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The Effectiveness of Low Intensity Cognitive Behavioral Therapy (Li-Cbt) On Reducing Symptoms of Depression in Arab Clients

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THE EFFECTIVENESS OF LOW INTENSITY COGNITIVE BEHAVIOURAL THERAPY (LI-CBT) ON REDUCING SYMPTOMS OF DEPRESSION IN ARAB CLIENTS

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Under the Supervision of Dr. Brettjet Cody

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Declaration of Original Work

I, Safa Ali Bait Jameel, the undersigned, a graduate student at the United Arab Emirates University (UAEU), and the author of this thesis entitled "*The Effectiveness of Low Intensity Cognitive Behavioural Therapy (Li-CBT) on Reducing Symptoms of Depression in Arab Clients*", hereby, solemnly declare that this thesis is my own original research work that has been done and prepared by me under the supervision of Dr. Brettjet Cody, in the College of Humanities and Social Sciences at UAEU. This work has not previously been presented or published, or formed the basis for the award of any academic degree, diploma or a similar title at this or any other university. Any materials borrowed from other sources (whether published or unpublished) and relied upon or included in my thesis have been properly cited and acknowledged in accordance with appropriate academic conventions. I further declare that there is no potential conflict of interest with respect to the research, data collection, authorship, presentation and/or publication of this thesis.

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Abstract

This study examines whether an awareness of LI-CBT skills would result into the reduction of symptoms of depression in Arab clients. The study exclusively applies two techniques, behavioral activation (BA) and cognitive restructuring (CR), to clients of varying levels of depression residing in the United Arab Emirates. Utilizing a pre-test-post-test design, 50 participants (25treatment and 25control) were included in the analyses of the study and level of depression was measured using the PHQ-9. Results indicate that 76 percent of participants in the treatment group showed improvement in their level of depression, when compared to 30.4 percent of participants in the control group. Findings suggest that Li-CBT may be a plausible intervention for tackling depression among Arab clients.

Keywords: Depression, low intensity cognitive behavioral therapy, cognitive-behavioral therapy, IAPT.

Title and Abstract (in Arabic)

فاعلية العلاج المعرفي السلوكي منخفض الشدَّة في تقليل أعراض الاكتئاب لدى المراجعين العرب

الملخص

تهدف هذه الدراسة إلى تقييم ما إذا كانت مهارات العلاج المعرفي السلوكي منخفض الشدَّة استطاعت أن تقوم بتقليل أعراض الاكتئاب لدى المراجعين العرب. تحديداً، من خلال تطبيق اثنين من التقنيات ، التنشيط السلوكي وإعادة الهيكلة المعرفية على المراجعين بمستويات متفاوتة الشدة من الاكتئاب اللذين يسكنون في دولة الإمارات العربية المتحدة. باستخدام تصميم ما قبل الاختبار وما بعد الاختبار، تم إدراج خمسون مشاركا (خمسة وعشرون يمثلون المجموعة الضابطة و خمسة وعشرون يمثلون المجموعة التجريبية) في التحليل للدراسة وقد تم قياس مستوى الاكتئاب باستخدام مقياس استبيان الصحة للمريض – 9(PHQ-9) .وتشير النتائج أن 76 في المئة من المشاركين في المجموعة التجريبية أظهروا تحسناً في مستوى الاكتئاب لديهم، عند مقارنتهم ب 30.4 في المئة من المجموعة الضابطة. وتشير النتائج إلى أن العلاج المعرفي السلوكي منخفض الشدَّة قد يكون تدخلاً جديراً بالتطبيق لعلاج الاكتئاب بين المراجعين العرب.

مفاهيم البحث الرئيسية: الاكتئاب، العلاج المعرفي السلوكي منخفض الشدَّة، العلاج المعرفي السلوكي، العلاج النفسي،IAPT.

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Dedication

The journey from my humble beginning in the world of knowledge would not have been fulfilled without the support of my late father, for whom I dedicate this thesis. Also, I dedicate my thesis to my mother, brothers and sisters.

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List of Abbreviations

AAH	Al-Ain Hospital
BA	Behavioral Activation
BT	Behavioral Therapy
CBT	Cognitive Behavioral Therapy
CR	Cognitive Restructuring
DSM-5	Diagnostic Statistical Manual -5
EBM	Evidence Based Medicine
IAPT	Improving Access to Psychological Therapies
Li-CBT	Low intensity Cognitive Behavioral Therapy
MS	Medication Support
NICE	National Institute for Health and Clinical Excellence
OPD	Outpatient Department
PHQ-9	Patient Health Questionnaire -9
RCT	Randomized Controlled Trial
SH	Sleep Hygiene
UK	United Kingdom
UAEU	United Arab Emirates University
UAE	United Arab Emirates
WHO	World Health Organization

Chapter 1: Introduction

1.1 Overview

Depression is considered to be one of the most common mental health disorders. Initial Global Burden of Disease (IGBD) studies reported depression to be the fourth leading cause of disease burdens, accounting for 3.7% of total disability (Kemp, et al., 2010; Kirwin & Gören, 2005; Hamre & Glockmann, 2009). Depression is projected to be the second leading cause of disease burdens by 2020 (Murray & Lopez, 1996). It affects between 5% and 10% of the population and was found to be the third most common reason for primary care consultation (Eker, Richards, McMillan, Bland, & Gilbody, 2011; MacPherson et al., 2013). It constitutes one of the most common mental health concerns in psychiatric services around the world (Bower et al., 2013).

Regarding evidence based psychological therapies, CBT is currently the dominant therapeutic model and the first non-pharmacological choice for many psychological disorders. It has been demonstrated to be effective clinically through randomized controlled trials (Chambless & Ollendick, 2001). CBT is conceptualized as a brief, skill and solution-focused approach therapy that is aimed towards solving problems, learning new skills and altering the client's maladaptive emotions and emotional responses by modifying the client's way of thinking, his/her behaviors or both (Aron Beck Institute for Cognitive Behavior Therapy, 2016). There is a substantial evidence for the efficacy and effectiveness of the psychological interventions for depression most of which are CBT treatments, as first-line interventions (Hunsley, Elliott, & Therrien, 2014). Bennett-Levy et al. (2010) reported that in an effort to target more people and decrease the cost of service

delivery and the economic burden of depression, the idea of having less intensive CBT therapies has emerged at the beginning of this century. Bower and Gilbody (2005) has presented different types of low intensive therapies including group treatments and self-help approaches such as computerized therapies and suggested that the best therapy to be used in the stepped care is CBT.

Low intensity CBT is a guided self-help (Li-CBT), established to support individuals with mild to moderate anxiety and depressive disorders. Li-CBT guided self-help has a theoretical and conceptual link to CBT and has been embedded in service provision as a way of ensuring access to psychological treatments for people diagnosed with mild to moderate anxiety and depressive disorder (National Collaborating Centre for Mental Health (NCCMH), 2011).

Li-CBT guided self-help reduces the amount of time the practitioner needs to contact with clients, whether this is reduced through seeing more than one client at the same time (i.e. Group CBT), seeing them for shorter sessions (i.e. advice clinics), supporting their use of self-help materials (i.e. internet-based CBT interventions), or facilitating their engagement with community and voluntary resources (Bennett-Levy et al., 2010; Stallman, Kavanagh, Arklay, & Bennett-Levy, 2016). Practitioners are specifically trained to deliver Li- CBT or those who may not be working in a health profession may conduct Li-CBT sessions (Bennett-Levy et al., 2010; Stallman et al., 2016). “Li-CBT guided self-help training program targets people from a wide range of backgrounds reflecting the local community, with a special interest in psychological therapies, relevant care experience, and who are able to meet the academic levels of the course, are eligible to train as Psychological Well-being Practitioners” (Improving Access to Psychological Therapies (IAPT), n. d). Equally,

in Li-CBT guided self-help, CBT resources are used, but the content is often less intense and provides more rapid access to early intervention and preventive CBT programs (Bennett-Levy et al., 2010).

Richards and Whyte (2009) reported some descriptions about the nature of Li-CBT sessions such as, the therapist's attempt to empower the client by explaining that he/she is the most expert person in his/her condition and that his/her experience gives him/her an authority during sessions that is equal to the therapist. Through Li-CBT guided self-help sessions, the therapist aims to work with the client in order to reach his/her goals by the end of the designated sessions. Perhaps such an empowerment has a substantial influence on the client compliance, in which the client feels responsible for taking actions in his/her life and he/she applies skills learned to achieve the desired results. During Li-CBT guided self-help, the therapist should be equipped with the required therapeutic skills including being non-judgmental, but adhering to the principle of empathy, congruence, and unconditional positive regards. These factors help to establish the required rapport between therapist and the client (Richards & Whyte, 2009).

In the UK, the effectiveness of Li-CBT guided self-help interventions has been extensively evaluated for treating primary symptoms of many psychological disorders. A larger effect was found among clients who were showing more severe symptoms of depression at baseline than those who are not showing severe symptoms (Bower et al., 2013).

Most of the effort to incorporate Li-CBT guided self-help has been centered in western population, in particular, western Europe. There are very few studies that examine the treatment outcomes of Li-CBT guided self-help on non-western

populations. In the Arabian Gulf region, there are epidemiological studies indicating the increased cases of individuals presented with depression disorder (Al-Maskari et al., 2011).

Depression is a global mental health burden that has a negative impact on the individual in terms of disability and the dependency that entails. CBT has been shown to be the best evidenced based therapeutic approach among other psychological therapies for depression. Li-CBT guided self-help has been shown to be an effective method of treating mild to moderate depression among clients in the UK. Li-CBT guided self-help has not only been shown to shorten the time spent in treatment but also had reduced the financial impact of depression. In this research, the researcher aims to examine whether Li-CBT guided self-help is effective in reducing symptoms of depression on Arab clients.

1.2 Statement of Purpose

To the knowledge of the researcher, constructed on using data based search of Google scholar, PsycINFO, PubMed central, ProQuest Central, springer, and Social Science Research Network, no studies have examined the effectiveness of Li-CBT guided self-help among Arab populations diagnosed with depression. This research aims to assess the effectiveness of Li-CBT in reducing symptoms of depression in Arab clients of varying levels of severity. Exclusively, this study will engage two types of Li-CBT guided self-help techniques: Behavioral activation (BA) and Cognitive restructuring (CR), augmented with Sleep Hygiene (SH) and Medication Support (MS), if relevant. The severity of depression and its progress during intervention will be measured using Patient Health Questionnaire-9 (PHQ-9).

1.3 Relevant Literatures

1.3.1 Depression

Depression is one of the most common mental health concerns in psychiatric and primary care settings around the world (World Health Organization (WHO), 2008). The WHO reported the prevalence of Major Depressive Disorder (MDD) among Arab countries to be respectively higher in Morocco (26.5%), Lebanon (12.6%), Iraq (7.5%) and Egypt (6.4%) (Karam et al., 2006; Alhasnawi et al., 2009; Kadri et al., 2010; Ghanem, Gadallah, Meky, Mourad, & El Kholy, 2009).

The American Psychiatric Association (2013) reveals, in the Diagnostic and Statistical Manual-Fifth Edition (DSM-5), that in order for the client to be diagnosed with depression, the following criteria should be met: Symptoms should include five (or more) of the following manifestations. They occur most of the day time and nearly every day for 2 consecutive weeks with a clear change in the client previous functional level with either (1) depressed mood or (2) loss of interest or pleasure. Symptoms include depressed mood either subjective or have been observed by others, marked reduced interest in almost all previously pleasurable activities, significant weight loss when not dieting or weight gain, insomnia or hypersomnia, psychomotor agitation or retardation, feeling fatigue or loss of energy, feelings of worthlessness or excessive or inappropriate guilt, reduced ability to concentrate or think, recurrent thought of death with or without suicidal ideation, plan or intention. These symptoms must cause significant functional impairment in an important area of functioning as social and occupational, symptoms should not be attributable to the physiological effects of a substance or to another medical conditions. The occurrence of the major depressive episode is not better explained by schizoaffective disorder,

schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders and the client have never had a manic episode or a hypomanie episode.

Theories of Depression

There have been many theories explaining the factors leading to depression. One of the well-known theories is the Aaron Beck's cognitive theory. Aaron Beck cognitive theory proposed that depression is the presence of maladaptive or a distorted thinking process that leads to a pattern of emotional, behavioral, and physical symptoms (Beck, 2002).

Beck (2002) argues that in the cognitive triad, clients showing symptoms of depression have unrealistic negative thoughts about themselves in terms of blaming themselves for everything that goes wrong in their lives, blaming the world for being unforgiving and unfair, and perceive the future as bleak and devoid of colors. These thoughts toward the self, the world, and the future stem from maladaptive core beliefs, such as thinking that 'I am defective', "I am a bad person' (Beck, 2002).

The second aspect of Beck's theory addresses dysfunctional assumptions, known as silent assumptions that could be illuminated as follows: When an individual holds a negative belief toward him/herself that could be due to an unpleasant past experiences, he/she starts to create negative irrational thoughts toward him/herself. These negative assumptions are made mainly when the individual goes through unpleasant experiences or after hearing bad comments from people who may be close to him/her such as parents or close friends. Examples of silent assumptions are as follows: "If people get to know me, then they will find out

how useless I am and reject me', 'I must be good at everything I do, otherwise my uselessness will be revealed' (Beck, 2002; Townsend, 2012).

