



## Research report

## Adapted behavioural activation for the treatment of depression in Muslims



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## ARTICLE INFO

## Article history:

Received 19 December 2014

Received in revised form

28 March 2015

Accepted 30 March 2015

Available online 7 April 2015

## Keywords:

Depression

Religion

Muslim

Behavioural activation

Culture

Psychotherapy

## ABSTRACT

**Background:** Incorporating religious beliefs into mental health therapy is associated with positive treatment outcomes. However, evidence about faith-sensitive therapies for minority religious groups is limited.

**Methods:** Behavioural Activation (BA), an effective psychological therapy for depression emphasising client values, was adapted for Muslim patients using a robust process that retained core effective elements of BA. The adapted intervention built on evidence synthesised from a systematic review of the literature, qualitative interviews with 29 key informants and findings from a feasibility study involving 19 patients and 13 mental health practitioners.

**Results:** Core elements of the BA model were acceptable to Muslim patients. Religious teachings could potentially reinforce and enhance BA strategies and concepts were more familiar to patients and more valued than the standard approaches. Patients appreciated therapist professionalism and empathy more than shared religious identity but did expect therapist acceptance that Islamic teachings could be helpful. Patients were generally enthusiastic about the approach, which proved acceptable and feasible to most participants; however, therapists needed more support than anticipated to implement the intervention. **Limitations:** The study did not re-explore effectiveness of the intervention within this specific population. Strategies to address implementation issues highlighted require further research.

**Conclusions:** The adapted intervention may be more appropriate for Muslim patients than standard therapies and is feasible in practice. Therapist comfort is an important issue for services wishing to introduce the adapted therapy. The fusion of conceptual frameworks within this approach provides increased choice to Muslim patients, in line with policy and research recommendations.

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## 1. Background

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

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

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

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

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

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

Using the modification of BA for U.S. Latinos as a framework (Kanter et al., 2010), we conducted a two-part mixed-method study to (1) develop a faith-sensitive adaptation of BA for Muslim patients and (2) test the feasibility and acceptability of the adapted intervention. Because incorporating the specific themes and teachings of a minority religion (Islam) into a mainstream, evidence-based psychotherapy approach was somewhat novel, we describe the process of developing the adapted intervention (Study 1) and the qualitative feedback we received from patients, therapists and administrators associated with testing the feasibility and acceptability of the intervention (Study 2). Our goal was to develop a concrete set of adaptations to the existing BA manual; we anticipated that the adaptation would both help to facilitate effective relationships between therapists and Muslim patients and support therapists to engage patients with respect to their

religious identity. We aimed to achieve this without compromising the core mechanisms and interventions of an evidence-based psychotherapy approach that was developed without such considerations in mind.

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

## 2. Study 1: development of the adapted intervention

### 2.1. Method

#### 2.1.1. Participants

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

#### 2.1.2. Qualitative interview and procedure

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

#### 2.1.3. Data analysis

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

### 2.2. Results

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

#### 2.2.1. Relevance of the BA model

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

### 2.2.2. Social context

The second theme identified was the importance of social context. Our informants commented upon links between depression and environmental stressors affecting Muslim populations that are also documented in the literature – including discrimination and social exclusion (Commission on British Muslims, 2004; Muslim Council of Britain, 2004; Runnymede Trust, 1997), high levels of unemployment, poverty and poor health (CBMI, 2004; Office for National Statistics, 2004, 2013). Other issues identified included possible negative attitudes towards religion, and Islam in particular, by non-Muslim therapists, along with stereotyping, including stereotypes about somatisation in Muslim populations (Gureje et al., 1997). Informants also pointed out that therapies needed to take into account the possibility of beliefs in supernatural causes of depression amongst Muslim patients, the use of faith healers alongside mainstream therapists and the fact that there is some concern about the potential for financial exploitation by such faith healers (Dein et al., 2008).

Key informants highlighted ethnic, cultural and sectarian differences amongst Muslim populations in the UK and the need to distinguish between these diverse influences on how Muslim patients experienced depression. For example, selective religious teachings could be used to reinforce dominant family roles by parents and husbands, without balancing these against their religious responsibilities. This imbalance was perceived to cause or maintain depression in less powerful family members (Table 2). The published literature often conflated religious teachings with other cultural influences (Walpole et al., 2013).

### 2.2.3. Patient–therapist matching

Evidence was mixed about the need for patient–therapist matching. Key informants felt patients could potentially develop trust and openness more quickly with matched therapists and experience less need to explain and justify their values and behaviour. They could also draw on shared metaphors without being misunderstood; evidence from the literature suggested that Muslim therapists may bring understanding and empathy to therapy (Petee, 2009). On the other hand some key informants reported that patients had fewer fears of being judged and fewer

concerns about confidentiality when practitioners did not share the patients' background. A potential disadvantage of non-matching, however, was that racism, poor engagement with religious identity and stereotyping could damage patient–therapist relationships (Gorkin, 1986) (Table 3).

