the back of this manual. Recitation of the Qur'an and prayer in particular were described by key informants as important ways in which clients could feel relief from depression and hope for the future. Connecting to God enabled people to make sense of their experiences, gain resilience and a sense of calm as well as the ability to prevent themselves from constantly thinking about events. Rather than focusing on the actions of others, which can often contribute to depression, clients can be encouraged to think about what they themselves can do to feel better and improve their situation.

The Attributes of God[2] described in the Qur'an were also highlighted both in our fieldwork and existing literature as a resource for reframing understanding of oneself and one's situation. Islamic teachings describe God as Forgiving and Compassionate and the only One capable of passing judgment on a person's situation. The therapist can draw on such teachings from within the client's own framework of beliefs to challenge low self-esteem, hopelessness and guilt, which may maintain depression (Mubasshar 2000).

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[2] These are commonly known as 'The Names of Allah' and are provided in the Client Booklet

'Negative religious coping' also features in the way some Muslims respond to depression and key informants pointed out that illness could be perceived by some clients, or by others within Muslim communities, as a punishment from God. In such cases therapists can discuss Islamic teachings about illness and about events in life having a purpose and meaning. This can help clients reframe their understanding in ways that promote positive religious coping.

Key informants confirmed that religious beliefs and practices and ritual forms of worship can also inform obsessional disorders (El-Islam 2000) and excessive rumination (Azhar and Varma 2000). Therapists can draw on Qur'anic teachings or Hadith (Prophetic teachings) to help individuals break the cycle of these behaviours. For example, one therapist who was knowledgeable about Islamic teachings was able to explain to a client that he was not accountable for having thoughts of a sexual nature and this was not a sin on his part. Behaviours such as reciting prayers for protection from harm, which are generally recommended in Islamic teachings, can be used to help individuals act in ways they perceive to involve risk. However, an overreliance on such prayers can be unhelpful and lead to 'safety behaviours'. For example, a client was encouraged to use these prayers to help her leave her house and go shopping but later needed further work to enable her to enter a supermarket without having to recite them first. Therapists may need some knowledge of Islamic teachings in order to be able to distinguish a devout religious commitment from behaviour that is a symptom of illness (Varma 2008).

Similarly, praying may be seen as a form of avoidance, that is, a passive problem solving style. Kanter (2010) suggests that for clients using prayer in this way it is important to activate alternatives while not necessarily blocking the praying. A therapist may use the phrase, "Work like it depends on you, pray like it depends on God" with such a client. Another idea is to draw on the Hadith in the client booklet about relying on God after you have taken action yourself: 'Tie your camel first then put your trust in Allah'.

Key informants highlighted the need for therapists to be aware of broader cultural as well as religious influences on health and how people from Muslim backgrounds experience depression. Some of these have been outlined in the section Discussing Depression. Others, such as the dominant roles of some family members are discussed in the section on Family and Community Involvement. Religious and other cultural influences may be heavily intertwined in the way some clients practice their faith.

Culturally appropriate interventions may enhance recruitment and retention of participants (Cardemil, Kim et al. 2005) and it is recommended that assessment and therapeutic processes take account of cultural as well as religious and social experiences (Valiente 2003). Our fieldwork highlighted the need to understand religious influences on health beliefs and practices as distinct from broader cultural influences, however. Studies of Muslim populations rarely differentiate the two but key informants felt that religious teachings could have a particular role in promoting health and in challenging those cultural practices that help maintain depression. Some of these practices could arise from the way in which religious teachings have been interpreted or promoted in some contexts. For example, our key informants described clients in abusive relationships whose depression was

maintained by an emphasis on Islamic teachings about responsibility to others that was not balanced with teachings about the rights of individuals.

d) Scheduling activation assignments

The key to BA is identifying, assigning and reviewing activities. Every session essentially involves reviewing the previous week's assigned activities and assigning new activities. This should be approached in a way the client finds helpful, for example, some clients may prefer that the therapist suggests practical activities that seem in line with their values, rather than to be asked a very open question about what they would like to do. Other clients may prefer to explore their own priorities in a more open way or alongside advice from the therapist. Activities are assigned in detail, with the client and the therapist reviewing what, when, where and with whom activities will be completed. Obstacles to completing activities are also discussed and clients may be asked to visualize or role-play an activity. Therapists should ensure that organised activities to which the client is referred do not clash with therapy times.

Clients with very low levels of motivation,

Some clients may find it very difficult to motivate themselves to become active and express hopelessness about eg being unable to get out of bed. Therapists can use the metaphor of when the battery of a car has 'died' we need to give it a push start before it will get moving again. The initial stage of pushing is the hardest past – once it has started it is easier to keep it going. Acknowledge that taking the first step is the hardest part but encourage clients to try so that motivation increases.

Therapists can let the client know that they have been trained to help people to do this and that they have 'tricks and tips' that will help the individual get started; making the point that you will start off small and build on achievements. The therapist can reassure the client that they will start at a level that feels right for them. The therapist can ask the client to think about what they might be able to achieve in that particular week - something that will be a little challenging but not overwhelming.

If someone is faced with the choice of getting out of bed or staying in bed, they are likely to choose the latter because it is the 'safer', easier and so more attractive option – less effort is required and it is more comfortable. However if there was something that made staying in bed less comfortable, then this would no longer be the best option. If a client is asked to literally roll themselves out of the bed on to the floor, this requires little exertion on their part, but it means that once on the floor they are in a less comfortable place so have more incentive to get up instead. Another tip to motivate clients to make getting up easier in the morning is to encourage them to prepare the night before e.g. by laying out clothes or items for an attractive breakfast would also provide extra incentives to get out of bed.

Being so focused on concrete activities as the central theme of the session may be new to many therapists, but it is the primary emphasis in BA. For therapists who are CBT trained or used to focusing on cognition the following section gives some ideas about how BA fits with a cognitive model and also about how to deal with thoughts in BA.

Dealing with thoughts in BA

Behavioural theory treats thinking as behaviour. The BA approach does not ignore the client's negative thoughts, but takes the position that we can activate behaviour without having to change our thoughts first. Therefore we are working from the "outside-in". The therapist would normalise the negative thoughts as being natural responses, typical of someone who is depressed, rather than challenging them, but recognising that they maintain the cycle of depression and feeling stuck. Behavioural theory is that thinking is important but one does not need to challenge negative thinking in order to overcome depression. Therapists should:

- focus on the context and consequences of thinking: treat thinking in the way that you would treat any other behaviour i.e. focus on whether it is helpful in getting engaged with valued activities again, rather than on the content or accuracy of the thoughts. In BA unhelpful thinking would be described as rumination behaviour. When the client is ruminating about a particular thought, the therapist should not encourage the client to try to suppress, control or change the thought but aim to increase the client's awareness of when ruminating is occurring and whether the thinking is helpful or not. The example below demonstrates how to encourage alternative behaviour that helps get the client out of his/her thoughts and into experience:

"I was depressed all day yesterday because I was thinking about how my sister really doesn't love me."

When did you start thinking that? What was happening then? How long did it last?

What were you doing while you were thinking that?

What else could you have done during that time?