According to Beck (2002), the third aspect of depression theory is information processing, which is considered to be the source of distorted thinking, and misinterpretation of events and information. Clients who suffer from depression are more prone to self-defeating and negative interpretations that will eventually lead them to have low moods, being passive and having low self-esteem. Examples of distorted thoughts are catastrophic thinking (exaggerating a minor problem and making it seem like a disaster), personalization (self-blame and taking responsibility for everything that goes wrong), black and white thinking (seeing everything as either a success or a failure) and selective thinking (when focusing only on the negative details of an event) (Townsend, 2012; Beck, 2002).

The second theory of depression emerged from Behavioral Theory. This view posits that low mood and a loss of interest in previously pleasurable activities gradually leads to complete avoidance of activities and social gatherings (Ottenbreit & Dobson, 2004). Avoiding social activities prevents the individual from receiving psychological rewards, affiliated with positive reinforcement, from participating in these activities. Social isolation and behavioral inhibition prohibit depressed clients of receiving positive reinforcements (Ottenbreit & Dobson, 2004).

According to Richards and Whyte (2009), avoidance behaviors play a major role in maintaining a deeply low mood in addition to the persistence of symptoms of depression. Avoidant behaviors are behaviors used by clients with symptoms of depression trying to escape, prevent or reduce contact with a specific internal or external stimulus that could come in different forms such as thoughts, behaviors,

memories and/or emotions, that could be aversive or have minimal rewards (Ottenbreit & Dobson, 2004).

A third theory is known as the social signal transduction theory. This theory attempts to explain the social-environmental stress and biological aspects of depression (Yang et al., 2016). The social theory also proposes that when individual experience social threats, some components of the immune system will be activated. Activation of these components is involved in the inflammatory process which in turn causes behavioral changes and initiates symptoms of depression (Yang et al., 2016).

Depression and Arabic Cultures

Cultures play a major role in the ability to receive mental health services. The traditional value system among Arabs is collectivist in nature, with a society that has a collective mind-set (Al-Sinawi & Al-Adawi, 2006). In a collective society, self-acceptance is largely the importance of social acceptance and so, collectivist cultures promote enhanced sensitivity to social evaluation (Tafarodi & Smith, 2001). One of the characteristic of collective societies includes social patterning that inhibits showing and expressing emotion. Expression of emotions is not accepted and often viewed as a sign of selfishness. Collective mind-set renders people to lack of self or lack of understanding of themselves as it is known in western psychology (Al-Sinawi & Al-Adawi, 2006).

According to Al-Sinawi and Al-Adawi (2006), lack of insight of self or introspection is a common cultural patterning of collectivist societies, which attributes why people in the Arab world do not seek help for symptoms of depression until the condition reached an advanced level of pathology.

Having no sense of self, the collective people are likely to attribute their mental distress to external forces. For example, studies in Oman have indicated that mental difficulties in Oman are sometimes attributed to external agents i.e. jinn (Al-Sinawi, Al-Adawi & Al-Guenedi, 2008; Al-Adawi, Al-Busaidi, Al-Adawi & Burke, 2012; Chand et al., 2001).

This means that the expression of depression is assumed to be due to the possession of spirits. Such collectivist mindset has many implications for psychiatric services. As people with depression attribute their symptoms to external forces such as the 'Evil eye' or witchcraft, seeking help from traditional healers becomes their first line of intervention. A second implication is that, in collective societies, depression is not perceived as a psychiatric disorder or as having an "intra-psychic conflict", which makes it very difficult for people to see the benefit of psychiatric help to heal themselves (Al-Sinawi & Al-Adawi, 2006; Möller-Leimkühler, 2002)

According to Jaju et al. (2009), in the Sultanate of Oman, the prevalence of depressive disorder among young adults (14-23 years of age) was found to be 3%, which is low in comparison with the international rate of the same age group (7-20%). The rate of detecting depression in the primary care centers was found to be 8.1% which is close to the international rate of 3.6-20% (Al-Salmani et al., 2015), post-partum depression prevalence was 10.6%-13.5% compared with the international prevalence rate of 11% to 42% (Al Hinai & Al hinai, 2014). Al-Sabahi, Al Sinawi, Al-Hinai, and Youssef (2014) found that geriatric symptoms of depression and late life depression was found to be 16.9% compared with the international rate which is 3-40%.

1.3.2 Low Intensity-CBT (Li-CBT) Guided Self-Help

According to the IAPT (n.d.), in the UK, prior to 2008, less than 25% of clients were receiving therapy for depression and anxiety with 2% only receiving CBT. “In the first three years after the IAPT was initiated, IAPT has seen 900,000 more people treated for depression and anxiety, 450,000 clients in recovery, with another 200,000 moving towards recovery, 25,000 fewer people with mental health problems on benefits, and the average waiting time reduced from 18 months to a few weeks” (IAPT, n.d.).

“The global burden because of depression has increased dramatically despite the availability of multiple approaches of therapeutic intervention. There is a growing need for assessing different effective therapeutic interventions that are cost-effective and time limited” (Juice, Freeman, Toplis, & Bienkowski, 2011). The IAPT services program in the UK was developed in 2006 to help improving the mental health services provided to clients with mild and moderate depression and anxiety and being a new protocol, there is few literatures referring to Li-CBT guided self-help techniques (IAPT, n.d.).

NICE guidelines have done rigorous research on the effectiveness of different psychotherapeutic interventions in treating depression and found that many low intensity interventions are effective in treating clients showing depression symptoms (Clark, 2011). Li-CBT guided self-help has been shown to be an effective therapy in treating mild to moderate depression among clients in UK (Bennett-Levy et al., 2010). Bennett-Levy et al (2010) have also reported its effectiveness in treating symptoms of depression of different severities and depression of a co-morbid

presentation as well. Li- CBT has not only been shown to shorten the time spent in treatment, but also the financial impact of depression (IAPT, n.d.).

To date, no study has examined the effectiveness of Li-CBT guided self-help among Arab populations diagnosed with depression. Specifically, this research proposes to assess the effectiveness of two low-intensity psychological interventions BA and CR augmented with SH and MS as a psychological intervention for different severities of depressive disorder

In an attempt to define Li-CBT guided self-help, Bennett-Levy et al. (2010) defined it according to its description that "Li-CBT guided self-help interventions aim to communicate key CBT principles in accessible ways, and deliver content in a variety of flexible forms (e.g. face-to-face, phone-based) which maximize the opportunity for client choice". "Li-CBT guided self-help interventions are simple and brief and focus on the use of CBT self-help materials and techniques. Li-CBT guided self-help emphasizes the value of the between-session homework, and assesses, monitors and evaluates progress as an intrinsic part of the intervention. The content may constitute a treatment intervention in itself (e.g. BA and CR), may support or promote an intervention, and/or may be preventive of treatment interventions. It also increases access to treatment, service flexibility, responsiveness, and capacity, client choice and cost-effectiveness of services" (Bennett-Levy et al., 2010 p. 8-9).

Bennett-Levy et al. (2010) reported that "Li-CBT guided self-help is most convenient for clients in the sense that it can be seen as a 'healthier' 'low dose' of treatment techniques, which often represents less support from a mental health worker in terms of duration or frequency of contact". It also provided self-help

materials that a client can use to follow the instructions and use them as guidance for therapy. In order to provide healing of the self, the researcher believes that, deep understanding of the individual's own mental processing that leads to depression is the key to establishing the journey of therapy. Li-CBT guided self-help builds bridges between client's thoughts, feelings, body physiology and behaviors (Bennett-Levy et al., 2010).

The primary purpose of Li-CBT guided self-help is to increase access to evidence-based psychological therapies to improve mental health, using the minimum level of intervention necessary to create a maximum gain. (Bennett-Levy et al, 2010). It has a theoretical and conceptual link to CBT and has been embedded in service provision as a way of providing access to psychological treatments for people diagnosed with mild to moderate anxiety and depressive disorder in the UK (National Collaborating Centre for Mental Health (UK), 2011; Barton, Karner, Salih, Baldwin & Edwards, 2014). It consists of specific clinical procedures such as BA, CR, medication Support (MS), exposure therapy, problem solving, managing panic and sleep hygiene (SH). Li-CBT guided self-help is known as a guided CBT: During therapy, the therapist is guiding clients through a succession of adopting new skills. In contrast, CBT based self-help, without minimal support, leaves the client to master these skills and be able to apply them independently (Richards & Whyte, 2009).

As reported by Bennett-Levy et al. (2010), the therapist should have the most important basic common factors or skills in dealing with clients, such as: (1) Acceptance: In which the therapist should be able to accept the client no matter what his condition, race ethnicity and beliefs. (2) Genuineness: The therapist uses supportive, nonverbal behavior in harmony by making sure that his words, nonverbal

behavior, and feelings match each other when conducting psychotherapeutic sessions and by being spontaneous in his responses. (3) Unconditional positive regards formulated another important factor that the therapist should be skilled in, showing commitment in his therapy and not cancelling sessions, showing a nonjudgmental attitude and finally displaying warmth through using low tone of voice, facial expressions and body postures, or being aware of the thoughtfulness of his responses. (4) Empathy and Active listening constituted another common factor the therapist should be well versed in. (5) Active listening is achieved by certain skills including clarification, paraphrasing, reflection, and summarizing

The researcher aimed to evaluate the effectiveness of Li-CBT guided self-help as it is shown according to studies undertaken in UK which created a major shift on the provided mental health services and incredibly increased the access to the psychological services and secured the evidenced based CBT to a wide range of the UK population in a very few years of application (IAPT, n.d.). Application of such a therapeutic protocol on Arab population may yield similar results which can help boost mental health services in Arab regions.

The researcher hypothesized that Li-CBT guided self-help will be as effective in mitigating the depression symptoms among Arab population seeking psychiatric consultations in the mental health sector in the UAE. Secondly, it is hypothesized that the effectiveness of Li-CBT guided self-help will be more robust among client presenting with less severe forms of depression.

Chapter 2: Methods

2.1 Participants

Fifty Participants constituted the sample size in this research calculated using the G power with a power of 0.95 and an effect size of 0.8. Participants were selected from the psychiatric OPD in Al-Ain Hospital who have been diagnosed by psychiatrists with depression and had a PHQ-9 score of 5 and above. Most of the participants were females (69.6%). The age of the participants ranged from 18 years to 70 years old. The meant age of the participants was 37.3 and the SD = 10.9. All participants were identified as Muslims and the majority of them completed a secondary school level (43.5 %). Sixty nine percent of participants started on anti-depressant medications. The majority of them had at least a secondary level of education.

In order to be included in this study, participants had to adhere to the following standards 1) Agree to inform their psychiatrist of their participation; 2) be diagnosed with depression based on DSM 5 criteria; 3) be at least 18 and no more than 70 years of age; 4) be cognitively aware and able to communicate and understand the purpose of the study; 5) able to read, write and comprehend Arabic language; 6) not receive any other form of psychological intervention throughout the duration of the study and 7) be free from misusing drugs, alcohol or taking of other drugs for recreation purpose or without the physician prescription.

Participants were excluded from the study in both the experimental and the control group if (1) they failed to inform their treating psychiatrist about their participation in Li-CBT guided self-help sessions (2) the participant was younger than 18 years old ,(3) the participant endorsed having problems with substance

abuse, alcohol dependence, abusing any other self-medicating drugs, or ingesting other intravenous substances prescribed by traditional healers (4) the participant in the experimental group received less than two sessions of Li-CBT guided self-help.

The first 25 participants were allocated to the experimental group 23 participants (Males = 8 (34.78 %), Females = 15 (65.21%) with two clients dropped out and the following 25 participants to the control group. The means of the sessions provided to participants was 4.4 sessions. Ninety-two percent of participants attended two or more sessions of Li-CBT guided self-help. For the control group, 23 participants met the inclusion criteria (n = Males (6) 26 %, Females (17) 73.91 %. All participants were from Arab countries and living in the United Arab Emirates (UAE). The meant age for the experimental group (37.78) was comparable to that of the control group (36.87)

Table 1 shows the distribution of the nationalities of the participants in both the experimental and control groups.

Table 1: Descriptive Statistics of the Nationalities of the participants

Nationality	Experimental Group		Control Group	
	n	%	n	%
United Arab Emirates	14	60.9 %	7	30.4 %
Syria	2	8.7 %	1	4.3 %
Egypt	1	4.3 %	7	30.4 %
Sultanate of Oman	0	0 %	7	30.4 %
Morocco	1	4.3 %	0	0 %
Sudan	2	8.7 %	0	0 %

Palestine	1	4.3 %	1	4.3 %
Somalia	2	8.7 %	0	0 %
Total	23	100 %	23	100 %

Table 2 reflects the frequency and percentage of the gender of the participants and educational level in both experimental and control groups.

Table 2: Descriptive Statistics of the Gender and Educational Level of the Participants

	Experimental Group		Control Group	
Gender	n	%	n	%
Male	8	34.8 %	6	26.1 %
Female	15	65.2 %	17	73.9 %
Total	23	100 %	23	100 %
Educational Level	n	%	n	%
Junior high	2	8.7 %	1	4.3 %
Secondary	10	43.5 %	2	8.7 %
University	7	30.4 %	10	43.5 %
Diploma	3	13.0 %	9	39.1 %
Others	1	4.3 %	1	4.3 %
Total	23	100 %	23	100 %

Table 3 includes the number of participants who are on anti-depressant medication and those who are not on anti-depressant medication in both experimental and control groups.