Whilst some key informants promoted patient–therapist matching because of the shared understanding it could offer, others described instances in which both Muslim and non-Muslim practitioners had crossed professional boundaries because of mistaken or biased assumptions about patients and a failure to recognise their own limitations. Practitioner training was seen as often failing to prepare therapists for effective engagement, regardless of background (Table 3).

### 2.2.4. Religion and therapy

The importance of openness to, and specific inclusion of, religious teachings and an 'Islamic way of life,' which is often linked by patients to good health (Walpole et al., 2013), was emphasised by a number of key informants and within the literature. Presenting therapeutic goals through the framework of Islamic teachings was considered by many key informants to be an important means of adapting BA. A range of Islamic teachings was identified as promoting 'positive religious coping' (Pargament et al., 2001) such as resilience, hope, making sense of experience and increased self-esteem (Pargament and Lomax, 2013; Lipsker and Oordt, 1990). Where religious or cultural values were felt to contribute to depression, the importance of supporting patients to explore these more positive interpretations of religious teachings to dispel beliefs that promoted 'negative religious coping' (Pargament et al., 2001) was also emphasised.

However, the recognition of individual differences and diverse levels of interest in religious practice was also highlighted, as it was emphasised that not all Muslim patients would welcome a focus on their religious practice (or lack thereof), for a variety of reasons. It was noted that patients could need professional support to discuss the relevance of their religious values to health and treatment (Mir and Sheikh, 2010). In general, however, a key finding was that therapists lacked training on engaging with patients' religious identity when it was appropriate or potentially beneficial to do

**Table 1**  
Relevance of the BA model.

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*"I again adapt to use a lot of Islamic proverbs and analogies, like 'God helps those who help themselves' and 'if you start, kind of, helping yourself by doing things more or changing your lifestyle and things like that, then you will see benefits and so on ... often, what I found in Muslim, depressed people that, behaviourally, they are not too bad really."*  
ZI, Clinical Psychologist  
*"after I had prayed, because I felt good I wanted to do it again. [...] it was the incentive for me to want to do it again and carry it on."*  
AB, male Service User, English speaker  
*"it's about doing what works, the strategies tend to be behavioural things: 'Do X and you'll feel Y' [...] if I was more informed and knew more about Islamic religious practice I will be better able to suggest directly activities. But I rely more on drawing it from them."*  
SD, Therapist  
*"I do a lot of role play with people [...] if you can help them rehearse ... negotiating their needs and talking about what they want, so I think, I think that can be helpful .... I think that's very compatible with religious practice, I don't think its incompatible, is it?"*  
SN, Family therapist

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**Table 2**  
Social context.

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*"the husband has rights over his wife, the parents have rights over the children and it's always somebody who is in authority has rights over the person who doesn't so it's not the other way round [...] I think it's the Imams of the Mosque that need to say these things and tell the community that, that the children have rights as well."*  
AB, male service user, English speaker  
*"professionals need to know about that political context, and they need to have explored those stereotypes and their own assumptions to start with, to see if they are really open to work with someone who is Muslim and is genuinely curious rather than imposing their own views. So I think they need to know the political - socio-political kind of context"*  
SN, Clinical psychologist  
*"poor physical and mental health. part of it is deprivation, it could be. some people say it's indirect racism"*  
OI, Psychiatrist/Academic

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so, and there was considerable inconsistency in professional practice. A minority of therapists reported that they proactively created space to discuss religion with patients, but most reported a reactive stance: responding only if patients raised the issue. A number of therapists, including Muslim therapists, avoided such discussions altogether and expressed anxieties about the impact of religious discussion on their professional role (Table 4).

### 2.3. Development of the adapted manual

To adapt the BA manual, the above results were discussed by three advisory groups that included all relevant stakeholders in the adaptation process: one of professionals and Muslim patients, another exclusively of Muslim patients and a third virtual expert group of practitioners and academics. An existing BA manual for use with Latinos in the United States (Kanter et al., 2010) was used as the basis of the adaptation. As stated above, much of the manual remained unchanged, and care was taken to maintain the integrity of the basic mechanism of BA, namely, activating the client to increase contact with positive reinforcement. However, several important adaptations were integrated into the manual.

