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Development of modified cognitive behavioural therapy for depression in Sri Lanka

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Abstract

Depression is an important public health issue in Sri Lanka and an essential component of its treatment is psychotherapy. Standard Cognitive Behavioural Therapy (CBT), the most widely used psychotherapy in depression. originates in the West which has a culture and value system different from Sri Lanka. Despite multiple parallels and points of overlap between Buddhism, the majority religion in Sri Lanka, and CBT, the latter is underused in Sri Lanka.

This thesis aimed to design a culturally modified cognitive behavioural therapy for depression in Sri Lanka. The thesis was conducted in two phases. Phase 1 aimed to gather the necessary information to modify the existing CBT manual to suit Sri Lanka. Phase 2 aimed to evaluate the feasibility and effects of the modified CBT manual developed in Phase 1.

Phase 1 used a mixed methodology. A wide range of stakeholders including patients, carers, medical practitioners, psychologists, traditional healers and religious leaders took part in this phase of the study. The semi-structured interviews used were audio recorded, transcribed and translated. The data were analysed based on systematic content and question analysis by identifying emerging categories and themes. These results were used to develop a culturally modified CBT manual.

Phase 2 was of an experimental prospective design. Patients with depression were recruited from Colombo North Teaching Hospital, Ragama, Sri Lanka, by convenient sampling. Participants were provided with 6 sessions of psychotherapy fortnightly as per the modified CBT manual and were followed up for 6 months. This was in addition to the usual treatment. Outcomes were assessed using the validated Hamilton Rating Scale for Depression (HRSD), Beck Depression Inventory II (BDI), and Global Assessment of Function (GAF) scales.

Briefer and fewer psychotherapy sessions, a more didactic style of therapy and greater emphasis on behavioural therapy, family involvement in therapy and use of local literature in explaining therapy, were identified as necessary modifications to standard CBT by the participants of Phase 1. Phase 2 saw the participation of 12 patients, the majority of whom were females. Their average length of treatment for depression was 3.1 years. Their HRSD, BDI and GAF scores improved significantly at weeks 10 and 26 with better scores at 10 weeks. All patients believed that psychotherapy was useful and practical. A majority (73%, 8/11) reported the modified psychotherapy as providing them something significantly different from treatment as usual. All the clinicians reported modified CBT as being ‘feasible’ and ‘easily deliverable’.

This thesis suggests that culturally modified CBT for depression is an acceptable and practical treatment option in Sri Lanka.

Declaration

This is to certify that

1. the thesis comprises only my original work towards the degree of Doctor of Philosophy, except where indicated in the Preface,
2. due acknowledgement has been made in the text to all other material used,
3. the thesis is fewer than 100,000 words in length, exclusive of tables, maps, bibliographies and appendices

Asiri Rodrigo

Preface

The main body of work presented in this thesis was carried out at the Faculty of Medicine, University of Kelaniya, Ragama, Sri Lanka and Colombo North Teaching Hospital, Ragama, Sri Lanka under the supervision of Prof Harry Minas, Prof Richard Newton, Dr Ritz Kakuma and Prof Piyanjali De Zoysa.

This work is original, except where acknowledgements and references are made to previous work. I was assisted by research assistants of the Faculty of Medicine, Ragama, Sri Lanka in collecting data for Phase 2 of the study. Clinical psychologists helped me in conducting the modified CBT for depression in Phase 2 of the study. All other data collection, analysis, writing, and revision of manuscripts were all performed primarily by myself.

The findings of this study have been disseminated in the following manner up to now:

Oration of the Sri Lanka College of Psychiatrists 2017 - "Depression: Is psychotherapeutic management possible in Sri Lanka?"

Oral presentation on “Astrological Cognitive Bias of Depression in Sri Lanka” at the Annual Scientific Congress of Sri Lankan College of Psychiatrists on 01/03/2014 in Kandy, Sri Lanka and Annual Scientific Congress of South Asian Federation of Psychiatry Associations in Mysore, India in 2014.

Oral presentation on “Beliefs, attitudes and practices pertaining to psychotherapy among traditional healers in Sri Lanka” at Annual Scientific Congress of Sri Lankan College of Psychiatrists 2015, in Colombo, Sri Lanka.

Oral presentation on “Depression in Sri Lanka” at RANZCP Annual Congress in June 2015 in Brisbane, Australia

Oral presentation on "Modifying Cognitive Behavioural Therapy for Depression in Sri Lanka" at RANZCP Annual Congress,May 2016 in Hong Kong

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I thank the Vice Chancellor of the University of Kelaniya and Dean Faculty of Medicine for granting me leave which enabled me to read for my PhD at the University of Melbourne. I also extend my thanks to the Head of the Department of Psychiatry, University of Kelaniya, for releasing me from clinical, academic and research work, my colleagues who carried out my clinical and teaching work during the period of my absence and all staff members for their support in various ways.