What is going on in your life that you are not enjoying/engaging with/ or is passing you by whilst you are thinking in this way?

A Thought Record Sheet is provided at Appendix 7.

- when people express the need to feel better on the inside before they can change their behaviour: discuss with the client that we often behave one way even though it may not correspond with how we feel on the inside. For example, we may feel hungry but we would not eat food that may be in front of us that doesn't belong to us. Or we may restrain ourselves from shouting when we feel angry. Therefore we are capable of behaving differently to how we feel internally.

Behavioural experts may sometimes describe BA as a form of CBT. Some forms of CBT emphasize cognition, while some emphasise behaviour but in any form of CBT both cognition and behaviour are expected to change. In BA, the focus is on behaviour because this is often efficient and easy to do, but it is expected that cognition will change as well. In fact, there is evidence from an early study that

BA is just as effective as cognitive therapy in changing negative thinking (Jacobson et al 1996). This demonstrates that BA is not antagonistic to a CBT model[3].

Scheduling religious activities

In general, BA aims to empower clients to take action steps to overcome the difficulties and triggers that caused depression. This manual highlights the additional importance of taking religious and cultural values into consideration when developing assignment activities for Muslim clients who would find this helpful. Religious behaviours should be treated like any other behaviour to be activated in BA and the therapist should think about issues of shaping, scheduling and structuring the behaviour. Examples of how religion can be drawn on as a resource within or outside therapy sessions, taken from our fieldwork, Advisory Groups and existing studies are provided below.

- Religious practices, such as performing daily prayers, reciting the Qur`an, and being prayed for by others were confirmed as particularly effective responses to depression (Cinnirella and Loewenthal 1999). Members of our Service Users Advisory Group reported that passing time can be a big issue – reading the Qur'an, praying and *dhikr* (remembrance of God) keeps people occupied and helps them feel less alone. Talking to Allah or writing a diary addressed to Allah can help clients make sense of things when feeling overwhelmed.

- The Client Booklet aims to support both therapists and clients to increase their understanding of key concepts in the Qur'an that can help clients use positive religious coping (Pargament 2001; Koenig et al 2001). For example, illness is described as a test in the Qur'an and depression can also be seen as a test that will not endure (Youssef and Deane (2006). Clients could be encouraged to read the booklet and identify any teachings that they find helpful. The booklet also includes space for clients to add their own notes or thoughts about these or other teachings.

- Stories of the prophets mentioned in the Qur'an can provide a rich source of material for developing resilience in the face of difficulties or to help clients work through specific problems, for example problems with family relationships. Muslim clients can find the personal example of the Prophet Muhammad (the Sunnah) particularly helpful as there are so many Prophetic traditions (Hadith) that cover an enormous range of issues and situations.

> "……*if you look at the example of the Prophet himself, people learned tremendous amounts from him, from his way of being, because he was so balanced. So……..you know it's like if I'm somebody who is really scared of relationships and I see somebody who is very good at relationships, I can learn a .. lot just from being in their presence.*
>
> *Family therapist*

- Where an inaccurate understanding of religious teachings is contributing to depression, some education about the correct understanding can be included in BA if the therapist has the religious authority to provide this. However, where the client does not accept the religious authority of the

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[3] Personal communication with Jonathon Kanter, University of Wisconsin-Milwaukee

therapist, it will be unhelpful to enter into debates about a client's interpretations of religious teachings (Peteet 2009). The therapist can, however, encourage the client to seek out alternative interpretations from those they consider to have religious authority as an activation assignment, and involve religious teachers if standard BA techniques do not help (see Community Resources).

- Clients might not feel able to raise issues relating to supernatural causes of depression themselves in case they are misunderstood or dismissed. Initial assessment should include a detailed discussion about what the person sees as the cause of the depression. If supernatural causes are mentioned the therapist should demonstrate sympathetic understanding and encourage discussion about what responses to such situations are encouraged by Islamic teachings (see Discussing Depression). The manual should be seen as part of a package of care if necessary and collaborations with others who can help the client should be explored.

- Assessment should include a discussion about spiritual values that is fairly open-ended, but which can become much more detailed and specific if these are identified as important (see Appendix 2). The level of congruence between the client's daily activities and his or her religious beliefs should be explored in Session 2 and, where the client feels there is a mismatch, activities that would help improve congruence should be discussed. Small steps to increasing religious activity leading from one activity to another should be encouraged rather than large and unrealistic goals.

- Literacy and childcare responsibilities that make it difficult to complete homework activities are a cross cultural issue and will need reviewing on an individual basis (see section on General Issues when Conducting BA).

- Activation assignments may target poverty, unemployment, social exclusion issues (eg discrimination, negative media coverage) and poor health if the client feels ready to address these. BA may be framed as empowering the client to fight these battles and not give up. Therapist support and modeling of helpful behavior for issues that may cause or exacerbate depression is very useful to clients; for example in our pilot study one therapist rang up a school and housing department on behalf of a client to explain about the difficulties she was facing and reduce the pressure they were putting on the client. Deciding how to behave in the face of social adversities and listing some of the behaviours that could be helpful, including those encouraged by Islam for clients who would find this helpful, could help with experimenting these encouraged behaviours and increase resilience. At the same time it should be recognised that clients may have limited ability to influence the social context in which they live and this context may continue to cause and maintain depression.

> *"….one of the skills of a BA therapist is ..…….actually coaching the change, because the main …..agent of change is activity scheduling so …... In terms of stigma, again I think it's down to functional analysis with the … individual about how they might approach and deal with those things ………. What we can't do of course is get rid of that sort of stigma in whatever community because it's there. It's thinking about the impact that either the real stigma or the fear of stigma is having on that person's engagement in their world and then discussing that with them."*
>
> ***BA practitioner***

- Graphic representations that help clients express themselves using pictures have been found helpful for those who find it difficult to articulate their situation or emotions verbally (Alyamy 1995). Whilst Islamic teachings discourage the representation of human forms, not everyone will observe this teaching. The therapeutic value and need for treatment may be used to argue for flexibility on this issue for those with reservations (ibid). The choice about how far religious boundaries need to be maintained should, however, be made by the client rather than the therapist (Gesundheit 2008).

e) Family and Community Involvement

Involving family members

In general, the evidence both from existing studies (Al-Issa 2000) and our fieldwork suggests that involving family and social support early in treatment can be important for some Muslim clients. A number of further issues relating to family dynamics in Muslim communities could influence the experience of depression and therapy:

- If clients fear stigma within the family or extended family they may not disclose that they feel depressed or are being treated for depression. Pakistani key informants reported that derogatory terms such as 'pagal' (mad) or 'challa' (simpleton) could sometimes be used for people with depression (see also Dein 2008 for similar dynamics in Bangladeshi groups).
- Religious teachings cover the rights and responsibilities of family members such as parents, children, husbands and wives. Individuals may feel unwilling to challenge those to whom they have a religious duty of respect as this could result in crossing religious boundaries. Therapists may need to support clients to develop assertiveness skills that maintain respectfulness and do not cross these boundaries. Naeem (2010) suggests a tactic of apologetic assertiveness, where the duty of respect is acknowledged as a precursor to further discussion.