Table 3**:** Anti-Depressant Medication Use Among Participants

	Experimental Group		Control Group	
	n	%	n	%
Yes	19	82.6 %	13	56.5 %
No	4	17.4 %	10	43.5 %
Total	23	100 %	23	100 %

2.2 Materials

During the first session, a consent form was signed by the participants for acceptance to take part in the research and issues of confidentiality were clearly addressed (see Appendices A and B for English an Arabic forms). A therapeutic contract that summarizes important research issues i.e., Location, Times of Session, Communication with External Agencies, Cancellations, Emergency, Self Help, Termination of Contract and Medications, was also signed by the participants during the first session (see appendices C and D for English an Arabic forms).

Participant information packets were provided in Arabic (see Appendix E for a complete form). Each packet included information about the purpose of the study, how the research will be conducted, the nature of the sessions, what is expected from the participant, what is Li-CBT guided self-help, notice of confidentiality and their right to withdrawal at any time, and the contact information for the researcher.

The PHQ-9 questionnaire is one of the most popular instruments used for making criteria-based diagnoses of depression according to the DSM-IV (Kroenke & Spitzer, 2002). It is a brief self-report tool which is easy to be administered and can be used for different purposes such as monitoring and screening for symptoms of

depression. It consists of a 9-item depression module from the full PHQ that was used previously to assess 8 different psychological disorders. Each participant received an identical Arabic form of the questionnaire to record his/her responses. The questionnaire included 9 items that describe symptoms of depression according to the DSM-IV criteria. It asked the participants to rate each item according to their psychological condition in the last two weeks (Kroenke & Spitzer, 2002).

After the participants rated each items either with 0 = not at all, 1= several days, 2= more than half the day and 3= nearly every day, the researcher assessed the depression severity according to each participant's scores. If the participant scored between (0-4) he/she is diagnosed with minimal depression, (5-9) mild depression, (10-14) Moderate depression, (15-19) Moderately severe depression and (20-27) severe depression (Kroenke & Spitzer, 2002).

According to Kroencke, Spitzer and Williams (2001), the internal reliability and the test-retest reliability for the PHQ-9 was also found to be excellent with a Cronbach's α equal to 0.89 with a mean of 17.1 and a standard deviation equal to 6.1 for depression. In the present research, after translating the PHQ-9 into an Arabic version, construct face validity was assessed by eleven professional bilingual clinical psychologists from different Arabic cultures for their semantic equivalence, cultural sensitivity and acceptability. A back-translation technique was also conducted. The researcher translated the measures from English to Arabic then another bilingual translator from a different specialty was chosen by the researcher and was asked to translate the measures back to the source language (English). After that, the last back-translated version was compared with the original version and resulted in a very close translation to the researcher's translation (Brislin, 1986). The internal

consistency estimates of reliability for the PHQ-9 Arabic version was computed for the 9 items of PHQ-9 and the Cronbach Alpha was fount 0.90.

An example of a questionnaire item that assesses the level of interest in the participant and to what extent his/her depression has affected his/her enjoyment in the past activities is “Little interest or pleasure in doing things” (see Appendices F and G for English and Arabic forms)

2.3 Procedure

This study was approved by the Ethics committee at the United Arab Emirates University as well as the Ethics and Research Review Board at Al Ain Hospital. Moreover, Li-CBT guided self-help sessions were conducted in the psychiatric OPD clinic environment that was reasonably free from distraction. On their arrival, participants were asked to sign a consent form (see Appendices A and B) and a therapeutic contract (see Appendices C and D) and were reminded that they could abandon the research at any time. During the first session, participants were also asked to fill a demographic information form then a clinical interview was conducted for information gathering purposes. Case formulation and goals setting of the Li-CBT guided self-help were outlined. Participants received information about the research orally and in writing in the participant’s information sheets (see Appendix E). Only participants in the experimental group received Li-CBT guided self-help sessions and the PHQ-9 was conducted for them in every session for 6 consecutive sessions. Li-CBT guided self-help sessions were conducted either as a face-to-face or through a phone interview or both.

Behavioral Activation (BA) worksheets were used during the first three sessions (BA session) as part of the Li-CBT guided self-help (see Appendices H1,

H1, H3 and I1, I2 & I3) (Clark et al., 2009). Three worksheets were provided as activities outside of the session such as homework and assignments. First, the Behavioral Activation sheet 1 consists of three questions that ask the patient to outline examples of routine, pleasurable, and necessary activities. In the Behavioral Activation worksheet 2, a hierarchy of the previously outlined activities according to their difficulty are recorded. The Behavioral Activation diary is a document where the outlined routine, pleasurable and necessary activities are scheduled during the week days according to their difficulties (Clark et al., 2009).

Cognitive restructuring (CR) worksheets were introduced in the following three sessions (CR sessions) of the Li-CBT guided self-help (see Appendices J1, J2 and K1 & K2 for English and Arabic forms). There are two CR worksheets: the evidence recording sheet and thought diary. In the evidence recording sheet, it is asked to record thoughts according to specific steps: Identifying the hot thoughts, rate of believing them from 0-100, evidence with and evidence against these thoughts and finally reviewing thoughts in the light of the new evidence (Clark et al., 2009).

Relapse prevention forms are provided to the participants in the experimental group in Arabic language (see Appendices L1, L2 and M1 & M2 for English and Arabic forms). It is composed of statements that the participant answer during the last session to be used as a reference plan for him/her in the future to help learn from current episode of depression and to remind his/her with what techniques worked the best for him/her when were in a depressed mood.

BA technique was conducted in the first three sessions and the CR technique was used in the following three sessions. The Li-CBT guided self-help sessions ended with a relapse prevention plan. Home works and assignments were also

provided for participants during these sessions. The minimum sessions of Li-CBT guided self-help conducted was two and the maximum was six sessions. For the control group, during the first a face-to-face contact, participants were asked to sign a consent form and fill out the demographic information form. The PHQ-9 was conducted only in the first contact and after 6 weeks through a phone conversation.

Design

This thesis is approached using within subject experimental construction and pretest-posttest design. The data were collected in two experimental conditions: In the psychiatric OPD clinic face-to-face semi-structured interviewing or through phone call interviewing for experimental and control groups. Depression (levels: Mild, moderate. moderately severe and severe) was the within subject factor. The rejection level for all analyses was set at $p = .05$.

The PHQ-9 was the measurement tool used for assessing depression severity. From the PHQ-9 items scores, the researcher measured the level of improvement in the severity of symptoms of depression after receiving Li-CBT guided self-help sessions. This level of improvement in symptoms of depression was the dependent variable and it reveals how effective was the Li-CBT guided self-help sessions in reducing the participants' symptoms of depression. Moreover, the items were analyzed independently. Finally, a comparison of the scores of the participants before and after receiving Li-CBT guided self-help in the experimental group was conducted using the Statistical Package for the Social Sciences (SPSS).

Chapter 3: Results

The purpose of this study is two-folds. It aims to examine: (1) Whether Li-CBT guided self-help will be effective in reducing symptoms of depression among Arab clients; and (2) If there is a significant difference in the level of improvement according to the severity of depression. In order to examine the research hypotheses, the 4 dropped out cases were excluded from the analysis firstly, and the statistical analysis was consequently done for 46 participants only. Secondly, data including PHQ-9 scores of the participants and demographic information were analyzed using the Statistical Package for the Social Sciences (SPSS).

Statistical analysis was conducted using independent-samples *t* test, paired-samples *t* test and descriptive statistics. In order to test the first research hypothesis - "Whether Li-CBT guided self-help will be effective in reducing symptoms of depression among Arab clients"- initial analysis was conducted using an independent-samples *t* test.

As a first step, the researcher checked if there is any effect/s of nationality and gender on the level of improvement on the part of the participants using the Independent-Sampled t test for both the experimental and control groups. Results showed no significant differences between UAE national participants and participants from other nationalities. The same result was reached with regard to the existence of potential differences between males and females participants. Therefore, data were pooled for further statistical analysis. The following statistical analysis was conducted using independent-samples t test, paired-samples *t* test and descriptive statistics (Frequencies, Mean and Standard Deviation).

3.1 The Independent-Samples *t* Test

In order to examine the researcher's first hypothesis -" Li-CBT guided self-help will be effective in mitigating the depression symptoms among Arab population seeking psychiatric consultations in the mental health setting in the UAE"- the Independent-samples *t* Test is used. Independent-samples *t* Test is used to assess the difference between the means of the two independent groups (experimental and control groups). The *t* test evaluates whether the mean value of the test variable (Li-CBT guided self-help) for the experimental group differs significantly from the mean value of the test variable for the control group (Salkind & Green, 2012).

The Independent–Samples *t* test was administered to test the difference between the experimental and the control groups in the level of improvement (see Table 4)

Table 4: Independent – Samples *t* Test

Group Statistics							
	Group	n	Mean	SD	*t*	df	*p*
PHQ	Experimental	13	12.15	5.86	4.60	20.43	.00
GAP	Control	23	3.47	4.59			

As Table 4 shows, there is a significant level of improvement in favor of the experimental group when comparing the two independent groups.

Figure 1 shows the PHQ-GAP between the experimental and control groups using a Boxplot graph.

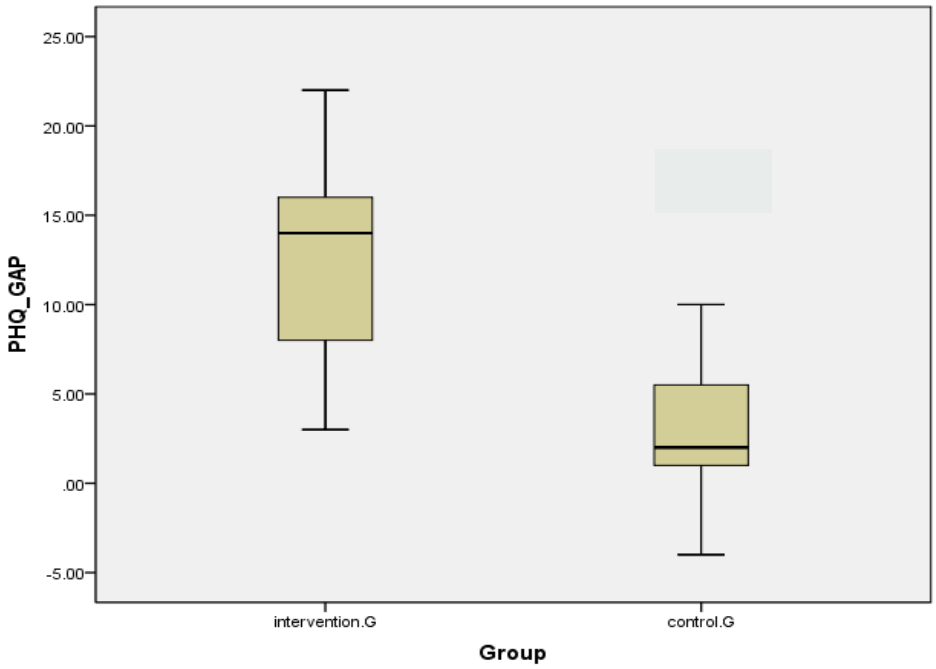

Figure 1: Boxplots for PHQ-9_GAP

The Boxplot also uncovers that in the experimental group there is a wide difference in the PHQ-9 scores compared with the control group where clients PHQ-9 scores are more convergent.

3.2 Paired-Samples *t* test

Regarding the second hypothesis -"the effectiveness of Li-CBT guided self-help will be more robust among client presenting with less severe forms of depression"- besides the purpose of analyzing if there is a significant difference in the level of improvement in participants with different severity of depression and treatment outcome after receiving Li-CBT guided self-help, a paired-samples *t* test and the effect size for paired-samples *t* test (*d*) were conducted to evaluate whether participants in the intervention group had a statistically significant improvement when they received Li-CBT guided self-help by comparing each week with the following week.

According to Salkind and Green (2012), the effect size (*d*) statistics evaluate the degree that the mean of the difference scores deviates from 0 in standard deviation units and is calculated by dividing the *t* value on the square route of N. As *d* diverges from 0, the effect size becomes larger. The *d* values of 0.2, 0.5, and 0.8 (of a standard deviation unit) regardless of sign, are interpreted as small, medium, and large effect sizes, respectively (Salkind & Green, 2012).

The Paired-Samples *t* test is used to evaluate the difference between the mean of each pairs of weeks in the experimental group (see Table 5).

Table 5: Paired-Samples *t* Test for Experimental Group

Paired Samples Statistics				
		Mean	n	SD
Pair 1	PHQ_PRE	17.13	23	5.27
	PHQ_W1	11.34	23	6.71
Pair 2	PHQ_W1	13.11	19	5.90
	PHQ_W2	9.42	19	6.40
Pair 3	PHQ_W2	9.12	17	5.21
	PHQ_W3	8.00	17	4.92
Pair 4	PHQ_W3	7.31	13	4.48
	PHQ_W4	4.00	13	3.06
Pair 5	PHQ_W4	4.00	13	3.06
	PHQ_W5	3.9231	13	3.30

Note. PHQ = Patient Health Questionnaire; PRE = pre-assessment week; W = week.