First, regarding social context, the link between the above-mentioned environmental stressors and depression was described in detail in a new section in the manual. Therapists were encouraged to target adverse social circumstances through activation assignments, consistent with the patient's goals and readiness to address these issues. The manual also explained and differentiated between cultural and religious influences on the experience of depression in

Muslim populations. In addition, therapists were encouraged to increase their knowledge of Islam and convey a message of understanding and social inclusion to counter the adverse social context. Therapists were encouraged to accept patients' religious and health beliefs without judgement and to promote BA's basic idea of activating personally meaningful behaviours, whatever the perceived cause of depression. The manual also encouraged therapist self-exploration about preconceived ideas that might lead to stereotyping and prejudice.

A reference list of relevant social organisations and religious experts that therapists could potentially consult was included in the manual; however, findings suggested a need for more research on collaboration with faith healers, given reports of exploitation (Dein et al., 2008). The adapted manual, therefore, promoted collaboration but suggested that therapists work with professionals, such as NHS chaplains, when possible.

Given the mixed findings on patient–therapist matching, the adapted intervention promoted professionalism, a non-judgemental approach and some knowledge of Islam above shared identity as the most important therapist attributes. At the same time, offering a choice of therapist, where possible, was also recommended to accommodate potential patient concerns.

The adaptations to the BA manual to support engagement with religious practice were somewhat novel and will be described in detail. First, the manual advised therapists to assess patient religiosity and tailor the intervention to individual patient needs, depending on level of religiosity and religious identity. Whilst the therapy was always seen as 100% BA, the extent to which religious

**Table 3**

Patient–therapist matching.

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“without knowledge of the kind of cultural background of the patient, and religious background of the patient, it's very difficult to engage them. The language which they speak, sometimes, they use different metaphors or things like that [ . ], which are not understood by other people from other cultures”
XX, Clinical Psychologist
“He said you just need to get married or have a girlfriend and it'll cure all your problems, all your depression go away and you won't need these tablets... I think he was using that because he thought he could get away with me because of he's Asian you know”
GB, male service user, English speaker
“it's about our training; it's easier for us to treat a patient who is coming with a Western model. That's how we think, that's how we've been trained. And that's why I say that ethnic matching doesn't work, and I find at times my Caucasian colleagues to be much more culturally competent than my South-Asian colleagues. Where at least my Caucasian colleagues know their limitations and they are sensitive about it. Some of us, we don't recognise that”
O I, Intercultural therapist, academic
“clinicians need to be not influenced by what's going on in the media; they shouldn't be discriminatory against people, [...] I know plenty of doctors who are like that; racist and all the rest of it”
TB1, General Practitioner
“I think what we have to do is make sure that whoever is in post takes into account all those cultural aspects which might have shaped somebody's experience of depression”
TH Mental Health Service Manager
“there are two extremes, you get very, very religious therapists to those who are, you know, quite anti-religious [...] the value base of the therapist needs to be open to spirituality and religion in some sort of way to enable them to have that kind of connection to a different sort of role that a Muslim might want to be seeking, otherwise it may not, may not work as well [...]. We do get Muslim patients who don't want to see a Muslim therapist as well, you know so we do need to consider that.”
SB, Clinical Psychologist
“a Muslim therapist dealing with the Muslim set of patients could, if they were on, should be on, the same wavelength, make a very big impact, you know in that particular group because the trust element, the openness, all of that can happen quite quickly. Whereas, people may feel that they can't talk about the things that are important to them because that other person won't understand them; you know there may be a therapist who's got a totally different belief system altogether and you're trying to tell them something which is alien to them or doesn't, they can't comprehend; [...] you still need to have that, those skills to be able to provide that therapy.”
TB, Psychological Well-being Practitioner

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**Table 4**

Religion and therapy.

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“it's generally true that as psychiatrists and psychologists. and it doesn't matter what your faith is, that when something related to faith comes we avoid it.”
GI, Intercultural Therapy Academic/Psychiatrist
I don't think I would have the courage.[...] it's generally frowned upon. [...] There was a problem with some of the nurses . because she prayed for somebody. So it's kind of a risk to do that then is it?”
NB, Intercultural Therapy Academic/Psychiatrist
“We look at what's important to the individual, will ask them questions around faith, um family, you know, in terms of their values, in terms of, you know hobbies, interests kind of thing, financial situation. So it's kind of you're getting a whole picture of an individual.”
GT, Mental health service manager
“you may not even go in that territory at all so you may not make an impact with that person either because you don't understand where that individual is in terms of their thinking, in terms of their beliefs from a religious perspective. So therapists have got to be cognisant to that [...] otherwise you can do as much therapy as you want to and you'll never get anywhere.”
TB, Psychological Well-being Practitioner

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behaviour and beliefs were addressed would depend on how important these were to each patient. Assessment of patient values is part of standard BA; however a specific values assessment tool (adapted from [Walsler and Westrup \(2007\)](#)) was included in the manual to facilitate the process and support therapist identification of religious and other important values.