> "…….which I call 'apology technique', so people ……… before they disagree, they say 'I'm really sorry, I apologise …......but I have this point of view which is slightly different from yours...but I still respect...' "
>
> Farooq Naeem, Psychiatrist

- Most therapists felt that families are an underused resource and engagement with family members could be important for some clients. Building a relationship with family members could be particularly important where the client's access to therapy requires support from other family members. Individuals, particularly women, may be dependent on other family members to access healthcare. For example, one key informant described a client who was depressed because of a physical health problem that had not been treated. Persuading her husband to

take her health more seriously increased her access to help for both conditions. Al-Krenawi et al (1994) highlight the importance of engaging with family power structures in such situations.

- The therapist, as a neutral party, may be able to raise issues the client feels unable to because of perceived boundaries between family members. Empowering clients to discuss difficult issues with family members themselves is also important and some therapists felt that the majority of the activity involved in therapy should primarily be undertaken by the client. However, where a family member has been asked to attend sessions but has refused the therapist should help raise the relative's awareness of why this could be helpful and persuade them to attend.

- Family expectations can keep people active when otherwise they might not continue with certain behaviours. For example, a service user continued attending the congregational Friday prayer with his father and brothers even though he had stopped praying in private because of his depression.

- The rights of some family members may be promoted more than others within families and communities, distorting the balance in these relationships. Valiante (2003) highlights the common mismatch between Islamic teachings and actual family dynamics in Muslim communities. Dominant family members (e.g. parents, husbands and in-laws) may use their understanding of Islamic teachings to apply pressure and produce guilt in other members. Drawing on religious teachings about rights and responsibilities can help clients and family members reframe their understanding of how these relationships should be maintained. One therapist, for example, gave an example of how he asked a husband to research Islamic teachings about the rights and responsibilities of husbands and wives and how this knowledge made the client alter his views about his own behaviour.

> *"…..We hear in the mosque of the parents rights over the children you never hear the rights of the children. I understand that there are rights but it is a two way process."*
>
> *Service user*

- Individuals may have difficulty considering their own needs before the needs of other family members. Women with caring responsibilities may find it difficult to complete homework tasks, for example. Eldest sons may feel pressure to take responsibility for younger siblings as well as parents, and be constantly in demand, even when parents or siblings do not live in the same home. Therapists may find it helpful to involve supportive family members as 'co-therapists' who can help the client make time for themselves and support them through the therapy. Family members can be a source of encouragement and support and may be more successful than the therapist on his or her own in getting the client to do what is needed.

- Family members can create restrictive conditions that prevent people from developing or sustaining friendships and cause them to become isolated, a major cause of depression. Restricted access to work and education for women has also been shown to significantly affect levels of depression (Amowitz et al 2003). Family members who have a good relationship with the client as well as with dominant family members may be able to act as mediators/ intermediaries in such situations. Religious teachings about individuals' rights can also

increase the confidence of clients to challenge injustices they feel are contributing to their depression. Where a therapist feels that family relationships are abusive to the extent of breaking the law, for example where violence or abuse of children is involved, the normal process for dealing with such situations should be followed.

In line with the culturally adapted version of BA on which this manual is based, it is recommended to consult with the client about family involvement during the first session of therapy. However, some therapists suggested that family members could be involved before sessions start, in order to obtain support and enhance their understanding of how therapy might help the client. In all cases it is important that the client decides whether or not family members should be involved and that he or she is able to discuss this without family members being present. The therapist should discuss family involvement more than once with clients - our research showed that some clients did not realise or remember that this option was possible and felt it would have been valuable.

The adapted approach to BA developed by Kanter (2010) contains specific suggestions for how to discuss family involvement in treatment with the client and these were confirmed by our own evidence as likely to be helpful for Muslim clients:

"First, the therapist should tell the client that it is up to him/her how much their family can be involved, but the therapist would like the family to be involved to help the client with the primary goal of treatment—taking action. Family members can be useful in reminding clients about activation assignments and encouraging completion of assignments. Thus, ideally family members are fully informed about the treatment plan and the functional conceptualization of depression as presented in BA. Often, family members will appreciate meeting with the therapist to learn about the diagnosis of depression, what it means, and the treatment plan.

In addition, often family members inadvertently reinforce avoidance, passivity, and other depressed behaviours by taking responsibility from the client, offering sympathy for sick-role behaviours, and so forth. While BA does not suggest that family members should be cold or uncaring toward the client, the family should be focused on responding to the client in ways that will be helpful in the long run. This may involve contracts between family members that the client will be lovingly encouraged to continue household responsibilities, to get out of bed, and so forth, and that family members will not do the client's dishes, laundry, etc. if so doing will reinforce depressed and passive behaviours.

The therapist should tell the client that family members can be invited to session, and ask the client how he/she feels about inviting family members in to session. If the client is interested in bringing a family member in to treatment, the therapist needs to develop an understanding of the nature of the relationship with the family member. If the person is clearly supportive and helpful, arrangements should be made to bring the person to session as soon as possible and involve the person as much as possible. Ideally, the family member should come to the second session. If a husband is being invited to treatment, the therapist should get the client's permission and call the husband him or herself rather than relying on the client. The therapist should really try to sell the treatment to the husband, convincing the husband to come: "Would you be willing to come to our

session next week? It would be so important for you to come to a session and learn about what we are doing."

If the relationship is more complicated and not clearly supportive, the therapist should tell the client that they will need to work out how to get the family member to be helpful, and it may be an important aspect of treatment. If it is unclear whether the family member can be helpful in session, it is not suggested that the therapist encourage family involvement early in treatment. Instead it is best to spend some additional time with the client determining how and if the person can be supportive.

For example, it obviously is important to work with the client to address the difficulties that may be arising in the home if a spouse is not supportive. If the spouse does not have time because of a busy work schedule, it is important to discuss with the client that it would help facilitate treatment if they could find a time when the spouse could come into session. This may include having sessions in the evening or on weekends if possible or having the spouse come for a short period of time (Kanter 2010).

Community resources
Our fieldwork confirmed that partnering with faith-based and community organisations can support the development of cultural sensitivity in health interventions (Bopp, Wilcox et al. 2009). Key informants felt that therapists who had links within Muslim communities could draw on these as a resource for individual clients and also to raise awareness of mental health issues in ways that would improve wellbeing at the community level. Specific resources mentioned by practitioners and service users are described below:

- **Imams (mosque leaders), sheikhs (experts in Islamic teachings) and other individuals with religious knowledge** (both male and female) may be consulted by clients or therapists for advice and guidance on religious questions and clients may be able to join groups in which religious knowledge can be learnt. Therapists may refer clients to such religious leaders or facilitate their involvement in therapy when depression involves questions of religious belief. Some therapists we spoke to had also worked with imams to promote awareness of mental illness within Muslim communities or to challenge unhelpful community practices that were contributing to depression, through sermons delivered as part of the Friday congregational prayer. Imams who can deliver such sermons in more than one language, including English, will be able to influence a larger proportion of the congregation than those who only deliver the sermon in a single language.