As shown in table 5, using paired-Sampled *t* test means that we are comparing the scores of the same client across every following week in pairs. If the

client has been discharged, his/her data will not be included in the analysis of the following week. Apparently, the client will automatically be excluded from the statistical procedure. Table 5 also shows that there is a significant difference between three pairs: Week 1 Vs. pre-assessment week, week 2 Vs. week 1 and week 4 Vs. week 3.

Paired-Samples *t* Statistics is used to test if there is a significant difference between each pairs of weeks in the experimental group (see Table 6)

Table 6: Paired-Samples *t* Test between Weeks for Experimental Group

		Paired Differences				
Pairs Numbers	Weeks Comparison	Mean Diff	Pooled SD	*t*	*df*	*p*
Pair 1	PRE Vs. W1	5.78	6.45	4.29	22	0.00
Pair 2	W1 Vs. W2	3.68	5.56	2.88	18	0.01
Pair 3	W2 Vs. W3	1.11	5.27	.87	16	0.39
Pair 4	W3 Vs. W4	3.30	5.03	2.36	12	0.04
Pair 5	W4 Vs. W5	0.08	3.35	.09	12	0.94

Note. PRE = pre-assessment week; W = week; Mean Diff = mean difference; Pair = every pair is comparing the following week with the previews week, for example Pair 1 is comparing week 1 with the previous pre-assessment week.

Table 5 and 6 show that the mean of week one is significantly less than the mean of pre-assessment week with a $p < 0.05$. The effect size, d is (0.89), showing a large effect size suggesting a high practical significance. The 95% confidence interval for the mean difference between the two weeks is 2.99 to 8.57.

The mean of week two is significantly less than the mean of week one with a $p < 0.05$. The effect size, d is (0.66) showing a significant medium effect size

suggesting a medium practical significance. The 95% confidence interval for the mean difference between the two ratings is 1.00 to 6.37.

The mean of week four is significantly less than the mean of week three with a $p < 0.05$. The effect size, d is (0.67) showing a significant medium effect size suggesting a medium practical significance. The 95% confidence interval for the mean difference between the two ratings is -1.95 to 2.10.

As showed in Appendix N, the degree of improvement in response to Li-CBT guided self-help in reference to the depression severity is assessed using the percentage and frequencies, as some participants recovered before the intended last session and is discharged earlier. The researcher compares the percentage for each severity starting from the first session with the following session.

Results clearly show that the number of clients whose initial diagnosis is severe, moderately severe and moderate has been dramatically reduced and those whose initial diagnosis is mild and moderate has increased.

Percentages were calculated to compare the levels of improvement among different severity of depression between the pre-assessment session and the last session (week 5) between the experimental and the control groups (see Table 7).

Table 7: Descriptive Statistics of First Session (PHQ-PRES) and Sixth Session (PHQ-W5S)

	Groups					
	Control			Experimental		
SL	PHQ-9 PRES	PHQ-9 Week 5	Degree of Imp	PHQ-9 PRES	PHQ-9 Week 5	Degree of Imp
ND	0 %	17.39 %	17.39	0 %	69.23 %	69.23
MD	8.70 %	13.04 %	4.34	8 %	23.08 %	15 .08
MOD	21.74 %	34.78 %	13.04	16 %	7.69%	8.31
MSD	39.13 %	13.04 %	26.09	32 %	0 %	32
SD	30.43 %	21.74 %	8.96	44 %	0 %	44
			69.82			168.62

Note. Control group (n= 23); Experimental group (n=13); SL = severity level; PHQ-9 PRES = PHQ-9 scores in the pre-assessment week; ND = No Depression; MD = Mild Depression; MOD = Moderate Depression; MSD = moderately severe; SD = Severe Depression; Degree of Imp = degree of improvement.

As shown in table 7, the degree of improvement among participants in the experimental group is much higher than the control group. The order of depression severity level from the highest recovery rate to the lowest is as follows: Mild and moderate, moderately severe and finally severe depression. At the end of the therapy, the recovery rate (PHQ-9 < 10) of the experimental group is calculated at 76 % and 30.4% for the control group.

Figure 2 showing participant's PHQ-9 scores from the experimental group across Li-CBT's guided self-help six sessions.

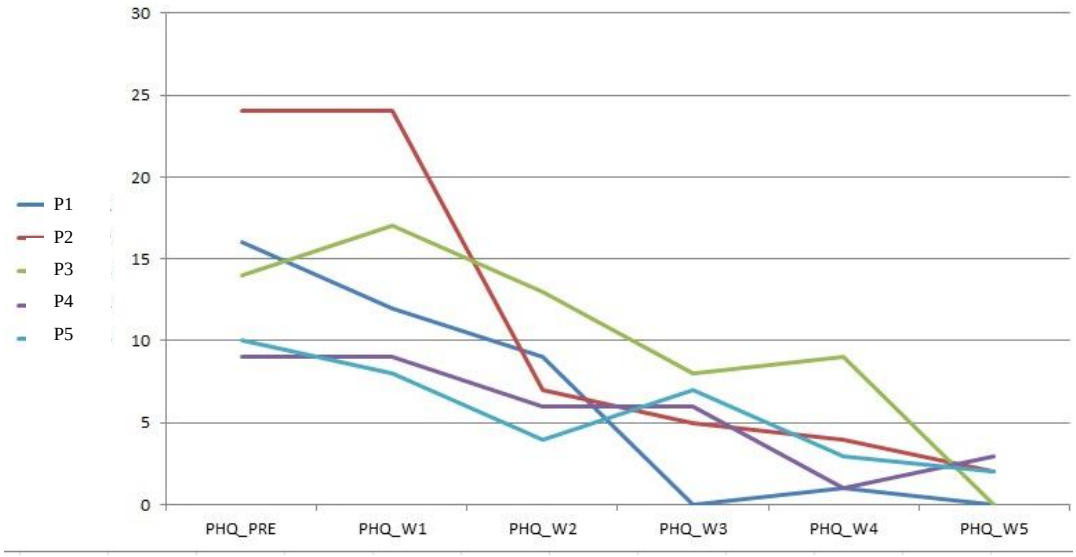

Figure 2: Participants Progress on Patient Health Questionnaire-9 Scores in 6 Sessions. P = participant

As shown in figure 2, participant's PHQ-9 scores was reducing from the first session going to the sixth session.

Chapter 4: Discussion

Since the implication of the Li-CBT guided self-help in the UK to improve the mental health services provided to clients with psychological disorders, researchers have approved that this guided self-help has a substantial effect in improving access to mental health services. Thereupon, Li-CBT was implemented in 2008 through the IAPT services (Exeter, 2012). Li-CBT guided self-help has been mainly developed for participants with mild to moderate psychological disorders (Bennett-Levy et al., 2010). It helped in improving overall mental health services in the UK and was able to increase the number of clients treated from psychological disorders by 900,000 in three years after establishing Li-CBT guided self-help (Exeter, 2012). After extensive evaluations on the effectiveness of Li-CBT, its clinical significance has been approved to treat primary symptoms of a number of psychological disorders (Rodgers et al., 2012).

Based on the literature reviews on the effectiveness of Li-CBT in reducing symptoms of depression, the clinical outcomes in this study are broadly in line with the researcher's expectations. The results of this study suggest that Li-CBT guided self-help is successful in reducing symptoms of depression in Arab participants. These results are almost consistent with previous research findings in the UK. In the UK, similar findings were reported for the effectiveness of Li-CBT guided self-help in reducing symptoms of depression for mild and moderate depression. For example, the recovery rate of Li-CBT reported by the IAPT services in the UK in treating clients diagnosed with depression was 76% (Richards, 2009) and in this study, the recovery rate is similar to Richards findings 76%. The effect size for Li-CBT for

depression as reported by Richards and Suckling (2008) is large (0.8) and in this study the effect size for Li-CBT for depression ranged between large (0.8), medium (0.6) and small (0.4) according to the severity of depression.

The researcher also hypothesizes that Li-CBT is more effective on clients with mild and moderate depression than moderately severe and severe form of depression. As hypothesized by the researcher, results have also showed that the effectiveness of this guided self-help sessions varied among different levels of depression severity, as participants with less severe form of depression have responded better and showed more clinical improvement than those who had severe symptoms of depression. The results of this research contradict with the results reported by Bower et al. (2013), as the former reported a better improvement in response to Li-CBT among clients with more severe form of depression.

Using independent-Samples *t* Test (see Table 1), results reveal a statistically significant difference between participants in the experimental group who had Li-CBT and their counterparts in the control group. This result confirms the researcher's observations and support the research hypothesis. The PHQ-GAP (see Figure 1) also shows a wide difference in the PHQ-9 scores of participants in the experimental group indicating a substantial change and improvement in their symptoms after receiving Li-CBT compared with the PHQ-9 scores of the participants in the control group.

Overall, the recovery rate of participants who had attended Li-CBT guided self-help sessions at least two sessions (including the assessment interview) in our study was found to be 76% by the end of therapy. The recovery rate in the control group reached 30.4% with 44% reached recovery level and 44 % showed a clinical

significant improvement. These results are expected due to the effect of anti-depressant medication prescribed by the client's treating psychiatrist (Fournier et al.; 2010; Kirsch, Moore, Scoboria, & Nicholls, 2002; Kirsch et al., 2008; Chilvers et al., 2001). Recovery of clients could be attributed to the phenomena of spontaneous remission which is the topic of recent research. Spontaneous remission could occur due to many reasons such as positive life events (Johnson, Han, Douglas, Johannet, & Russell, 1998), attributional style and hopefulness (Needles & Abramson, 1990).

When "Li-CBT guided self-help (BA & CR techniques) was offered to Arab clients, participants showed a significant difference in the level of improvement according to their degree of severity of depression" and results showed that there was a statistical significant improvement when comparing every following week with the previous week with different effect size detected using Paired-Samples *t* Test (see Table 5 and 6). These results indicated that the degree of severity of symptoms of depression on the part of the participants was significantly reduced in response to Li-CBT. These improvements varied between each pairs of weeks. For example, when week one was compared with the pre-assessment, week 2 with week 1 and week 4 with week 3, there was substantial improvement in the participant's PHQ-9 scores. Results suggested that the largest effect detected was after the first Li-CBT session which may indicate that the processes of information gathering, problem statement and psycho-education had a great impact on the improvement of the participants. These findings may need further evaluation in future research.

Another observation by the researcher was that after participants started showing positive response to BA sessions, the level of improvement was reduced in week 3 with a small size effect. The researcher attributes this reduction in level of

improvement to the difficulty participants encountered in applying CR techniques. It was reported by many clients that they experienced difficulty in accepting, identifying and modifying their thoughts, as this was the first time for them to practice these techniques. The following week (week4), the level of improvement on the part of the participants increased again with a medium effect size which indicates that, by the second week of applying CR technique, participants started adopting CR techniques and responded positively to it.

During the last comparison between week 5 and week 4, again the level of improvement has dropped with a small size effect size. The researcher inferred that CR techniques may require more sessions to be applied and show a substantial improvement, as it may be difficult for clients to practice it in a self-help way without the support of a therapist (Mark Dombeck, 2008).

The researcher observed that participants with less severe form of depression showed very positive response in terms of attendance, participation, following up appointments and working on homework compared with other participants with more severe symptoms of depression. This was obviously translated through their outcomes in which all participants with mild and moderate depression had reached recovery level (PHQ-9 < 10) by the end of Li-CBT sessions. The results of the current research are similar to those reported by Bennett-Levy et al (2010) of the better improvement reported among clients with mild and moderate depression. This study predicts that adherence rate of Li-CBT is higher among participants with less severe form of depression. It is suggested that future studies will attempt to measure levels of adherence rate to examine this prediction.

In a related scenario, participants who had moderately severe and severe depression showed less compliance and struggled in responding to Li-CBT sessions according to their PHQ-9 scores. Eighty-seven percent (87%) of participants demonstrated moderately severe depression and only 44 % with severe depression recovered by the end of Li-CBT sessions. This could be due to the impact of their ongoing social stressors such as difficulty finding a job, going through a divorce process and/or difficulty to accept retirement from job. The same finding could also be attributed to the fact that this form of Li-CBT sessions is new to the knowledge of the participants. Potentially, they probably had difficulties in understanding and applying them while showing severe symptoms of depression. The later finding suggests that the more severe symptoms of depression are, the less effective is the Li-CBT guided self-help session. This suggestion can be further examined in future research.

The effectiveness of Li-CBT guided self-help was found among participants who had face-to-face or phone conversation interviewing methods. Researchers reported that telephone interview CBT guided self-help was as effective as face-to-face intervention in reducing symptoms of depression (Simon, Ludman, Tutty, Operskalski & Von Korff, 2004; Simon, VonKorff, Rutter & Wagner, 2000; Kessler et al., 2009). The researcher/writer of this study also argues that providing Li-CBT guided self-help through phone conversations motivated clients to participate in the research. This form of intervention may have solved the issue of social stigma of attending mental health clinics, the reason that could also explain participant's acceptance and motivation of having phone calls intervention.

In their feedback toward the phone conversation intervention option, participants confirm that it is the first time to know that a therapeutic session can be provided over the phone. For example, participant N.S said “providing this type of communication in a therapy to reach and help us is a first time for me to hear about”. Ludman, Simon, Tutty, and Von Korff, (2007) has also reported that telephone psychotherapy is very effective in reducing symptoms of depression.