The adapted manual included suggestions for religious activities and encouraged therapists to treat such activity in line with the BA model by scheduling and structuring the behaviour on a case-by-case basis. Where patients' ambivalence about religion contributed to depression, therapists were encouraged to signpost patients to individuals with expertise in Islamic teachings from the list of local resources provided, and to consult experts themselves where necessary.

To increase patient and therapist awareness of and access to Islamic teachings as appropriate, a self-help booklet ([Shabbir et al., 2012](#)) was developed in English and Urdu, inspired by other research on mental health in Muslim communities ([Maan, 2010](#)), and with input from advisory group members and a Muslim clinical psychologist. The booklet avoided sectarian differences and religious teachings that could support negative interpretations of depression or induce guilt. Therapists were advised to only offer the booklet to patients who had identified religion as an important value. The resource was presented as enhancing, rather than substituting for, BA approaches and therapists were encouraged to discuss and draw on the content during sessions, if appropriate.

The final content of the adapted intervention differed from the original manual in terms of: an introduction outlining the need for the adapted therapy; additional resources in the form of a values assessment tool, the self-help booklet and a list of local religious groups and experts; guidance for therapists on how to engage with Muslim patients to treat depression and understand the social context in which these patients live.

### 3. Study 2: feasibility and acceptability of the adapted intervention

#### 3.1. Method

A full description of the methods and results of this open trial is available elsewhere ([Meer et al., 2012](#)). In this paper, we focus on methods relevant to the post-treatment qualitative interviews of therapists and patients who participated in the trial.

##### 3.1.1. Participants

The study was conducted in Bradford, a northern UK city with a 25% Muslim population ([BMDC, 2014](#)). Therapist participants with at least one year of psychological training, and their supervisors, from primary and secondary care mental health services, were invited to participate. Ten therapists subsequently volunteered or were selected by managers to attend an initial two-day training event covering the basic theory of BA, reflexive exercises and use of the adapted therapy. Feedback from trainees following this training was used to further refine the adapted manual before patient recruitment ([Meer et al., 2012](#)). Seven therapists subsequently left the study before recruitment began: two left due to sick leave, three left work, one was refused management permission and one lacked confidence without further training on Islam. Three therapists consequently delivered the intervention.

Patients self-identified as Muslim, following preliminary identification by a recruitment partner who provided information about the study to potential participants. Patient recruitment was slow, despite local demographics. Initially, patient participants were referred to the study by primary care mental health professionals, but recruitment strategies were expanded to include

publicising the study to GPs, secondary care therapists and community organisations. This stimulated referrals, particularly for patients with English as a second language, who had not previously been recruited via mainstream therapy services. A total of 19 patients were enrolled in the trial. Most patients were from Pakistani backgrounds ( $n=17$ ), with one African and one Indian participant, all of whom self-defined as Muslim. The group consisted of five men and 14 women, aged from 23–56 years old, with the sample being more skewed to older service users. The group included those in employment ( $n=6$ ), unemployed or looking after the home ( $n=11$ ), a student ( $n=1$ ), and a carer ( $n=1$ ). Ten patients (50%) received therapy in Urdu, Mirpuri or Hindko rather than English, in contrast to 8% of non-English speaking patients within Bradford mental health services.

Consent covered digital recording of therapy sessions and also qualitative interviews. Of the 19 service users recruited to the pilot, 13 were interviewed for Study 2. The six participants who were not interviewed had not yet completed therapy by the project deadline ( $n=2$ ), were out of the country ( $n=1$ ), did not want any further contact from the researchers ( $n=1$ ), were not well enough ( $n=1$ ) or were not available to speak to the researchers within the study period ( $n=1$ ). Of the 13 patients interviewed, 7 had completed therapy, 5 began sessions but withdrew before completing therapy, and 1 was referred elsewhere during the study.

Therapists, supervisors and team managers were also interviewed. Therapists included those who had delivered the intervention and five therapists who received the training but did not deliver therapy. One of the therapists was male and 4 were Muslim. Five supervisors (1 male) and two team managers (both female) were also interviewed to ensure that management and supervisory issues relating to delivering the intervention were adequately explored.