  Collaboration with, or referral to, those who can advise on religious teachings may be particularly helpful when a client holds beliefs about Islamic teachings that contribute to his or her depression. The client may benefit from learning about alternative interpretations of Islam that challenge his or her beliefs. Collaborating with someone from within the client's own community who is respected and has religious authority avoids undermining the client's beliefs and also avoids treating these as inalienable when alternative ways of understanding Islamic teachings exist. Some common practices or interpretations of religion within the Muslim community are not supported by Islamic scriptural teachings (that is, the Qur'an and Hadith),

and may indeed conflict with them, but clients can be unaware this is the case or feel unable to adopt practices that are not supported by other family members. The client should always be involved in deciding whether and how such collaboration takes place and any third party involved should be aware of the need for confidentiality. Some imams already working within professional settings, such as hospitals or community organisations, have developed knowledge of mental health issues and are aware of the need to maintain professional boundaries. They may, however, have multiple calls on their time, making collaboration difficult. Key informants felt that more training and assistance was needed, confirming existing evidence about how collaboration might be supported to increase mutual training and referral structures (Shaikh and Hatcher 2005).

- Alongside medical, or allopathic, treatment and therapy, Muslim clients may also seek help from a range of **alternative practitioners, such as spiritual healers, herbalists (hakims) and homeopaths** (Sembhi and Dein 1998; Shaikh and Hatcher 2005). The context in some of the countries from which Muslims may originate is that trained mental health professionals are rare and greatly outnumbered by traditional healers, who may consequently be the first choice for treatment (Shibre, Spangeus et al. 2008; Shaikh and Hatcher 2005), particularly for older people who have been brought up with this tradition. Furthermore satisfaction with such healers may be higher than with practitioners in health centres (Shibre, Spangeus et al. 2008).

> *"….The two go together very commonly, that people go and see a doctor, but concurrently will see a healer and an Imam and sometimes several healers…"*
> *Therapist*

Existing studies show that alternative treatment is likely to be sought by people from Muslim communities for reasons relating to faith beliefs and accessibility as well as the perceived ineffectiveness and social stigma attached to allopathic treatment (Sembhi and Dein 1998). Amulets and visits to the graves of pious people are not promoted in Islamic scriptural sources but may be perceived as faith-based solutions to depression and our key informants accepted these practices as part of the client's belief system and did not undermine these. Family pressure and positive community opinions may also play a role in promoting these practices (Shaikh and Hatcher 2005).

Studies of South Asian service users in the UK have revealed concerns about communication and attention to religious needs and a need to improve mental-health services (Bowl 2007). Muslim minorities elsewhere have also expressed concerns about confidentiality and lack of trust in service providers (Youssef and Deane 2006) and all these issues were raised by some of our own key informants.

> *"…… their worries are around the therapist, are around confidentiality…..They might tell my parents. They might tell my husband, that type of thing...my wife……."*
> *Mental Health Services Manager*

Lessons can be learned from community practitioners in relation to these issues (Shaikh and Hatcher 2005) and culturally integrated services have resulted from innovative approaches that build on traditional pathways for treating mental health and bring together the diverse models of healthcare (Mubbashar 2000). Key informants did also, however, highlight a risk that the distress of people with depression could be exploited through some alternative practitioners. There were reports of people being charged large sums of money for alternative treatment (see also Dein 2008) and some key informants suggested that those who did not charge for their services were likely to be more credible and work in the interests of the individual.

- **Group activities** were felt to be helpful for many Muslim clients, and offered an opportunity for forming links and friendships that reduced isolation, which can contribute to depression. Discussions in groups formed to support service users can help people make sense of their situation. Involving religious leaders within a group can help reinforce therapists' messages from a religious perspective and address incorrect understanding of Islamic teachings by group members. For example an imam who was invited to speak to members of an aggression management group provided an Islamic perspective on anger. Organising such groups within community venues, such as a mosque, can make them less stigmatising and more accessible to clients. Groups offering religious instruction as well as social groups and adult education classes were also felt to be helpful by many key informants. A key informant who was a service user found English classes a helpful distraction that made her feel 'normal' because the activity was not directly focused on her mental health

7. General Issues when Conducting BA

The following description of strategies for dealing with difficulties during therapy is taken from the manual on which this adaptation is based, developed by Kanter (2010):

What to do when treatment is not a priority

One difficulty is that treatment is often not a main priority for many clients. This causes two main problems: (1) clients begin treatment in a heightened crisis because prior to this point they did not see a need for treatment and (2) once clients begin to feel better they terminate treatment. It is very difficult to address clients beginning treatment in a heightened crisis, but preventative care can be taken to address clients terminating treatment early. For example, in Session 1, the therapist discusses the expected course of treatment. It is important to address in this session that often clients do begin to feel less depressed during the course of treatment, but that it is important not to terminate treatment immediately upon feeling better. The therapist should state that the goal of treatment is to teach the client a new skill – the skill of responding with activation when difficult life events happen and you feel bad. Learning a new skill takes time and it is important to come to sessions and learn this skill, even if you start to feel better immediately. For our research on this manual, we stated that therapy would involve 12 sessions and that we would like the client to commit to at least 6 sessions, even if they felt better beforehand.

In addition, the importance of returning to Session 2 is emphasized, and returning to Session 2 is treated as an activation assignment like any other. Thus, the therapist and the client discuss possible

avoidance patterns that missing Session 2 would represent, obstacles to returning to Session 2 and how to overcome them, and employ other BA techniques to maximize the possibility of a return (e.g., tell someone about the appointment, put reminders in key places).

When a stable decrease in the client's depression is noted it may be advisable to move sessions to bi-weekly then bi-monthly if possible before terminating. By doing this, the therapist is better able to monitor whether the changes and activities discussed in sessions are continuing to generalise outside of treatment when decreasing client and therapist contact.

When clients terminate because of medication
Similar to the example above about when treatment is not a priority, clients may take medication and as soon as the medication relieves depression somewhat they will terminate treatment. Again, discussing this early in treatment is important. The therapist should specifically discuss with the client research that suggests that the combination of psychotherapy and medication is very effective, but medication without psychotherapy may lead to relapse if the medication is discontinued.

When clients are unreliable in attendance
Missing sessions is very common with many clients with lots of environmental stressors. A variety of logistical issues can get in the way, such as transportation, childcare, difficulty getting time off work, family crises, and so forth. Furthermore, if a client does not improve quickly when treatment begins, coming to therapy may become less reinforcing.

These issues are important to address. Session attendance should be treated as a treatment target and submitted to the BA model. This should be done in every session at the end of the session. In other words, obstacles to session attendance should be predicted in advance and plans to overcome these obstacles should be discussed and scheduled. Avoidance of sessions can be treated like other forms of avoidance and discussed with the client. Collaborative arrangements can be made for the therapist to provide a reminder call the day of the appointment, and contingency contracts with the therapist for session attendance can be made. The therapist may write a letter to a client after several no-shows in a row (see Appendix 8).

Doing BA on the fly
In addition, during treatment development a variety of situations led to therapists doing "BA on the fly". This typically occurred over the telephone. In each of the situations described below, therapists tried to make these phone calls consistent with the BA model and to reference issues that had been discussed in therapy.