The findings of this research also suggested that BA which was conducted in the first three sessions showed a dramatic improvement on the condition of the participants than CR in terms of reducing symptoms of depression and improvement in their work and social life activities. The findings of this research with regard to the effectiveness of BA techniques in reducing symptoms of depression- when clients with depression were exposed in the initial phase of therapy to BA- were similar to the results reported by Ly et al., (2014). Ekers and Richards (2011) and Ekers, Richards, McMillan, Bland, and Gilbody (2011) reported that behavioral activation appears as effective as CBT in the treatment of depression.

The researcher observed that participants were very compliant with BA, compared to CR techniques. Subsequently, the improvement in symptoms of depression was faster. This result could be due to a number of reasons, such as easy activity scheduling, especially when started on simple daily routine activities leading to a significant improvement in their mood, activities were relatively uncomplicated, time efficient and did not require complex skills to be achieved. This finding is supported by a similar finding in the meta-analysis done by Cuijpers, Van Straten, and Warmerdam, (2007) who reported that activity scheduling BA is a more attractive treatment for depression than CR. Behavioral interventions were reported

by many researchers to be superior to many other psychotherapies as an effective treatment for depression (Ekers, Richards & Gilbody, 2008). Similar to Ly et al (2014), the results show a decrease in symptoms of depression when participants were exposed in the initial phase of therapy to BA techniques.

All these findings support the use of Li-CBT guided self-help with Arab clients diagnosed with depression and have/have not been prescribed anti-depressants medication. The researcher expected improvement on Arab participants exhibiting symptoms of depression in response to Li-CBT guided self-help because regardless of their cultural background, nationality, religion and gender, all humans share a similar component of the sequences of events. All human share similar components of depression in terms of cognitions, behaviors, emotions and autonomic symptoms, that either the participant's cognition or behaviors contribute to his/her feeling of depression.

When participants were asked in every session to reflect on the researcher attitude and communication as a practitioner during sessions (what was the most helpful approach, what they wished to have done differently, what was helpful and what was not) they commented that it was the first time they had been asked to give their opinion on a therapist and a treatment session, which they appreciated and made them feel respected.

The researcher was always showing participants their scores and the change they had made and asked them whether those improvements by numbers met their subjective feeling of improvement. Eventually, the response of the participants was objective. This approach may have increased trust in their own abilities, the Li-CBT guided self-help effectiveness and persuaded the participants to continue their

sessions for a better outcome. The researcher argues that showing resistance and deterioration during Li-CBT sessions could be attributed to the following: Ongoing court cases, ongoing divorce proceedings, and family and social stressors.

The daughter (M.A) of one of the participants thanked the researcher through a phone call for the positive change she had noticed in her mother from the beginning of therapy to the last session. Participant S.K from the second session started planning to look for a job abroad, and finally got her plan into action. She took the ILETS and applied for work in the United Stated of America and she is awaiting their response. Participant S.A, a single mother whose initial diagnosis was severe depression started her private work. Currently, she is working in supplying foods and desserts for parties around the UAE.

Limitations

This research has confronted many limitations. First, one potential limitation of the current study is the duration of the study. In fact, the researcher had only four months to conduct the research which led to the selection of a small sample size for the study, recruiting the first chosen participants by the psychiatrists for the experimental group instead of randomly sampling her participants as scheduled earlier. Further, short time limitations did not allow the researcher to conduct a pilot study prior to the original study and forced her to only analyze one measurement tool (PHQ-9) results. Nevertheless, the researcher used other tools such as GAD-7 and WSAS to assess improvement on the part of the participants in their associated anxiety symptoms and their social life activities. It is possible that the results of this study may have been different if all these factors were controlled and taken into consideration.

Another potential limitation involves the design of the study. The researcher is not able to take measurement readings from participants in the control group in the full six weeks and only took measures for the first and sixth week only. Due to this complication, the researcher had to compare between the two independent groups using only the first and last sessions, which only include 13 participants out of the total of 25 participants. Therefore, the researcher is not able to consider the effects of following up in the control group as well.

Participants started on BA for the three sessions then moved to CR in the following three sessions. This approach allowed the researcher only to comment and comprehend the effectiveness of BA in reducing symptoms of depression, as participants were not being exposed to any other psychotherapy at the start. The researcher was not able to answer which was more effective BA or CR as participants were already exposed to BA in the early sessions and showed improvement. The researcher suggests having two separate groups and each one of them should be exposed to one of these techniques only in order to be able to compare their effectiveness.

Of the challenges the researcher encountered is related to the participants themselves who take time to understand the rationale behind BA, simply because many of them were aware that their negative thoughts are the origin of their problems. Some participants, once they started feeling improvement in their condition, they referred it to anti-depressant medications. Moreover, the concept of being treated by psychotherapy -‘talk therapy’- is still new in the Arab world and it is not yet trusted by people to be effective.

There may be limitations with the representation of nationalities among participants. In the current study, the host hospital preserves most of the working day for UAE citizens (from 8 am to 2 pm) leaving only 2 hours (from 2 pm to 4 pm) for other nationalities to access mental health department services. This meant that non-Emiraties have limited coverage in this study. Future studies are recommended to consider having equal numbers from each nationality.

Implications

The researcher hopes that, this study provides initial evidence that this approach may be effective in reducing symptoms of depression in participants diagnosed with depression in the Arab world, particularly since the research results go in line with researches conducted in UK. Therefore, it may be helpful for researchers in this field to conduct further studies to assess the effectiveness of Li-CBT guided self-help on Arab populations. This suggested approach may improve the quality of services currently on offer to Arab clients.

According to Bennett-Levy et al. (2010), this kind of therapy, with all its various techniques and new approaches of communication (face-to-face, internet based and phone call interviews) may help increase access to psychological therapies and will make clients in need of psychotherapies reachable.

CR and BA techniques can help improving symptoms of depression associated with Arab clients according to the symptoms severity. This can help increase the choices offered for treating depression in Arab communities.

With Li-CBT guided self-help as a new comprehensive, cost-effective, and time limited intervention, client's perceptions may be positively changed toward mental health services and further make psychotherapists seems more approachable,

which will indirectly affect the psychological wellbeing in the Arab region. This guided self-help therapy may also help reduce the economic burden of depression and other psychological disorders in the Arab world. This study will also serve as a gateway to future researches on Li-CBT guided self-help as a treatment of depressive disorder.

Future Suggestions

Future studies are recommended to plan enough time to do a pilot study, to randomly assign participants to research groups and to choose a large representative sample.

Future researchers should also take control group readings during the intervention phase of the experimental group into account in order to have a more accurate comparative analysis using a powerful statistical tool. This approach may have an impact on the study results, as item by item analysis for the full six weeks was not possible to be achieved between both groups.

In order to assess the effectiveness of each technique in Li-CBT guided self-help, the researcher suggests having two separate groups, and each should be exposed to either BA OR CR techniques in order to be able to compare their effectiveness.

One of the researcher's observations was that approximately 95% of participants improved after the first session, which could be due to the process of information gathering, assessment interviewing, psycho-education and/or introduction to BA. Further studies need to be conducted to assess the effectiveness of the first session of Li-CBT guided self-help.

Although the degree of participants' improvement was faster and higher when BA was conducted than CR, most of the participants in the last session -when they were asked which technique helped them more -reported that CR was more effective in changing their mood. This is an area that should be extensively explored in the future.

Conclusion

This study provides preliminary information about the effectiveness of Li-CBT guided self-help in reducing symptoms of depression among Arab participants. Findings support that this type of guided self-help sessions may be effective with Arab clients with a recovery rate of 76% that is equal to the recovery rate in the UK in response to Li-CBT guided self-help.

In addition, this effectiveness or level of improvement was proved to be varied among different levels of depression severity. However, it further underscores the presence of several major gaps in this research. Further, longitudinal researches is required to be applied on Arabs before Li-CBT guided self-help can be recommended as a prevention or intervention strategy of depression.

The aim of this study was to provide an initial insight into the effectiveness of Li-CBT guided self-help for psychologists and psychotherapists as an approved new potential preventive strategy for depression, in order to improve access to psychological services and construct a foundation for future research in this area for adults and perhaps adolescents in the Arab world.

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Appendix

Appendix A– Consent Form – English Version

" The Effectiveness of Low Intensity Cognitive Behavioural Therapy (Li-CBT) on reducing symptoms of depression in Arab Clients "

You will be asked to provide or deny consent after reading this form.

Topic of the research, the researcher(s) and the location

You have been invited to take part in a study to evaluate the effectiveness of Low Intensity Cognitive Behavioural Therapy on Arab Participants diagnosed with depression of different severity.

This study will be conducted by Dr. Safa Ali Aman Bait Jameel in the Department of Humanities and Social Sciences at United Arab Emirates University. The study will take place at Al-Ain Hospital, Department of Psychiatry located at Shakhboot Ibn Sultan Street, Al Jimi – Abu Dhabi – United Arab Emirates

Participation in this study will take 360 minutes for each participant divided as following: one session/week, 60 minutes /session.

First session

10-15 minutes (verbally discussing and signing the therapeutic contract and participation consent using pen and paper)., 40 minutes (conducting therapy)., 5 minutes (filling post-assessment forms), Second – sixth session, 5 minutes (filling post-assessment forms) and 55 minutes (conducting therapy).

Benefit of the research

You will be receiving a full course of six sessions of low intensity cognitive behavioural therapy in six consecutive weeks, one session/week, 60 minutes /session. This research will help us learn about how effective is low intensity cognitive behavioural therapy on Arabs , as it was never been experimented and evaluated before being a new therapy introduced only in England and have showed its effectiveness on participants diagnosed with depression of different severity.

Procedure/setting

Initially, in the first session, you will be filling the demographic information and a pre- Assessment scales through a computerized form. You will also be signing manually a therapeutic contract and the participation consent. This will be done individually in an evaluation clinic at the presence of the therapist- PI who will be conducting the therapy in Al-Ain Hospital, Department of Psychiatry.

Safety Information

You will be informed in details about the therapy that will be applied prior to signing the therapeutic contract and participation consent and that there is no any potential physical or psychological risk by participating to this research.

Confidentiality and Privacy Information

Your private information will be revealed only to the researcher and if it will be revealed any time during therapy you will be informed and asked for your permission and that if the study is published, the data will not be identifiable as yours.

Right to Withdraw

You will be informed verbally and in the participation consent that you can withdraw at any stage in the process without you being penalized or questioned.

Recording sessions

All the therapeutic sessions will be recorded in order to be evaluated by the clinical supervisor to make sure that you are receiving the best quality of therapy by the researcher and also for other purely academic reasons related to the researcher. No information that could lead to your identity will be included in the recorded.

I confirm that I have read and understood the above information sheet and have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw.

I understand that my data will be kept confidential and if published, the data will not be identifiable as mine.

I agree to take part in this study:

(Name and signature of participant) (Date)

(Name and signature of person taking consent) (Date)

Appendix B – Consent Form – Arabic Version

لجنة أخلاقيات البحث للعلوم الاجتماعية
- إفادة الموافقة للمشاركة في الدراسة البحثية -

" فاعلية العلاج المعرفي السلوكي منخفض الشدَّة في تقليل أعراض الاكتئاب لدى المراجعين العرب"

سوف يطلب منك تقديم الموافقة أو منعها بعد قراءة هذا النموذج.

موضوع البحث، الباحثين والموقع
لقد تمت استضافتك للمشاركة في دراسة لتقييم فاعلية العلاج المعرفي السلوكي منخفض الكثافة في تقليل أعراض الاكتئاب لدى المرضى العرب المصابين بأعراض الاكتئاب مختلف الحدة .
هذه الدراسة سوف تقوم بها الدكتورة صفاء بنت علي بن امان بيت جميل من قسم العلوم الإنسانية والاجتماعية في جامعة الإمارات العربية المتحدة. سيتم تطبيق هذه الدراسة في مستشفى العين في إمارة أبوظبي .
المشاركة في هذه الدراسة سوف يستغرق 360 دقيقة لكل مشارك (جلسة واحدة كل أسبوع لمدة 60 دقيقة)مقسمة كالتالي:

الجلسة الأولى

5 دقائق (تعبئة النسخة الإلكترونية لاستمارة قبل التقييم)

10- 15 دقيقة (مناقشة الخطة العلاجية ،عقد العلاج، والموافقة على الاشتراك شفهياً والتوقيع عليهم باستخدام الورقة والقلم).

40 دقيقة (تطبيق العلاج)

الجلسة الثانية – السادسة

55 دقيقة (تطبيق العلاج)

5 دقائق (تعبئة النسخة الإلكترونية لاستمارة بعد التقييم)

الاستفادة من البحث
سوف تستقبل دورة كاملة مكونة من ستة جلسات من العلاج المعرفي السلوكي منخفض الكثافة في ستة أسابيع متتالية بمعدل جلسة واحدة في الإسبوع ، 60 دقيقة للجلسة الواحدة. هذا البحث سوف يساعدنا لنتعرف على مدى فعالية العلاج المعرفي السلوكي منخفض الكثافة على المرضى العرب اللذين تم تشخيصهم باضطراب الاكتئاب بمختلف الحدة، حيث أنه لم يتم اختبار وتقييم هذا العلاج سابقاً كونه من العلاجات الحديثة والتي تم تطبيقها فقط في إنجلترا حيث أظهرت فعاليتها على مرضى الاكتئاب بمختلف الحدة.