##### 3.1.2. Therapy and supervision

Patients were offered up to 12 sessions of therapy using the adapted BA manual described above and a minimum of six sessions were recommended. Adaptations to the manual focussed mainly on sessions 1, 2 and the final session. Sessions 1 and 2 were aimed at allowing the patients to tell 'their story' and for the therapist to explain the BA model of depression. The therapist would also ask if the patient would like to involve a family member in their therapy. Family involvement did not require the family member to attend the sessions.

Sessions 3–11 made up the main body of the therapy and followed a format focused on reviewing and scheduling activity linked to valued goals. Sessions included homework assignments that focused on getting the individual active in ways consistent with their values. It was suggested that therapists start with easier activities and work collaboratively with the patient to build up to more difficult, but achievable tasks. In addition to routine therapist supervision, bi-monthly reciprocal supervision meetings were arranged for therapists and supervisors by the research team.

Therapist adherence to the manual was checked by two members of the research team (SM and DM), one of whom is a clinical psychologist. The two researchers independently rated a selection of the therapy recordings against a series of adherence criteria.

##### 3.1.3. Qualitative interview and procedure

Interviews were conducted in person by SM and lasted approximately 90 minutes on average. All interviews were audio-recorded for later coding. Interviewers did not follow a structured protocol but rather followed a topic guide which drew on processes and themes developed in Study 1 to explore participants' views about the

experience and impact of the therapy and any suggested refinements. Specific questions about the manual and training received (for therapists and supervisors) and the client booklet were also included. Our aim was to elicit information relevant to the experience of delivering or receiving the intervention that could then be used to further develop the manual, training and client booklet. We also explored issues relating to recruitment, supervision and management to inform recommendations for future research.

#### 3.1.4. Data analysis

Interview data were coded using NVivo9 software, with 20% double-coding by two researchers, drawing on themes developed in Study 1, and analysed using Qualitative Framework Analysis (Ritchie and Spencer, 2002).

### 3.2. Results

Results relating to therapy delivery are presented below, beginning with the three key areas developed from Study 1 above.

#### 3.2.1. Relevance of the BA model

Therapists generally followed the behavioural model; however some struggled to suggest specific activities to patients, preferring a more exploratory approach than is typically encouraged in BA. Patients confirmed the BA model was acceptable but some critiqued the exploratory approach taken by some therapists; these patients would have appreciated more suggestions about potentially helpful practical activities and more direction from therapists alongside questions about patient preferences. One participant felt a more concrete application of BA could have motivated her to continue:

*I just did not understand the process...they could have said anything such as 'perform your prayers' [...] but they did not say anything like that. [...] When you speak to someone, they should suggest something to overcome those problems. It's one's choice whether to take the advice or not, but at least you have peace of mind that there is something that can be done to resolve the issues, there is some way out to those problems.*

GN, female, 40, Pakistani Urdu speaker

Therapist suggestions were linked by this patient to feeling more hopeful about the therapy without feeling obliged to comply - not to be confused with the patient wanting to be told what to do by therapists.

#### 3.2.2. Social context

Both patients and professionals confirmed the value of family involvement for raising awareness of depression and improving communication and support. However, patients sometimes feared being contradicted by their relatives, or loss of privacy, and some family members refused to be involved. Some therapists also resisted family involvement, giving lack of training, their own perceived role and patient disempowerment as reasons, and some patients reported not being given this option (Table 5).

#### 3.2.3. Patient–therapist match

Interviews confirmed Study 1 results concerning preferences for therapists from shared or non-shared backgrounds; patients additionally highlighted language barriers and anxieties that discussing their behaviour with non-Muslim therapists might reinforce negative perceptions of Muslim communities. Understanding and respect for Islam were important to patients along with a 'genuine' acceptance that the approach was potentially helpful to patients (Table 5).

#### 3.2.4. Religion and therapy

Most patients were very positive about the intervention and felt becoming distant from Islam could cause depression and guilt. Some felt the therapy paid less attention to religion than they had expected. Most therapists recognised the benefits of the approach; however, many lacked confidence to discuss religion. Assessment of therapy adherence revealed that therapists had generally delivered BA in accordance with the adherence criteria (described in Meer et al. (2012)), but religious beliefs mentioned by patients were not followed up at times and use of religion as a resource was sometimes not explored. Qualitative feedback from therapists highlighted barriers such as poor familiarity with Islam and worries that patients would know more or would feel patronised. Some therapists suggested the manual should include a therapist script to support sensitive engagement. Those who had delivered the therapy reported their confidence increased with practice, suggesting confidence is linked to normalising this kind of discussion.

Despite reassurances in the manual and training, therapists who had not delivered the therapy sometimes felt the intervention involved 'preaching' or 'imposing' on non-religious patients and inducing guilt. Even where professionals appeared to accept the value of the approach, an underlying opposition to the religious/Islamic framework was sometimes apparent (Table 6).