Client cancels appointment because not feeling well. One example consists of a client calling to cancel an appointment and when asked what the reason for the cancellation is, states something similar to, "I just feel really down. I am just going to stay in bed. I will come in next week when I am feeling better." This is an ideal opportunity to use BA techniques. The therapist can discuss with the client that by staying in bed they are falling into an avoidance pattern. The therapist can briefly discuss the potential short-term benefits of this avoidance pattern and emphasize the long-term problems that will arise from staying in bed (e.g., missing a therapy appointment, not problem solving). Then the therapist can suggest that coming into the clinic for their session would be taking an active step towards feeling better.

Client discusses termination over the phone. In addition, if a client calls over the phone to terminate treatment it is important to stay consistent with BA. Specifically, if the client is terminating and you feel as though the client is ready to leave treatment this situation would be treated differently than if you felt that termination was a form of avoidance. In either situation it would be important to try to get the client in for an additional session. If the client decides to terminate during a session it is important to try to review the termination materials in that session (see Final Session outline). If the decision to terminate treatment is deemed an avoidance pattern, then it is important to use this as an example to walk through the model.

Client calls about a crisis. Another example consists of a client calling in crisis. Assuming the client is not actively suicidal (in which case hospitalization would be considered), this is another ideal situation for BA to be implemented "on the fly". It is important in such a situation to get a brief, yet clear idea of the current situation. Then by walking the client through the specific avoidance patterns they are engaging in and identifying action steps they can take to address the difficulty. If a crisis is discussed and coached through over the phone it is essential to put that interaction on the agenda for the following session.

Appendix 1: Behavioural Activation Depression Scale – Short Form (BADS-SF)[4]

Please read each statement carefully and then circle the number which best describes how much the statement was true for you DURING THE PAST WEEK, INCLUDING TODAY.

0 = Not at all 1 2 = A little 3 4 = A lot 5 6 = Completely	0	1	2	3	4	5	6	AC	AV	T
1. There were certain things I needed to do that I didn't do.	O	O	O	O	O	O	O	–		R
2. I am content with the amount and types of things I did.	O	O	O	O	O	O	O	–		–
3. I engaged in many different activities.	O	O	O	O	O	O	O	–		–
4. I made good decisions about what type of activities and/or situations I put myself in.	O	O	O	O	O	O	O	–		–
5. I was an active person and accomplished the goals I set out to do.	O	O	O	O	O	O	O	–		–
6. Most of what I did was to escape from or avoid something unpleasant.	O	O	O	O	O	O	O		–	R
7. I spent a long time thinking over and over about my problems.	O	O	O	O	O	O	O		–	R
8. I engaged in activities that would distract me from feeling bad.	O	O	O	O	O	O	O		–	R
9. I did things that were enjoyable.	O	O	O	O	O	O	O	–		–

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[4] The range of scores is 0 to 54, with high scores representing higher activation. Activation = AC; Avoidance/Rumination = AV. For the total score (T), follow the markings on the column furthest to the right. High scores on the total scale indicate greater levels of activation. Items with an "R" in the scoring template should be reverse scored for the total score only, not when computing the Avoidance/Rumination subscale score (for further details see Manos, R. C., Kanter, J. W., & Luo, W. (2011). The Behavioral Activation for Depression Scale-Short Form: Development and validation. Behavior Therapy, 42, 726-739).

Appendix 2: Clarifying Values
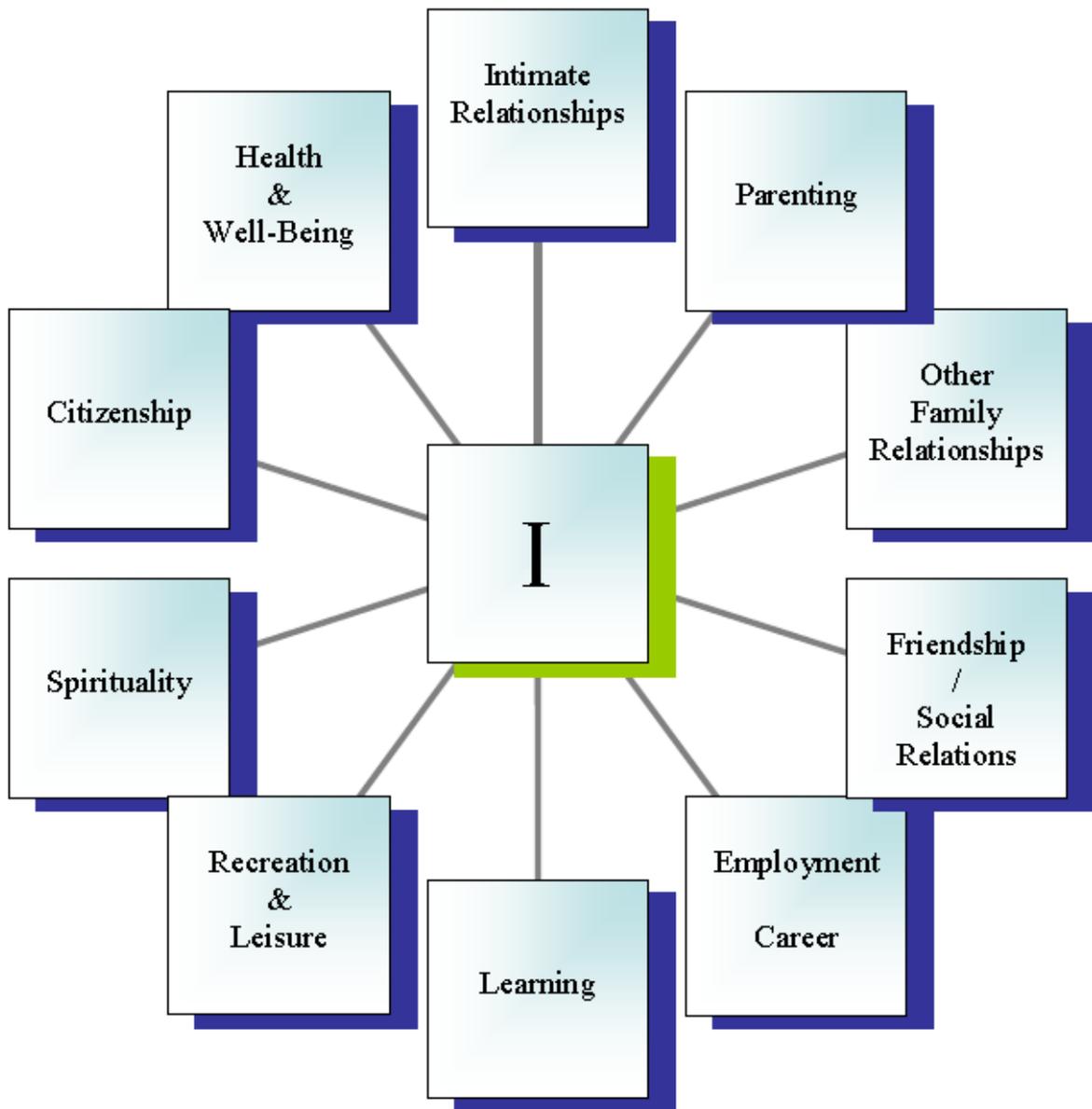
The sheets you are about to fill in are used to help with clarifying your own personal life values.