الخطوات
بدايةً ، في الجلسة الأولى، سوف تقوم بتعبئة استمارة بياناتك الشخصية ومقاييس قبل التقييم باستعمال استمارات إلكترونية. وسوف تقوم أيضا بالتوقيع يدوياً على عقد العلاج و الموافقة على المشاركة في الدراسة. سوف يتم هذا الإجراء بشكل فردي في عيادة التقييم في حضور الباحث المعالج والذي بدوره سوف يقدم العلاج للمريض في جناح الطب النفسي في مستشفى العين في إمارة أبوظبي.

معلومات السلامة

سوف يتم إعلامك بالتفصيل عن العلاج الذي سوف يقدم إليك قبل التوقيع على عقد العلاج واتفاقية المشاركة في الدراسة وإعلامك بانه لا يوجد هناك أي خطر جسدي أو نفسي محتمل من خلال المشاركة في هذه الدراسة البحثية.

السرية والخصوصية معلومات

إن معلوماتك الخاصة سوف يتم إظهارها فقط للباحث وأنه إذا تم إظهارها في أي وقت خلال الفترة العلاجية سوف يتم إعلامك وطلب الموافقة للسماح بذلك. وإذا تم نشر الدراسة ، فأنه لن يتم تعريف البيانات بانها لك.
أن هذه الخصوصية قم يتم اختراقها في حال كان هناك أي خطر عليك لإيذاء نفسك أو الآخرين، وفي حالة ظهر أي أمر قانوني يجب أن يتم إبلاغه وإشراك الجهة القانونية فيه

الحق في الانسحاب

سوف يتم إعلامك شفهياً وفي استمارة الموافقة للمشاركة في الدراسة بان لديك الحق في الانسحاب في أي مرحلة من مراحل العلاج دون تعرضهم للعقاب أو المسائلة.

تسجيل الجلسات

سوف يتم تسجيل الجلسات التي سوف تقدم إليك خلال الدورة العلاجية وذلك بهدف تقييمها من قب الأخصائي المشرف على الباحث وذلك لضمان تقديم أفضل مستوى علاجي ممكن من قبل الباحث ولأسباب أخرى علمية بحته تخص الباحث. وسوف لن يتم الكشف عن أي دليل قد يكشف عن هويتك.

الموافقة المسبقة

1. أؤكد أنني قد قرأت وفهمت ورقة المعلومات الواردة أعلاه، وأتيحت لي الفرصة لطرح الأسئلة.
2. أنا أفهم أن مشاركتي طوعية وأنا حر في الانسحاب.
3. أنا أفهم أنه سيتم الاحتفاظ بالبيانات بكل سرية وإذا نشرت، فإن البيانات لا يمكن التعرف من خلالها أنها لي

أنا أوافق على المشاركة في هذه الدراسة:

_____	_____
(اسم وتوقيع المشارك)	(اليوم)
_____	_____
(اسم وتوقيع الشخص الذي يوقع الموافقة)	(اليوم)
_____	_____

Appendix C – Therapeutic Contract – English Version

Low Intensity- CBT Therapeutic Contract

This is an **agreement** that helps make clear important practical arrangements and administrative procedures.

Location: We will be meeting at Al-Ain Hospital in the Psychiatric Department Out Participant Department.

Times of Session: We will be meeting every week on (……) at *(……)*. In case of any change in day or time, you will be informed well in advance.

Fees: The service you will receive is completely free of charge.

Confidentiality: I am bound by my professional code of conduct regarding confidentiality. Therefore, anything you tell me in the session is confidential. The only people that have access to your information are my supervisor and myself. I will only breach your confidence if you say something that implies a danger to yourself or others, or if you disclose a legal matter that obliges me to seek legal advice.

Communication with External Agencies: with your permission, we would like to inform your G.P that you are receiving Li- CBT treatment. Also at the end of treatment, we aim to send a discharge notification – indicating the outcome of treatment. This service is free of charge.

Self Help: Li-CBT requires you to actively engage in inter-session tasks and practice (such as reading, diaries, and exercises). This practice is an important aspect of therapy, the purpose of which is that you master these skills and eventually learn to become your own therapist.

Cancellations: I will attempt to reschedule cancelled appointment if you are unable to attend your booked appointment. We do however operate a 24 hours cancellation policy, so please do inform us at least 24 hours before a cancellation

Emergency: My role during our Li-CBT sessions is to support you and help you move towards recovery. However, I am not qualified to be offering emergency care. I will provide you with details of services to contact in case of a crisis or emergency.

Termination of Contract: Both parties have the right to terminate a therapy contract at any time.

Medication: Li-CBT is compatible with most medications. For some disorders, a combined approach (medication and therapy) has been shown to work best. If this is the case I will discuss your options with you.

Signed (Clinician) Signed (participant)

……. ……..

Appendix D – Therapeutic Contract – Arabic Version

عقد العلاج منخفض الشدَّة- العلاج المعرفي السلوكي

هذا هو الاتفاق الذي سوف يساعد على جعل الترتيبات العملية والإجراءات الإدارية المهمة واضحة.

الموقع: سنجتمع في (_____)

أوقات الدورة **:** سوف نجتمع كل أسبوع في (_____) في الساعة (_____). في حال وجود أي تغيير في اليوم أو الوقت، سوف تكون على علم قبلها بوقت كاف.

الرسوم **:** سوف تتلقى خدمة خالية تماما من الرسوم.

السرية أنا مرتبطة بالقوانين المهنية للسلوك بشأن السرية. ولذلك، فإن أي شيء سوف تخبرني به في الجلسة يعتبر سري. الأشخاص الوحيدين الذين لديهم حق الوصول إلى المعلومات الخاصة بك هما الأخصائي المشرف علي وأنا فقط . وسوف أتجاوز هذه السرية فقط إذا قمت بقول شئ قد يشكل خطرا على نفسك أو الآخرين، أو اذا قمت بكشف مسألة قانونية والتي قد تستدعي مني طلب المشورة القانونية.

يتم تسجيل الجلسات دائماً وسوف يتم الاستماع إليها وتقييمها من قبل الأخصائي النفسي المشرف علي في هذه الدراسة حتى يتأكد من انك تتلقى العلاج مني على أكمل وجه وفي أفضل صورة ممكنه وأنه يتوافق مع المعايير المتوقعة من الأخصائي النفسي الذي يقدم العلاج المعرفي السلوكي منخفض الكثافة.

خلال تسجيل الجلسة ، لن يتم الإفصاح عن أي معلومات قد تدل على هويتك. على سبيل المثال سوف يكون المعرف كالتالي " الجلسة الأولى، المريض الأول " . فقط. وسوف يتم التحكم في هذا التسجيل عن طريق رقم سري في الجهاز حتى لا يتمكن أي شخص آخر غير معني من الوصول إليها.

التواصل مع الجهات الصحية الأخرى :بعد إذنكم ، نود إبلاغ الطبيب النفسي الخاص بك بأنك سوف تتلقي العلاج المعرفي السلوكي منخفض الكثافة. وأيضا في نهاية العلاج سوف نقوم بإرسال رسالة نهاية العلاج المعرفي السلوكي منخفض الكثافة والإشارة إلى نتائج العلاج إليه . هذه الخدمة مجانية.

المساعدة الذاتية: العلاج المعرفي السلوكي منخفض الكثافة يتطلب منك المشاركة بنشاط في المهام ما بين الدورات والممارسات (مثل القراءة، والمذكرات، والتمارين). هذه الممارسة تشكل جانبا مهما من جوانب العلاج، والغرض منه هو أن تقوم بإتقان هذه المهارات وتتعلمها في نهاية المطاف لتصبح المعالج الخاص بك.

الإلغاء **:** سوف أقوم بمحاولة إعادة جدولة الموعد الذي تم إلغائه إذا كنت غير قادر على حضور موعدك الذي تم حجزه. ولكن نحن نعمل بسياسة الإلغاء خلال 24 ساعة، لذا يرجى اعلامنا ب 24 ساعة على الأقل قبل الإلغاء.

في حالات الطوارئ : دوري خلال جلسات العلاج المعرفي السلوكي منخفض الكثافة لدينا هو أن أقوم بدعمك، ومساعدتك على المضي قدما نحو التعافي . لذلك، أنا لست مؤهلا أن أقدم الرعاية في حالات الطوارئ. وسوف أوفر لك تفاصيل عن الخدمات التي يمكن الاتصال بها في حالة حدوث أزمة أو حالة طارئة.

إنهاء العقد : كلا الطرفين لديهم الحق في إنهاء العقد العلاجي في أي وقت.

الدواء : العلاج المعرفي السلوكي منخفض الكثافة متوافق مع معظم الأدوية. وقد تبين أن استخدام النهج الموحد (الأدوية والعلاج) في علاج بعض الاضطرابات يعملون معاً بشكل أفضل . إذا كان هذا هو الحال سأناقش هذه الخيارات معك.

توقيع (الأخصائي النفسي) توقيع (المريض)

....

Appendix E – Participant Information Sheet (Arabic Version)

عنوان الدراسة

"فاعلية العلاج المعرفي السلوكي منخفض الشدَّة في تقليل أعراض الاكتئاب لدى المراجعين العرب "

(دراسة مدى فاعلية العلاج المعرفي السلوكي منخفض الكثافة في القيام بتقليل أعراض الاكتئاب لدى المرضى العرب اللذين قد تم تشخيصهم باكتئاب بسطي، متوسط أو شديد الحدة)

عزيزي/عزيزتي (_____) أقدر عاليا مساهمتكم في إنجاز هذا البحث العلمي والذي قد تمت دعوتكم إليه . وقبل اتخاذك القرار من المهم جداً لك أن تفهم لماذا تم القيام بهذه الدراسة وما العلاج الذي سوف تحتوي عليه. خذ وقتك لقراءة المعلومات التالية بانتباه وناقشه مع الآخرين إن كان لديك الرغبة في ذلك؟ لا تتردد في سؤالنا إذا كان هناك أي شيء غير واضح أو كنت بحاجه إلى معلومات اضافيه. هذه الدراسة سوف تقوم بها الدكتورة صفاء بنت علي بن امان بيت جميل من قسم العلوم الإنسانية والاجتماعية في جامعة الإمارات العربية المتحدة. سيتم تطبيق هذه الدراسة في مستشفى العين في إمارة أبوظبي . خذ وقتك في اتخاذ قرار المشاركة أو عدمه.

شكراً لك على القراءة

ما هو الهدف من هذه الدراسة ؟

تهدف هذه الدراسة بصورة أساسية إلى فحص فاعلية استخدام برنامج العلاج المعرفي السلوكي منخفض الكثافة في تقليل أعراض الاكتئاب لديكم عن طريق استخدام تقنيات نفسية وهي إعادة الهيكلة المعرفية ، التفعيل السلوكي بالإضافة إلى الدعم الدوائي ونصائح للنوم الصحي. هدفت هذه الدراسة بصورة أساسية الإجابة على السؤال التالي؟

ما مدى فاعلية البرنامج العلاجي المعرفي السلوكي منخفض الكثافة في تقليل أعراض الاكتئاب لدى المراجعين العرب الذين تم تشخيصهم باضطراب الاكتئاب مختلف الحدة؟

إن الفرضية الأساسية التي قامت عليها هذه الدراسة أن هذا البرنامج العلاجي الحديث نسبيا سيكون أكثر فعالية من البرامج العلاجية الأخرى المستخدمة حاليا في المستشفيات والمراكز العلاجية النفسية في التعامل مع اضطراب الاكتئاب. سوف تستغرق هذه الدراسة مدة 6 أسابيع فقط.

لماذا قد تم اختياري للمشاركة ؟

لقد تم اختياركم في هذه الدراسة بعد ان تم تشخيصكم من قبل الطبيب النفسي المعالج بأنكم تعانون من اضطراب عاطفي يسمى الاكتئاب وهو مختلف الحدة بحيث قد يكون اضطراب بسيط, متوسط أو شديد من حيث الأعراض. وسوف يشارك في هذه الدراسة 5 مراجعا .

هل هو واجب علي أن أشارك في الدراسة؟

المشاركة في هذه الدراسة هي طوعية تماما، وهذا القرار يعود إليك للمشاركة أو عدم المشاركة. وإذا قررت المشاركة سوف يتم توفير ورقة معلومات المريض هذه المعلومات إليك للاحتفاظ بها وسوف يطلب منك التوقيع على نموذج الموافقة. إذا قررت المشاركة في هذه الدراسة ما زالت لديك الحرية للانسحاب في أي وقت وبدون ذكر أي أسباب. إن قرار الانسحاب في أي وقت، أو القرار بعد المشاركة لن يؤثر على مستوى الرعاية الصحية المقدمة إليك.

ماذا سوف يحدث

لي إذا شاركت في الدراسة؟

مدة الدراسة هي ستة أسابيع بمعدل جلسة واحدة في الإسبوع مدتها ما يقارب ستون دقيقة. خلال هذه الجلسة سوف تتلقى العلاج المعرفي السلوكي حديث أثبتت الدراسات الحالية مدى فاعليته على المرضى اللذين يعانون من اضطراب الاكتئاب بصورة دقيقة . من خلال العلاج سوف تتعلم الكثير من المعلومات وتكتسب مهارات حياتيه وفكرية جديدة تمكنك إن شاء الله من التعامل مع أي موقف تمر فيه في حياتك بشكل صحي وإيجابي لا يؤثر على صحتك النفسية.