Patients felt therapists needed some knowledge about Islam and should make space to discuss religion in order to understand them. Both religious and non-religious patients were recruited to the study and none felt any pressure to try religious activation. Some patients felt they were already active in this area so they did not need this; however one such respondent said he wondered whether he was being punished but had not discussed this in therapy –highlighting the need to ensure existing religious behaviour fulfils a 'positive coping' function (Pargament et al., 2001).

The values assessment tool, used by therapists to guide activation assignments, was considered important by most patients, providing a valuable opportunity to talk about their world view. The tool was often introduced later than recommended because of limited time and was experienced as difficult for therapists in the context of a short intervention and lack of training. Some quotations in Table 6 also suggest therapists could experience an underlying tension when engaging positively with values with which they did not agree.

Patients were overwhelmingly positive about the self-help booklet, describing it as 'brilliant', 'very helpful', 'really good', and feeling 'excited' and 'reassured' that potential support from Islam was acknowledged (Table 6). The booklet's relevance to therapy appeared to have been poorly explained, however, and patients complained that links between the two were absent despite suggestions in the manual for connecting these. One, who dropped out after three sessions, did not receive the booklet and felt 'it would have been useful'; another received the English version although her first language was Urdu.

Therapists' and supervisors' reactions to the booklet differed significantly from those of patients. Whilst many could see the parallels between the Islamic teachings contained in the booklet and therapeutic goals, some therapists felt 'uncomfortable' and unsure about how to use it and again felt scripts in the therapist manual to introduce the resource would be helpful. Three therapists said having less knowledge of Islam than patients would be a barrier to offering the resource; another reported a patient being offended at a non-Muslim therapist offering the booklet. These perceptions were not validated by patients, who said poor familiarity with Islam should not stop therapists from offering the booklet or using the teachings to negotiate goals.

One therapist felt her own Christian identity made the booklet difficult to accept and she preferred to ask patients about Qur'anic

**Table 5**  
Study 2 feedback.

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**Family involvement**  
*"if someone's going to involve a family member it's their role to do that not mine [...] and actually not being trained [...] I think it requires particular skills to manage that [...] could they then feel then actually that they're being ganged up on by the therapist and the family?"*  
 Supervisor TT, White female  
*"I never got them involved. My sister knew I was taking therapy sessions. But I never really expended it out because that's what I would normally do; I would go and tell everyone and then they'll say [in a patronising voice] 'so, how was your therapy today? What did you discuss?' There goes the confidentiality out of the window."*  
 XL, female, 23, English speaker  
*"I knew that my husband wouldn't go. He thinks, it is just, he says no. He is like this. My son is like this. My daughters are studying, they don't have the time"*  
 WB, female, 48, Punjabi speaker

**Patient–therapist match**  
*"The person ought to be genuine, that is the biggest thing. That is my question: that a person should be genuine. You cannot just bring anybody to do it."*  
 BN, male, 48, Punjabi speaker  
*"the person fears that they might think what kind of Muslims are these? [.] if I had discussed [failure to remain clean and to pray] with some non-Muslim [...] I mean, such things, if they are discussed with them, I feel ashamed".*  
 BL, male, Punjabi speaker  
*"religion should be made part of therapy; it is a very important and good thing, but my point is the therapist should be Muslim; he/she would understand our values better. She was English, I think it was [therapist name]; she perhaps can learn about it, get trained but she won't be able to go in depths of it."*  
 GN, female, 40, Urdu speaker.

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**Table 6**  
Therapy and religion.

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*"You look at some religious practices and you think well in them days that would have made perfect sense but these days maybe not, do you know?... I felt that people who needed beliefs [laughs] somehow lacked belief in themselves in a sense... 'as long as I run by the rules nothing bad will happen to me!' Unfortunately, things happen to the best people don't they?"*  
 [...]  
*"the important thing is not whether I agree with it or not, I guess the important thing is if you are willing to pay the price for that. 'Cos I don't have to pay the cost for your religious beliefs! You have to pay the cost."*  
 DF Primary Care Supervisor, White male  
*I have my own faith and my own, sort of, spiritual basis to where I am coming from as an individual. So, reading some of it was quite hard really because you read it as you would recite it as a prayer*  
 TI, Secondary Care Therapist, White female  
*"she gave me a leaflet with all hadeeths [Prophetic teachings] on it, it was brilliant. I knew half of them, but the other ones I didn't know. I even got them checked out by my friend of mine and he said. 'look, you know, 'they're authentic you know, it's right'."*  
 NL, male, 46, English speaker  
*"I felt very distant from my deen [religion]. You know, the fact that I felt like that was a lot of the reason why I was feeling so depressed as well. and to be honest with you, I think just generally people in that position if they went to somebody like a counsellor, just general counsellor where there was no, sort of, emphasis on religion, I don't think it would have been as effective as something that's, you know, that understands, a therapy that understands you from that point of view"*  
 TN, female, 24, English speaker  
*"it was appropriate; because I know there is a solution to every problem in religion."*  
 BH, male, 42, Hindko speaker

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teachings rather than refer to those within the booklet. This suggests a perception of the booklet as conflicting with Christian values, rather than as a resource supporting patients to draw on values that are important to them (Table 6).