They list different areas of life that are valued by most people. It may be that you have values in each of these areas, or you may find that some are more relevant to yourself than others. Focus on any area that is of importance to you. This is not a test to see if you have the "correct" values, they are life areas designed to help you work out what your personal values are. You will be describing the qualities that you would like to be present for you in each area. Describe how you would like to treat people, including yourself, if you had the ideal situation. There is no 'right' or 'wrong' way to do this, just 'your way' so it is OK to use extra sheets of paper if needed.

Values Summary Form[5]

What do you care about, what would you want to work towards, in the best of all situations?

1. Marriage/intimate relationship values:

Importance:
Goals /actions:

Thoughts and emotions that could prevent you from living your values:

Write a short paragraph about what it would mean to you to live the value and what it would mean if you didn't:

2.   Parenting values:

Importance:
Goals /actions:

Thoughts and emotions that could prevent you from living your values:

Write a short paragraph about what it would mean to you to live the value and what it would mean if you didn't:

3.   Other family relationship values:

Importance:
Goals /actions:

Thoughts and emotions that could prevent you from living your values:

---

[5] Adapted from Walser R. D. & Westrup D. (2007) Acceptance & Commitment Therapy for the Treatment of Post-Traumatic Stress Disorder & Trauma-Related Problems New Harbinger Publications

Write a short paragraph about what it would mean to you to live the value and what it would mean if you didn't:

4. Friendship / Social Relationship values:

Importance:
Goals /actions:

Thoughts and emotions that could prevent you from living your values:

Write a short paragraph about what it would mean to you to live the value and what it would mean if you didn't:

5. Employment or Career values:

Goals / actions:

Thoughts and emotions that could prevent you from living your values:

Write a short paragraph about what it would mean to you to live the value and what it would mean if you didn't:

6. Learning values:

Importance:
Goals /actions:

Thoughts and emotions that could prevent you from living your values:

Write a short paragraph about what it would mean to you to live the value and what it would mean if you didn't:

7.   Recreation & Leisure values:

Importance:
Goals /actions:

Thoughts and emotions that could prevent you from living your values:

Write a short paragraph about what it would mean to you to live the value and what it would mean if you didn't:

8.   Spirituality values:

Importance:
Goals /actions:

Thoughts and emotions that are /might /could prevent you from living your values:

Write a short paragraph about what it would mean to you to live the value and what it would mean if you didn't:

9. Citizenship values:

Importance:
Goals /actions:

Thoughts and emotions that could prevent you from living your values:

Write a short paragraph about what it would mean to you to live the value and what it would mean if you didn't:

10. Health & Well-Being values:

Importance:
Goals /actions:

Thoughts and emotions that could prevent you from living your values:

Write a short paragraph about what it would mean to you to live the value and what it would mean if you didn't:

Thank you for completing the clarifying values form, I hope we can now use this as a guide for our therapeutic work together. Please use the information you have gathered in this Values Summary Form to complete the Values Action Map.

Values Action Map

Value:			
Goals	Actions	Barriers	Strategies

This form can be used to create a path that will help you achieve one of your values. Pick a value you are willing to work on, and set out some goals linked to the value that feel manageable. There may be short and long-term goals for each value. For each short term goal, write down specific actions, which may involve several further small steps. Then consider what barriers are likely to come up in terms of unwanted experiences or thoughts. For each barrier you list, consider what strategies could help you overcome these barriers.

Appendix 3: Activity Monitoring Form

6 – 7 am						
7 – 8 am						
8 – 9 am						
9 – 10 am						
10 – 11 am						
11 – 12 am						
12 – 1 pm						
1 – 2 pm						
2 – 3 pm						
3 – 4 pm						
4 – 5 pm						
5 – 6 pm						
6 – 7 pm						
7 – 8 pm						
8 – 9 pm						
9 – 10 pm						
10 – 11 pm						

Appendix 4: BA Activity Hierarchy

Activity	Anticipated Difficulty	Assigned	Completed	Actual Difficulty

Appendix 5: BA Activity Homework Sheet

Activity	What/when/where/with whom	Obstacles	Solutions to obstacles	Outcome

Appendix 6: STAYING ACTIVE GUIDE

Things to remember: What was helpful about therapy? What made me feel the best? What is important to remember?

1. _____

2. _____

3. _____

4. _____

How will I notice if I am becoming depressed again? What specific things do I do that suggest I may be depressed?

1. _____

2. _____

3. _____

4. _____

5. _____

Important activities to continue (both activities that I enjoy AND activities that are important to do but I would rather avoid doing):

1. _____

    Obstacles to doing it:_____

    Plan for overcoming obstacles:_____

2. _____

Obstacles to doing it:_____

Plan for overcoming obstacles:_____

3. _____

Obstacles to doing it:_____

Plan for overcoming obstacles:_____

4. _____

Obstacles to doing it:_____

Plan for overcoming obstacles:_____

5. _____

Obstacles to doing it:_____

Plan for overcoming obstacles:_____

Think about the next year of your life. What events—holidays, anniversaries, changes of seasons, specific things your partner may do or may not do—will be difficult for you to handle?

1. _____

2. _____

3. _____

4. _____

5. _____

How will I cope with these events and situations? What specific actions will I take? This list could include talking to family and friends, and calling your therapist for help if you need it.

1. _____

2. _____

3. _____

4. _____

5. _____

Appendix 7: Thought Record Sheet[6]

Situation	Unhelpful Thoughts/Images	Feelings/Physical sensations rate 0 — 100%	Alternative response/what could I do instead?	Action plan / Defusion technique What's the best thing to do?	Re-rate emotion 0 — 100%
What happened? Where? When? (Day & time) Who with?	*What went through my mind? What disturbed me? What did those thoughts/images/memories mean to me, or say about me or the situation? What am I responding to? What 'button' is this pressing for me? What would be the worst thing about that, or that could happen?*	*What emotion did I feel at that time?What else? How intense was it?What did I feel in my body?*	*Is this thought stopping me from doing something more helpful that is more in line with my values? goals? What am I not doing as a result of this thought/image?*	*What could I do differently? What would be more effective? Do something! What will be most helpful for me or the situation? What will the consequences be of doing or not doing....?*	*What am I feeling now? How intense is that feeling now?*

Appendix 8: Follow up letter following several non-attendances

[headed paper]

Date

Dear

Your therapy sessions on [dates]

I'm sorry you were not able to make the sessions we organised on the above dates. I understand that it can sometimes be hard to keep these appointments but I'm writing to encourage you to stick with the therapy even though it might seem difficult at the moment. I am confident that if we work together on the issues you are experiencing this will be more helpful in the long run than avoiding the treatment.

I hope you will agree to meet me on [**date and time**] even if you do not want to continue so that we can discuss this face-to-face. Attending this session will be an active step in trying to deal with the issues you have told me about. If the date or time is not convenient please ring me on the telephone number below to change this. I look forward to seeing you.