المسؤولية الملقاة عليك والتي نتوقعها منك أن تنتظم في حضور الجلسات الست المخصصة لتلقي العلاج في الوقت المتفق عليه والالتزام بأي واجبات أو انشطة تحدد إليك من قبل الباحث للتحقق من استفادتك القصوى من البرنامج العلاجي.

طريقة البحث

أحياناً لأننا لا نعلم دائما ما هو تأثير علاج معين على المرضى ، لذلك يجب أن نقوم بالمقارنة. سوف يتم تقسيم المرضى المشاركين في ثلاثة مجموعات وسوف يتم المقارنة بين نتائجهم لاحقا. المجموعة الأولى هي مجموعة التحكم ، وهي التي لن تتلقى أي علاج خلال فترة الدراسة . المجموعة الثانية سوف تتلقى العلاج المعرفي السلوكي المسمى (إعادة الهيكلة المعرفي) . المجموعة الثالثة سوف تتلقى العلاج المعرفي السلوكي المسمى (التنشيط السلوكي) . سوف يتم اختيار المرضى في المجموعات بطريقة عشوائية. إن نسبة تواجدك في أي من هذه المجموعات متساوية.

ماذا علي أن أفعل ؟

نتوقع منك أن تنتظم في حضور الجلسات الست المخصصة لتلقي العلاج في الوقت المتفق عليه والالتزام بأي واجبات أو انشطة تحدد إليك من قبل الباحث المعالج للتحقق من استفادتك القصوى من البرنامج العلاجي.

لا يوجد هناك أي برنامج علاجي محدد يجب أن تلتزم به خلال فترة الدراسة. تستطيع ممارسة حياتك اليومية بشكل طبيعي جداً وممارسة أي أنشطة صحية اعتدت على القيام بها. إذا كنت تعاني من أي أمراض وتأخذ أدوية لها فلا مانع من الاستمرار في أخذها خلال فترة الدراسة مع ضرورة ذكر ذلك للباحث المعالج. لا توجد أي خطورة على المرأة إذا حملت خلال فترة الدراسة.

إذا كنت تأخذ علاجا لأي اضطراب نفسي أو مرض عضوي يجب عليك الإلتزام بأخذ هذا الدواء بشكل منتظم.

ما هو العلاج الذي يتم دراسته ؟

يسمى هذا العلاج ب " العلاج المعرفي السلوكي منخفض الكثافة" وهو علاج قد تم اكتشافه وتطبيقه في انجلترا فقط حتى الآن على مستوى العالم . إن هذا العلاج أثبت فاعليته الكبيرة في تقليل أعراض الاكتئاب عن طريق استخدام تقنيات نفسية مختلفة وغير مكثفة أو لا تتطلب المجهود الكبير من المرضى ومن ضمن هذه التقنيات التي سوف يتم استخدامها في هذه الدراسة إعادة الهيكلة المعرفية ، التفعيل السلوكي بالإضافة إلى الدعم الدوائي ونصائح للنوم الصحي.

مدة هذا العلاج هي ستة أسابيع متتالية ،يتم فيها عمل جلسة واحدة في كل اسبوع مدتها ستون دقيقة تقريبا. في الجلسة الأولى يتم جمع المعلومات الرئيسية عن المريض وأسباب المشكلة ووضع خطة العلاج ، وفي الجلسات الخمس التالية يستقبل فيها المريض العلاج. بعد الانتهاء جلسات العلاج لن يكون هناك أي تواصل مع الباحث المعالج. لا يوجد أي دواء كيميائي في هذه الدراسة.

ما هي الخيارات للتشخيص أو العلاج ؟

هذا هو العلاج الوحيد الذي سيتم تقديمه لك خلال الدراسة ولا يوجد أي بدائل علاجية اخرى والتشخيص الوحيد الذي سيتم علاجه هو اضطراب الاكتئاب البسيط، المتوسط والشديد.

ما هي المؤثرات السلبية للعلاج الذي سوف يتم تطبيقه؟

لا يوجد أي أعراض جانبية سلبية من هذا العلاج، ولكن في بداية العلاج وبسبب النقاش الذي سوف يكون عن أسباب الاضطراب قد يسبب ذلك بعض التوتر للمعالج في البداية والذي يجب عليك إبلاغ الباحث به فورا، ولكن مع تلقي المعلومات النفسية وبدء العلاج سوف يتلاشى هذا الشعور, وهذا هو الأمر المتوقع من خلال العلاج.

إذا شعرت بهذا التوتر أو الضيق فبإمكانك التواصل مع الباحثة صفاء آل جميل على هاتفها وفي أي حالة نفسية طارئة قد تحدث إليك.

ما هي الإيجابيات المحتملة من المشاركة في هذه الدراسة؟

من خلال العلاج سوف تتعلم الكثير من المعلومات وتكتسب مهارات حياتيه وفكرية جديدة تمكنك إن شاء الله من التعامل مع أي موقف تمر فيه في حياتك بشكل صحي وإيجابي لا يؤثر على صحتك النفسية. نأمل بأن هذه العلاج سوف يساعدك في تخطي هذا الاضطراب العاطفي بنجاح. وأيضا النتائج لا يمكن أن تكون مضمونة دائماً. إن هذه المعلومات التي سوف نستنبطها من هذه الدراسة قد تساعدنا في علاج مرضى الاضطراب العاطفي ،الاكتئاب مختلف الحدة بشكل أفضل في المستقبل.

هل ستكون مشاركتي في هذه الدراسة سرية؟

إن معلوماتك الخاصة سوف يتطلع عليها فقط الباحث وأنه إذا تم إظهارها في أي وقت خلال الفترة العلاجية لشخص آخر فسوف يتم إعلامك وطلب الموافقة للسماح بذلك. وإذا تم نشر الدراسة ، فأنه لن يتم تعريف البيانات بانها لك بأي شكل من الأشكال.

إن طبيبك النفسي المعالج سوف يكون على علم باشتراكك في هذه الدراسة وبأنك تتلقى هذا العلاج بعد طلب الموافقة منك على ذلك. إن موافقتك على إعلام طبيبك النفسي هي شرط من شروط مشاركتك في هذه الدراسة.

أن هذه الخصوصية قم يتم اختراقها في حال كان هناك أي خطر عليك لإيذاء نفسك أو الآخرين، وفي حالة ظهر أي أمر قانوني يجب أن يتم إبلاغه وإشراك الجهة القانونية فيه.

ماذا سوف يحدث للنتائج من هذا البحث العلمي؟ أين يستطيع المشاركين تحديد موقع نتائج الدراسة وأي منشورات خاصة بها ؟

هذه الدراسة يتم تطبيقها لأهداف علمية بحته ضمن متطلبات التخرج من برنامج الماجستير في علم النفس الإكلينيكي، وسوف يتم مناقشة نتائج البحث مع اللجنة العلمية للتخرج . سوف تقوم الباحثة بنشر نتائج الدراسة في مكتبة جامعة الإمارات العربية المتحدة وسوف لن يتم عرض أي معلومات قد تعرف عن شخصية المشتركين بعد الانتهاء من الدراسة والذي يتوقع أن يكون في شهر ديسمبر 2016. وقد تقوم الباحثة مستقبلا بعرض الدراسة في المؤتمرات النفسية أو بنشرها في المجلات النفسية المختصة بهذا النوع من العلاج النفسي.

من الذي قام بمراجعة هذه الدراسة ؟

لقد تم الاطلاع على البحث وتقييمه من قبل لجنة البحث الخاصة والتي تتكون من أربعة متخصصين في البحوث والعلوم النفسية الإكلينيكية بجامعة الإمارات العربية المتحدة لبرنامج الماجستير في علم النفس الإكلينيكي في قسم علم النفس والارشاد.

من الذي ينظم ويدعم الدراسة مادياً ؟

إن الباحث المعالج هو الذي يقوم بتجميع وتنظيم وإعداد وتطبيق هذه الدراسة البحثية بدون أي دعم مادي من أي جهة حكومية أو خاصة.

ماذا لو كان هناك معلومات جديدة متوفرة ؟

في بعض الأحيان، خلال المشروع البحثي، قد تتوفر معلومات جديدة حول العلاج الذي يتم دراسته. إذا حدث هذا، فإن الباحث سوف يخبرك حول هذا الشأن. وسوف يناقش معك ما إذا كنت ترغب في الاستمرار في الدراسة. إذا قررت الانسحاب، فإن الباحث المعالج سوف يقوم بالترتيبات اللازمة لمتابعة رعايتك الصحية. أما إذا كنت ترغب في الاستمرار في الدراسة فسوف يطلب منك التوقيع على استمارة الموافقة الحديثة.

أيضاً ، عند تلقي معلومات حديثة ، فإن الباحث المعالج قد يعتقد بأن في مصلحتك الانسحاب من الدراسة. وهو سوف يشرح الأسباب ويقوم بكافة الترتيبات اللازمة لمتابعة علاجك.

ماذا يحدث عندما تنتهي هذه الدراسة؟

عندما تنتهي الدراسة , سوف لن يكون هناك أي مراجعات مستقبلية مع الباحث ولن يكون هناك تواصل معه. وسيكون نهاية هذا البحث الجلسات الست العلاجية فقط ولن تحتاج إلى أي جلسات إضافية.

ماذا لو حدث خطأ ما ؟

إذا حدث أي أمر غير متوقع أو عرض مفاجئ لك سوف يتم إبلاغ الطبيب النفسي المعالج مباشرة للتدخل ،أما إذا كان الأمر يشكل خطورة على أمن المشترك أو أسرته أو المجتمع سوف يتم الجهة الإدارية الخاصة بالمستشفى بذلك لأخذ الاجراءات اللازمة

إذا كان هناك أي شكاوى خلال العلاج سوف يتم التعامل معها من خلال الباحث المعالج والطبيب النفسي الخاص بالمريض ، أو من خلال إدارة المستشفى إذا دعت الحاجة إلى ذلك.

إذا لحق بك ضرر من خلال المشاركة في هذا المشروع البحثي، فإنه لا توجد ترتيبات خاصة للتعويض. إذا لحق بك ضرر بسبب اهمال شخص ما، فإن ذلك قد يكون سببا لاتخاذ بعض الإجراءات القانونية والتي قد تضطر لدفع ثمنها. بغض النظر عن هذا، إذا كنت ترغب في تقديم شكوى ، أو لديك أية مخاوف حول أي جانب من جوانب الطريقة التي تم التواصل بها معك أو علاجك خلال هذه الدراسة ، فإن آليات الشكاوى بخدمة الصحة الوطنية العادية يجب أن تكون متاحة لك.

تفاصيل الاتصال للحصول على مزيد من المعلومات:

للحصول على المزيد من المعلومات او الاستفسارات برجاء التواصل مع الباحث المعالج

اسم الباحث المعالج : صفاء بنت علي أمان بيت جميل

رقم الهاتف النقال : .....

وأخيراً

نشكر لك مشاركتك في هذا المشروع البحثي وأن تكون جزءا هاما منه، سوف يتم توفير نسخه من ورقة معلومات المريض ونسخة من نموذج الموافقة للاحتفاظ بهم.

Appendix F- Participant Health Questionnaire (PHQ-9) – English Version

STABLE RESOURCE TOOLKIT

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Column Totals	____ +	____ +	____	

Appendix G- Participant Health Questionnaire (PHQ-9) – Arabic Version

ضع علامة للإشارة إلى جوابك					
	كم مرة عانيت من أي من المشاكل التّالية في الاسبوعين الأخيرين؟	أبداً	عدة أيام	أكثر من نصف الأيام	تقريباً كل يوم
1	قلة الرغبة أو المتعة في فعل الأشياء.	0	1	2	3
2	الشعور بالإحباط، أو الاكتئاب، أو اليأس.	0	1	2	3
3	مشكلة في الخلود إلى النوم أوفي البقاء نائما، أو كثرة النوم.	0	1	2	3
4	الشعور بالتعب أو وجود القليل من الطاقة.	0	1	2	3
5	ضعف الشهية أو الإفراط في تناول الطعام.	0	1	2	3
6	شعور سيء عن النفس – أو الفشل في تحقيق أملك وأمل أسرتك.	0	1	2	3
7	مشكلة في التركيز على الأشياء، مثل قراءة الصحف أو مشاهدة التلفزيون.	0	1	2	3
8	التحرك أو التحدث ببطء حتى أن الآخرين قد لاحظوا ذلك ؟ أو العكس – الشعور بالملل وضيق الصدر حيث انك قد تتحرك أكثر بكثير من المعتاد	0	1	2	3
9	أفكار بأن الموت سوف يكون خير لك أو أفكار عن إيذاء نفسك بطريقة ما.	0	1	2	3

Appendix H1– Behavioral Activation (BA) Worksheet 1 (English Version)