These results suggest acceptance of Islamic teachings as a resource for therapy is linked, at least for some therapists, to personal acceptance of religious, or Muslim, identity. Patients could also perceive the act of offering the booklet as therapist acceptance of Muslim identity; one therapist was reportedly invited by a patient to become Muslim in response to her perceived interest in, and acceptance of, Islamic teachings.

### 3.2.5. Impact of therapy

Almost all patients were positive about the therapy, though for some this was a step towards recovery rather than a cure. Patients reported achieving valued goals such as restarting a business, performing prayers, learning more about Islam, reciting scriptures, spending time with children and walking outdoors. One patient who had been 'stepped up' for counselling would have preferred to carry on. Participants who withdrew said that: they were too busy and did not feel any benefit (3), they wanted the therapist to focus more on religion (1) or thoughts (1), session times clashed with a social group (1), they wanted to deal with problems within the family first (1) or that therapy had provided closure (1).

### 3.3. Intervention refinements

Results from Study 2 indicated that therapists and patients needed higher levels of support to engage with and deliver the intervention than had been provided through training or their own institutional resources and processes. In response to feedback about the manual, suggested scripts were added to support introduction of the booklet in ways that emphasised patient choice and acknowledged therapists' own identity and limitations (Mir et al., 2012). This emphasised that therapists were not preaching Islam but exploring the use of religion as a positive resource for patients to whom it was already important.

The manual acknowledged that the values assessment could take time but highlighted this as a key aspect of therapy that should not be rushed. Structured discussion of patients' values linked to concrete actions was emphasised in response to patient feedback that achieving valued goals had been an extremely positive outcome of therapy.

Therapists were additionally advised to repeat invitations to include family members and this option was also included in the self-help booklet. Training and institutional support to increase therapist confidence is indicated in this area, as in using the values assessment, booklet and community resources. Formal access to individuals with expertise in both BA and Islamic teachings is also likely to be needed by therapists delivering the intervention to increase their confidence (Totsuka, 2014) and reduce patient withdrawal or inappropriate 'stepping up'.

Refinements to the self-help booklet in response to Study 2 findings included providing information to patients about the therapy intervention. An explanation of the BA model was added to the booklet along with the values assessment and other tools provided in the therapists' manual. Increasing patient access to the process and model of therapy was intended to raise patient expectations and control of the therapeutic process and reduce the gatekeeping role of therapists. The text created links between the manual and self-help booklet and provided information to patients about how the booklet should be used. We suggest that more informed patients, who are less reliant on therapists to raise issues of relevance, improve the potential for co-production of therapy to take place.

#### 4. Discussion

Our findings accord with and extend areas and methods for adaption highlighted in Netto et al.'s (2012) systematic review of cultural adaptation studies, contributing empirical data on the form and content of a faith-sensitive therapy for Muslim patients. The study complements related work that has sought to provide culturally adapted treatments for predominantly Muslim populations (e.g., Gater et al., 2010; Naeem et al., 2011; Rahman, 2007; Rahman et al., 2008), adding a specific focus on assessing and incorporating religious beliefs as appropriate. In line with this previous work, the adapted intervention was found to be acceptable to most patients, therapists and referral agencies and feasible in practice, though requiring higher levels of support than we anticipated.

Our evidence confirms that religious identity can be a resource for mental health (Koenig et al., 2012). However, diverging from established practices that do not acknowledge the significance of religious identity is not straightforward. Results suggest that therapist confidence and comfort is an important issue for implementation of this intervention. Use of the self-help booklet, in particular, requires therapists to develop both familiarity with Islamic teachings and confidence to discuss these with patients. The skills needed for such engagement appear to be increased through practice and training; however, management leadership and discussion within therapy teams may also be helpful for influencing attitudes and confidence (Totsuka, 2014).