Best wishes

[therapist name and contact details]

Appendix 9: Reflection Checklist/Typical Supervision Questions

Session #: _____   Date: _____   Client: _____   Therapist: _____

In this session, did you:			What went well? How would you improve? Self-reflection
1	Discuss your client's problems in a way that was consistent with the BA model?	Y / N	
2	Maintain an activation focus throughout the session?	Y / N	
3	Discuss the client's family or involve the family in treatment?	Y / N	
4	Attend to the client's values, including religious/cultural values, in line with the the extent to which client wished to incorporate these in therapy?	Y / N	
5	Discuss and address obstacles to early termination?	Y / N	
6	Discuss the client's avoidance behavior or potential to avoid?	Y / N	
7	***Identify specific activities for the client to complete…*** ACTIVITY HIERARCHY?	Y / N	
8	…through general questioning?	Y / N	
9	…through use of activity monitoring? ACTIVITY CHART?	Y / N	
10	…through use of values assessment? VALUES ASSESSMENT?	Y / N	
11	Discuss or assign multiple activities related to BOTH mastery and pleasure?	Y / N	
12	***Assign specific activities for the client to complete…*** HOMEWORK SHEET?	Y / N	
13	…and make assignments concrete and specific?	Y / N	
14	…and break complex tasks into components or sequence the steps?	Y / N	
	…and maximize the chance that the client will complete the activity by…		

15	…discussing obstacles and solutions to the obstacles?	Y / N	
16	…mentally rehearsing completion of the activity?	Y / N	
17	…asking client to tell someone else about the activity?	Y / N	
18	…using reminders such as sticky notes, phone messages, and so forth?	Y / N	
19	…discussing with client use of self-rewards for completion of the activity?	Y / N	
20	*Review activities assigned the previous week?*	Y / N	
21	Discuss the importance of integrating activities into routines?	Y / N	
22	Discuss and plan for relapse prevention STAYING ACTIVE GUIDE?	Y / N	

Complete this session:				Complete in the next session:
	Specific assignment:	Did you review?	Estimate percent completion (0 – 100)	Notes on this assignment
1		Y / N		
2		Y / N		
3		Y / N		
4		Y / N		
5		Y / N		

Other reminders:

First session	Maintaining an activation focus	General questioning to identify activities	Specific activity issues

• Listen to client's story and link to 2 circles model:
    • Elicit negative life events
    • Elicit common responses
    • Demonstrate cycle
    • Discuss breaking cycle with activation
    • Summarize activation approach
• Ask for feedback
• Discuss second session
 	
Optional:
• Initial activation assignment
• Activity monitoring
• Values assessment
• Discuss family involvement
	"Action is the key to feeling better, and we can't wait for you to start feeling better, we've got to act first"
	
	Activating is like pushing a car…
	
	Work from the "outside-in"
	
	"What can we do to help you do this even if you don't feel like it…don't feel motivated?"
		• What have you stopped doing?
		• What are you doing ineffectively?
		• What are you avoiding?
		• What problems do you need to solve?
		• What gives you a sense of pleasure?
		• What gives you a sense of mastery?
			Sleep:
			• Sleep hygiene sheet
			• Relaxation
			
			Acculturation difficulties and discrimination (e.g., literacy):
			• Validate
			• Define problem
			• Break into steps
			• Set reasonable expectations
			
			Medical issues:
			• Focus on compliance
			• Make appointments in session
			• Determine obstacles to good care
			• Enlist supportive family

	Early termination		

	• Discuss expected course of treatment in Session 1
	• Tell client not to terminate if feeling better
	• Goal is to teach client a new skill
	• Commit to at least 6 sessions
	• Emphasize returning to next session at end of each session
	    • Troubleshoot obstacles to coming to session
	    • Tell others about the appointment
	    • Put reminders in place		

Typical supervision questions

1. What is the client's depression score? Is the client improving, staying the same, or getting worse?
2. How is your relationship with the client? Do you feel the client has a good, working, trusting alliance with you? Do you feel strong empathy for the client and feel a strong connection with the client? Do you have frustration or other negative feelings about the client that we need to address?
3. How confident do you feel about addressing the client's values in therapy? To what extent have you been able to do this so far?
4. Is the client expressing agreement with the BA model? Does the client understand the relationship between increased activity and improved mood? Does the client understand the focus in BA on concrete homework assignments to get the client more engaged in life?
5. Is the client getting more active? Is the client completing homework assignments?
    a. Are you assigning between 3 and 5 assignments per session?
    b. Are these assignments as concrete and specific as possible?
    c. Are you reviewing potential obstacles to assignment completion with the client?
6. What is getting in the way of the client completing assignments? Can the supervision team come up with additional solutions?
7. What is the client's core issue, and how are we addressing the core issue with activation assignments? Can the supervision team come up with additional ideas for how to activate the client with respect to the core issues?
8. What is the case conceptualization?
    a. Do you feel that, if the client successfully activated in all the ways specified on the case conceptualization, the client would no longer be depressed?
    b. Is there anything about this client that you feel clinically we are not addressing with the BA model? We do not want this model to be only superficial activation; we want it to address the client's core issues as you see them.

Appendix 10: Glossary

Ahadith: plural of Hadith (see below)

Allah – the Arabic name for God. Muslims believe that God has no partners, is neither female nor male and has no beginning or end.

Alhamdulillah: 'praise be to Allah'. Muslims say this to express thankfulness to God or praise Him.

Attributes of God (Names of Allah): the qualities God describes Himself as having in the Qu'ran, such as the The Provider and The Most Merciful (see client booklet for the 99 Names of Allah).

Bismilllah: 'in the Name of Allah' Islamic teachings promote beginning any good action with these words.

Dhikr/Zikr: an Arabic word meaning remembrance of Allah. This can take the form of short supplications that can be recited at anytime to increase one's worship and as a protection from harm, for example, from the evil eye or *jinn*.

Evil eye: the harm that can be caused to a person from the admiration or look of another. Islamic teachings are to pray for blessings on a person if one sees something one likes by saying '*Masha'Allah'*.

Five pillars of Islam: these are the foundations of the Islamic religion that Muslims are required to fulfill (see Client Booklet). The five pillars are: the declaration of belief in One God (*shahadah*); the five daily ritual prayers at appointed times (*salah*); giving a tax on one's wealth to support the needy (*zakah*); fasting in the Islamic month of Ramadan (*sawm*); the pilgrimage to Mecca (*hajj*).

Friday prayers (Jum'a prayers): Muslim men are commanded to attend congregational prayer each Friday at the mosque. The prayer is preceded by a sermon. Many women also choose to attend the mosque for Jum'ah prayer.

Hadith (plural *ahadith)*: a saying or reported action of the Prophet Muhammad. Islam promotes the personal example of the Prophet and Muslims try to emulate his way of life (see *sunnah* below). Alongside the Qur'an, Hadith can be one of the sources of Islamic teachings that Muslims may look to for evidence of what is permissible in Islam or recommended behavioiur.

Hakim: a traditional herbalist.

Halaal: this refers to what is allowed and permissible for Muslims. It applies not only refers to food and drink but to many other areas such as dress, speech and behavior in general. Muslim scholars generally follow the principle that if something is not explicitly forbidden (see *haraam* below) then it is halaal.