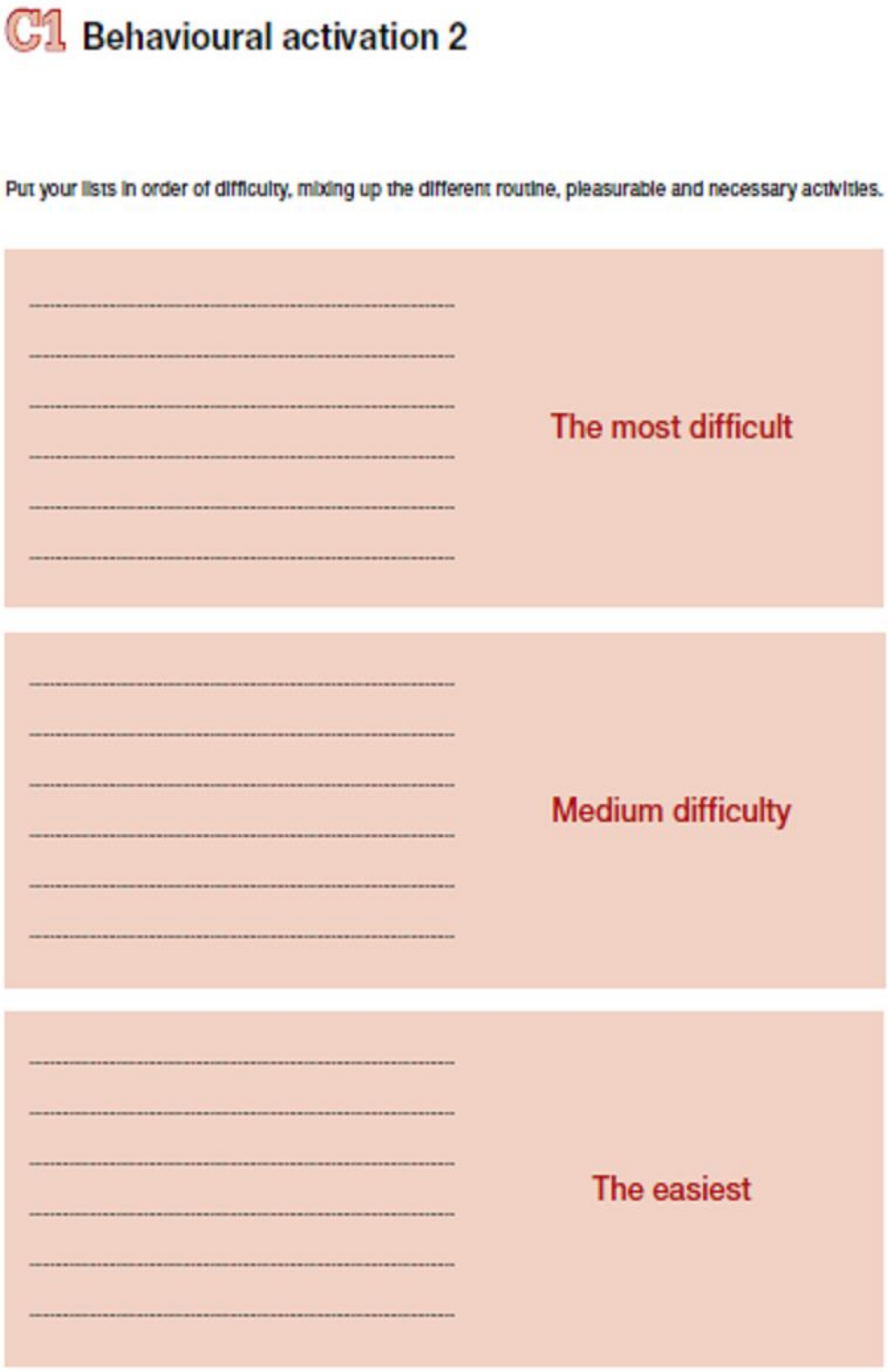
C1 Behavioural activation 1

List some routine activities here: e.g. washing up, cleaning the house

List some pleasurable activities here: e.g. going out with friends or family

List some necessary activities here: e.g. paying bills, dealing with difficult situations

Appendix H2– Behavioral Activation (BA) Worksheet 2 (English Version)



C1 Behavioural activation 2

Put your lists in order of difficulty, mixing up the different routine, pleasurable and necessary activities.

The most difficult

Medium difficulty

The easiest

Appendix H3 Behavioral Activation (BA) Worksheet 3 (English Version)

C1 Behavioural activation diary

		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning	What							
	Where							
	When							
	Who							
	What							
	Where							
	When							
	Who							
Afternoon	What							
	Where							
	When							
	Who							
	What							
	Where							
	When							
	Who							
Evening	What							
	Where							
	When							
	Who							

Appendix I1-Behavioral Activation Worksheet 1 (Arabic Version)

التنشيط السلوكي (1)

اذكر قائمة ببعض النشاطات الروتينية هنا: على سبيل المثال الغسيل، تنظيف المنزل

.....

.....

.....

.....

.....

.....

.....

قم بسرد بعض الأنشطة الممتعة هنا: على سبيل المثال الخروج مع الأصدقاء أو العائلة

.....

.....

.....

.....

.....

.....

.....

اذكر قائمة بعض الأنشطة الضرورية هنا: على سبيل المثال دفع الفواتير، والتعامل مع المواقف الصعبة

.....

.....

.....

.....

.....

.....

.....

Appendix I2- Behavioral Activation Worksheet 2 (Arabic Version)

التنشيط السلوكي (2)

قم بوضع القوائم الخاصة بك بالترتيب من حيث الصعوبة، قم بالخلط بين الأعمال الروتينية المختلفة، والأنشطة الممتعة والضرورية.

.....

الأكثر

.....

صعوبة

.....

.....

صعوبة

.....

متوسطة

.....

.....

.....

الأسهل

.....

.....

Appendix I3- Behavioral Activation Worksheet 3 (Arabic Version)

		السبت	الأحد	الاثنين	الثلاثاء	الأربعاء	الخميس	الجمعة
الصباح	ماذا أين متى من							
	ماذا أين متى من							
بعد الظهر	ماذا أين متى من							
	ماذا أين متى من							
المساء	ماذا أين متى من							

Appendix J1– Cognitive Restructuring Worksheet 1 (English Version)

C2 Thought diary

Situation	Feeling Rate how bad it was (0-100%)	Thought Rate how much you believe this thought (0 –100%)	Revised thought Rate how much you believe this thought (0–100%)	Feeling How bad was it (0-100 %?)

Appendix J2– Cognitive Restructuring Worksheet 2 (English Version)

C2 Evidence recording sheet

My thought	My % belief
Evidence for	Evidence against

Appendix K1– Cognitive Restructuring Worksheet 1 (Arabic Version)

مذكرة الأفكار

الموقف	الشعور قيم نسبة شعورك السيء (100-0)	الأفكار بنسبة كم % تظن أن هذا الاعتقاد صحيح (100-0)	الأفكار المراجعة قيم بنسبة كم % تؤمن بهذه الأفكار (100-0)	الشعور كيف كان هذا الشعور سيئا ؟(100-0)

Appendix K2– Cognitive Restructuring Worksheet 2 (Arabic Version)

ورقة تسجيل الأدلة

أفكاري	معتقداتي %
الأدلة عليها	الأدلة ضدها

Appendix L1– Relapse Prevention 1 (English Version)

Lapse and Relapse Management

Whenever we try to put a new plan into action it is common (even *normal*) to have setbacks. A lapse is a brief return to old uphelpful thoughts or behaviours. A relapse is a more prolonged return to old ways of thinking and behaving.

The most important thing is that we learn from each lapse or relapse so that next time around we are in a stronger position. Use this worksheet to learn from your setback.

It is understandable that I had a setback because:

What I have learnt is:

With hindsight what I would do differently would be:

Therefore what I'll do from now on is:

Other times I'm likely to be vulnerable (and will need to take more care):

Appendix L2– Relapse Prevention 2 (English Version)

Lapse and Relapse Management

Whenever we try to put a new plan into action it is common (even *normal*) to have setbacks. A lapse is a brief return to old uphelpful thoughts or behaviours. A relapse is a more prolonged return to old ways of thinking and behaving.

The most important thing is that we learn from each lapse or relapse so that next time around we are in a stronger position. Use this worksheet to learn from your setback.

It is understandable that I had a setback because:

Work got crazy, I neglected doing the things that I know help me stay on top of my moods, I reverted back to some of my old coping strategies (stopped seeing friends, stopped going to the gym)

What I have learnt is:

Keeping on top of my mental health is like keeping my car going - I have to do the maintenance if I want to keep things running smoothly

With hindsight what I would do differently would be:

Talk to a friend about how I was feeling, talk to my boss about my workload

Therefore what I'll do from now on is:

Manage stresses in my life more proactively. Ask manager at work to help me plan work, do more of what I know is good for me. Remind myself that everyone struggles at time - be kinder to myself

Other times I'm likely to be vulnerable (and will need to take more care):

When there is more going on than usual - more stresses
If I haven't taken a break in a long time (>3 months)

Appendix M1– Relapse Prevention 1 (Arabic Version)

إدارة الهفوة والانتكاسة

عندما نقرر ان نقوم بوضع خطة جديدة في حياتنا فإنه من الشائع والعادي أيضا أن نمر بانتكاسات. الهفوة هي العودة البسيطة للأفكار والسلوكيات القديمة الغير مفيدة. الانتكاسة هي العودة لفترة طويل للأساليب القديمة في التفكير أو السلوكيات. الشيء الأكثر أهمية هو أننا نتعلم من كل هفوة أو انتكاسة وبهذا في المرة القادمة سوف نكون في حالة أكثر قوة لتحدي هذه الهفوة أو الانتكاسة.

استخدم ورقة العمل هذه لتتعلم من حالات الانتكاسة التي تمر بك

إنه مفهوم لدي أنني مررت بهذه الانتكاسة لأنني:
والذي تعلمته منها هو :
مع الإدراك المتأخر لما حدث، ما الذي كان من الممكن ان أقوم به بشكل مختلف هو:
وبالتالي ، الذي سوف أقوم به من الآن فصاعداً هو :
في الأوقات الأخرى قد أكون أكثر عرضة وسوف أحتاج للاهتمام بشكل أكبر

Appendix M2– Relapse Prevention 2 (Arabic Version)

إدارة الهفوة والانتكاسة

عندما نقرر ان نقوم بوضع خطة جديدة في حياتنا فإنه من الشائع والعادي أيضا أن نمر بانتكاسات. الهفوة هي العودة البسيطة للأفكار والسلوكيات القديمة الغير مفيدة. الانتكاسة هي العودة لفترة طويلة للأساليب القديمة في التفكير أو السلوكيات. الشيء الأكثر أهمية هو أننا نتعلم من كل هفوة أو انتكاسة وبهذا في المرة القادمة سوف نكون في حالة أكثر قوة لتحدي هذه الهفوة أو الانتكاسة.

استخدم ورقة العمل هذه لتتعلم من حالات الانتكاس التي تمر بك.

إنه مفهوم لدي أنني مررت بهذه الانتكاسة لأنني:

- لأن العمل يصبح أحيانا مزدحم جدا، ولقد تجاهلت القيام بالمور التي أعلم أنها قد ساعدتني في السابق كي أكون في مزاج جيد جداً
- لقد عدت مجدداً إلى بعض السلوكيات والاستراتيجيات القديمة في التأقلم (توقفت عن زيارة الأصدقاء، توقفت عن الذهاب إلى النادي الرياضي)

والذي تعلمته منها هو :

- الحفاظ على مستوى عالٍ من الصحة النفسية هو بمثابة أن احافظ على سيارتي تعمل وتمضي في الطريق، يجب علي أن أقوم بصيانتها دائماً إذا كنت أريد الأمور أن تمضي بسهولة ويسر.

مع الإدراك المتأخر لما حدث، ما الذي كان من الممكن ان أقوم به بشكل مختلف هو:

- أن اتحدث إلى صديق أو زميل لي عن ما كنت أشعر به
- أن أتحدث إلى رئيسي عن الضغوطات التي أواجهها في العمل

وبالتالي ، الذي سوف أقوم به من الآن فصاعداً هو :

- أتعامل مع، وأقوم بإدارة الضغوطات التي أواجهها في حياتي بشكل مسبق (قبل أن تسوء)
- أن أطلب من مديري في العمل أن يساعدني في التخطيط لمهام عملي.
- أن أقوم بالأمور التي أعلم أنها تساعدني وأنها جيدة لي.
- أن أذكِّر نفسي بأن كل الناس في بعض الأوقات قد يواجهون صعوبات في حياتهم.
- أن لا أقسو على نفسي.

في الأوقات الأخرى قد أكون أكثر عرضة وسوف أحتاج للاهتمام بشكل أكبر(متى؟)

- عندما تزداد الضغوطات في العمل عن القدر المعتاد
- عندما لا أخذ إجازة عن العمل لفترة طويلة (اكثر من 3 أشهر).

Appendix N - Descriptive Statistics (Frequencies and Percentage) for Patient Health Questionnaire-9 Scores for the Experimental Group.

	PHQ-Pre		Week 1		Week 2		Week 3		Week 4		Week 5	
DSL	ns=25	%	ns=23	%	ns= 19	%	ns= 17	%	ns= 13	%	ns= 13	%
ND	0	0 %	4	17.4 %	5	26.3 %	3	17.6 %	8	61.5 %	9	69.2 %
M	2	8 %	8	34.8 %	5	26.3 %	9	52.9 %	5	38.5 %	3	23 %
MO	4	16 %	4	17.4 %	6	31.6 %	2	11.8 %	0	0 %	1	7.7 %
MS	8	32 %	4	17.4 %	1	5.3 %	3	17.6 %	0	0 %	0	0 %
S	11	44 %	3	13 %	2	10.5 %	0	0 %	0	0 %	0	0 %

Females = 17 , Males = 8 , DSL= Depression Severity Level, ns = number of cases according to depression severity, ND = Not Depressed, M= Mild, MO = Moderate, MS = Moderately Severe and S = Severe.

Shrieen

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