Our results suggest that some therapists, however, perceive the approach as equivalent to promoting religious activities and this can be a barrier to delivering the adapted therapy in practice. Therapist anxieties about 'imposing' a religious framework or 'preaching' may be understood partly in terms of differences between psychological and religious frameworks. The latter includes prescriptive teachings and may appear to contradict therapist training that promotes negotiation with clients. Some findings confirm that concepts of personal autonomy, prominent in Western thinking about mental wellbeing, can influence therapists' views about patients' religious identity (Fernando, 2010). However, therapeutic approaches do involve a level of instruction – for example, BA therapists promote the therapy model and the benefits of homework assignments (Kanter et al., 2009). Furthermore, our results suggest that patients who wish to increase their religious practice may welcome information about teachings on how to do this, understanding that their actions are choices they can ultimately make themselves.

We suggest the social context within which therapists operate must also be considered to fully understand the level of therapist discomfort we describe. Perceptions of religion and attitudes in Europe have been shaped by historical events, including separation of church and state and relegation of religious teachings to the sphere of private life as 'beliefs', with scientific enquiry replacing religion in public discourse about truth (Asad, 2009). These

cultural influences are likely to inform therapists' understanding and discomfort about discussing religion in clinical contexts (Mir and Sheikh, 2010).

The theme of social exclusion highlighted in our synthesis could be a helpful way of understanding the opposition to a religious framework and distancing from patients' Muslim identity that was expressed by some therapists. Totsuka (2014) suggests that such distancing can reflect therapists' prior negative experiences, or fear, of difference and a position of privilege. From the patient's perspective, therapists who reveal even subtle levels of discomfort with their patients' choice of Islam as a value framework may be experienced by patients as committing 'microaggressions' (Nadal et al., 2014; Sue et al., 2007) that are consistent with the long history of Islamophobia in Europe (CBMI, 2004; CRE, 1998; Said, 1995), replicate existing social exclusion (Laird et al. (2007) and potentially contribute to exacerbating or maintaining depression (Priest et al., 2013). Thus even well-intentioned practitioners may communicate unintended harmful messages, a risk that can be mitigated with training and other efforts to address these obstacles, without blaming the healthcare providers or labelling them as racist (McKenzie and Bhui, 2007).

Our findings offer signposts for how therapist discomfort in this area might be addressed. Patients for whom religion is an important part of their core values should, we suggest, be supported by therapists who do not undermine this aspect of patients' identity, and can sincerely accept that religious values and behaviour can promote mental health. We suggest that therapists whose discomfort results from inability to accept Islam as a potential resource for wellbeing should not deliver the adapted therapy, given that the relationship between therapist and patient is so important to therapy outcomes (Castonguay et al., 1996).

There is general recognition of the need to ensure that psychological treatments are suitably adapted to fit the needs of different cultural groups (Kareem and Littlewood, 2000), as well as evidence from a meta-analytic review that cultural adaptations improve outcomes compared to non-adapted treatments (Smith et al., 2010). Minority religious groups have expressed dissatisfaction with traditional therapies and there is an increasing demand for approaches that incorporate spirituality into therapy (Fernando, 2010) and interventions that address health inequalities (Mir et al., 2013; Walpole et al., 2013). The attention to religious values within our adapted approach responds to these concerns and provides increased choice to Muslim patients in line with national and international guidelines (NICE, 2011; APA, 2010; WHO, 2013). It is likely that patients from this population, particularly those who do not speak English, are under-referred for therapy and low referrals from GPs may result from therapies not addressing their needs (Conner and Heywood-Everett, 1998). The adapted intervention goes some way towards addressing this issue; our evidence indicates that therapists also play a key role in conveying social acceptance of Muslim patients and the legitimacy of Islam as a value framework.

#### 5. Limitations

With a small sample of both patients and therapists, we cannot be confident that all viewpoints have been identified. The effectiveness of the intervention for Muslim patients was assumed and not tested, given that BA is an evidence-based therapy (Ekers et al., 2014). Strategies to enhance implementation were not specifically explored and further research is required to determine how this intervention could most effectively be delivered and evaluated in practice.

#### Role of funding source

The National Institute of Health Research provided financial support for the conduct of the research. The funding source had no involvement in preparation of



the article, study design, collection, analysis and interpretation of data, writing of the report or decision to submit the article for publication.

### Conflict of interest

We confirm that there are no known conflicts of interest associated with this publication and there has been no significant financial support for this work that could have influenced its outcome.

### Acknowledgements

The research was supported by: Mohammad Shabbir and colleagues at Sharing Voices Bradford; Alijan Haider; Mick James and members of the three Advisory Groups established for the study.

This paper presents independent research funded by the National Institute for Health Research (NIHR) under its Research for Patient Benefit (RfPB) Programme (Grant Reference number PB-PG-1208-18107). The views expressed are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health.

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