Haraam: anything that is forbidden by Islamic teachings. As with *halaal (see above)* this does not apply only to food and drink. Doing something which is haraam is considered sinful.

Imam: the person who leads the prayers in the mosque.

Insha'Allah: 'God willing'. This is often said by Muslims when referring to future action in recognition that only God can be certain about the future.

Jinn: supernatural beings that are described in the Qur'an as part of God's creation. Like humans, jinn can be Muslim or not and can also be good or evil. Jinn can in rare circumstances possess a person and Muslims are taught to protect themselves by reading certain verses of the Qur'an, dhikr (see above) and, if necessary, seeking exorcism by a knowledgeable individual.

Masha'Allah: this means 'as Allah wills' and is often said when admiring or praising something/ someone as a means of avoiding the 'evil eye'.

Mosque: a building in which Muslims offer congregational prayers.

Muhammad: a Prophet described in the Qur'an as the last in a line of prophets sent by God to mankind. Muslims are commanded to say 'peace be upon Him' (in Arabic *'sallalaho allayhi wassallam'*) after saying the Prophet's name. This may be abbreviated in texts to PBUH or SAW.

Prayers (Salat): ritual prayer which Muslims are commanded to perform five times a day at appointed times. The prayers are known as *Fajr* (pre-dawn), *Dhuhr* (midday), *'Asr* (mid-afternoon), *Maghrib* (after sunset), and *Isha* (night). Additional optional prayers can also be performed at any time except when the sun is rising or setting. *Tahajjud* prayers in the last third of the night are especially recommended but are not obligatory.

Qur'an: the revelation of God's word via the Angel Gabriel to the Prophet Muhammad. Alongside the Sunnah (see below), the Qur'an is the scriptural source of teachings about the religion of Islam.

Sheikh: someone with Islamic knowledge and understanding of Islamic law

Subhan'Allah: 'glory be to Allah'. This term is used to praise Allah.

Sunnah: Prophetic tradition, that is, the way in which the Prophet Muhammad conducted himself. Islamic teachings encourage Muslims to follow the Prophet Muhammad's way of life as the best example of how to live in accordance with the teachings of the Qur'an.

Taweez: an Urdu/Punjabi word (Sylheti: *tabij*) meaning an amulet worn in the belief that it willprotect one against jinn or the evil eye. Although there are ahadith that forbid the use of amulets some Muslims may believe these are a means of protecting themselves from harm.

Wudu: ritual ablution or washing that that Muslims perform before they pray. It is usually performed by beginning with the Name of Allah and washing one's hands, mouth, nose, face, forearms, head and feet.

Appendix 11: References

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Appendix 12: Useful resources

Make a list of local organisations to which you can refer clients if appropriate. The organizations below were identified for our pilot study in Bradford, West Yorkshire:

Sharing Voices promotes self-help and mutual support, through community development. Groups are a large part of helping members to develop collective action. Participation in activities of their own choice including fitness, music and faith groups as well as activities around art and which are gender specific. The organisation hosts a 'Listening Imam' service where individuals can arrange to see an imam for religious advice. Address: Clifton House, Clifton Villas, BD8 7BY, Tel:01274 7311 66 , Email:info@sharingvoices.org.uk
http://www.sharingvoices.org.uk/

Roshni Ghar is a community development mental health organisation providing culturally appropriate and responsive support services for South Asian women who live in the Keighley area and are experiencing mental health issues. The organization offers a Spirituality Support Group (for Muslim women), peer-led activities, outdoor activities, Arts and Craft sessions, Walking for health, Individual advocacy, Alternative therapies, Access to allied services and service user involvement on service design and delivery forums.

Address: 13 Scott Street, Keighley, BD21 2JH, West Yorkshire, UK.
Tel: 01535 691758
Mobile/SMS: +447707893549
Web: http://www.roshnighar.org.uk
Email: info@roshnighar.org.uk

Naye Subah ('New Dawn') offers day care and support services for Asian women experiencing mental health difficulties. Provides therapeutic and support groups, drop-in groups, ESOL classes, advice sessions, advocacy, information and outreach. Aims to provide childcare and transport. Opportunities for Asian women to do voluntary work with the project.
Address: Quaker Meeting House, Russell Street, Bradford BD5 OJB
Telephone: 01274 307 639
Fax: 01274 307 644
Contact Name: Ghazala Khan
Email: nayesubah@tiscalli.co.uk
Opening Times: Mon, Tues, Wed, Fri 9.30am – 5.00pm
Supported Languages: English, Urdu, Punjabi. Can provide interpreters.

Websites and online resources:

- Web version of the booklet 'A Brief Illustrated Guide to Understanding Islam':

  http://www.islam-guide.com/

- Muslim Council of Britain:

  http://www.mcb.org.uk/index.php

- Muslim Mental Health:

  http://www.muslimmentalhealth.com/

- Muslim Women's Resource Centre publications including a booklet about what Islam says regarding domestic violence:

  http://www.mwrc.org.uk/#/publications/4535340442

- Muslim youth helpline:

  http://www.myh.org.uk/

- Mind has resources available in various languages:

  http://www.mind.org.uk/help/foreign_language_resources

- Online resource of all the verses of the Qur'an available with translations and in different languages:

  http://quran.com/

- Online searchable website of Qur'an and Sunnah teachings

  http://www.islamicity.com/mosque/sunnah/

- Online resource with prayers from Hadith for different situations, including prayers for worry, fear and pain

- http://www.islamawareness.net/Dua/Fortress/

- This website allows you to type in Arabic words using the transliterated version of the word in English and gives the meaning as well as how the word should sound:

  http://www.islamic-dictionary.com/

- A helpful publication about medications which may be of porcine origin:
  http://www.npci.org.uk/therapeutics/cardio/diabetes1/resources/library_other_publications_drugs_of_porcine_origin.pdf

Appendix 13: Research Project Team and Advisory Group Members

Research Project Team:

Shaista Meer, David Cottrell, Allan House, Judy Wright   University of Leeds

Dean McMillan   University of York

Mohammad Shabbir, Fozia Sarwar   Sharing Voices, Bradford

Paul Carder, Simon Gelsthorpe, Linda Haynes, Yasmin Hussain,
Ghazala Kazmi, Angela Ross, Ann Simon   Bradford District Care Trust

Ali Jan Haider, Mick James, Lynne Carter   Bradford Primary Care Trust

Service User Advisory Group:

Service users of Sharing Voices, Bradford

Project Advisory/Expert Group:

David Ekers   Durham University

Wali Wardak, Rasjid, Skinner, Chris Trepka
Rukhsana Arshad, Khalida Sheikh   Bradford District Care Trust

Suman Fernando   London Metropolitan University

Robbie Foy, Barbara Potrata   University of Leeds

Nusrat Husain   University of Manchester

Philip Thomas, Mohammed Rashed   University of Central Lancashire

Simon Dein   University of Central London

Mohammad Ayub   NHS Newcastle

Adeel Iqbal   NHS Bradford

Saeed Maan   Maan Somali Mental Health

Farooq Naeem   Queens University, Canada