My deep appreciation goes to the Director and staff of Colombo North Teaching Hospital, Ragama for allowing me to facilitate and conduct the research pertaining to my PhD, and the staff of the Faculty of Medicine, University of Kelaniya for making the necessary provisions to conduct this research without hindrance.

My deepest gratitude to all the patients, their carers, healthcare professionals and traditional healers who participated in Phase 1 of this study and supported me wholeheartedly by providing honest information. Without their assistance, this research would not have been possible.

Special thanks to all the patients who participated in Phase 2 of the study, and the clinical psychologist who conducted the therapy sessions in this phase, in particular. My sincere appreciation of all the hard work of my research assistants in helping me conduct this study.

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Finally, I thank my family for their love and support through a seemingly endless process and my wife Ranmali in particular whose personal courage, valuable suggestions and confidence has always been an inspiration. My heartfelt appreciation is extended to my mother and parents-in-law for all their support in helping me complete this journey.

My father always encouraged me to do better and was instrumental in preparing me for this PhD. Sadly, he passed away recently leaving a void that I will never be able to fill. I only wish he could have seen the completion of my PhD. To him, I dedicate my work.

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Chapter 1

Introduction

Chapter 1

1.1 Introduction

Sri Lanka

Sri Lanka is a multi-ethnic and multi-religious South Asian country with a population of 22 million. It is a low to middle income (LMI) country transitioning from an agricultural economy to a manufacturing and services based one with a gross domestic product (GDP) of US$4,184 in 2017 (World Health Organization, 2019). Sri Lanka's social and health indicators compare favourably with other LMI countries and rank best in South Asia. This is particularly true for infectious diseases, immunisation, maternal mortality and infant mortality. Sri Lanka has been able to successfully eradicate some of the most menacing infectious diseases such as polio and malaria (Abeyasinghe, Galappaththy, Smith Gueye, Kahn, & Feachem, 2012; Holmes, Bertozzi, Bloom, & Jha, 2017). This success is due to the healthcare system in Sri Lanka with universal health coverage delivered through a public health system supplemented by private sector health facilities and traditional healthcare systems. Both public and private healthcare are predominantly delivered by western medical practitioners. However, Sri Lanka has rich alternative medical traditions which have been practiced for centuries, well before western medicine was introduced to Sri Lanka.

However, Sri Lanka has not been able to emulate its success in eradicating communicable diseases with non-communicable diseases, particularly mental illnesses. This has been identified as one of the hindrances in the development of post-war Sri Lanka. The small number of mental health professionals in the country (Jenkins, Mendis, Cooray, & Cooray, 2012), stigma towards mental illness as well as mental health treatment (Fernando, Deane, McLeod, & Davis, 2017), poor mental health literacy (Ediriweera, Fernando & Pai, 2012), some cultural beliefs about mental illness and lack of culturally appropriate, acceptable and easily deliverable mental health interventions are some of the important reasons for the mental health treatment gap in Sri Lanka. Therefore in Sri Lanka, its culture, which is influenced by a Buddhist heritage, agricultural economy, close links with India and colonial occupation (Gunawardena, 2005) play a significant role in mental health treatment.

We discuss Sri Lanka's country profile, healthcare system and culture and its relevance to the study in Chapter 2.

Depression

Depression is a serious mental illness characterised by a pervasive low mood and a lack of enjoyment that can affect a person's thoughts, behaviour, tendencies, feelings and sense of wellbeing, which lasts for at least 2 weeks. Depression is a recurring disorder with a recurrence rate of 60% in 5 years, 67% in 10 years, and 85% in 15 years (Hardeveld, Spijker, De Graaf, Nolen, & Beekman, 2010). Depression is associated with poor quality of life, diminished role functioning, increased incidence of co-occurring medical problems and higher mortality (Spijker et al., 2004; Ustun, Ayuso-Mateos, Chatterji, Mathers, & Murray, 2004). Depression was ranked as the fourth leading cause of disability worldwide and is projected to be the second leading cause by 2020 (Murray & Lopez, 1996). Depression is linked with decreased productivity in the workplace, increased absenteeism from work, increased unemployment and decreased annual salary (Judd et al., 2000; Reddy, 2010). In a 5-year study conducted in the US, one-third (33%) of depressed patients reported new unemployment. Another US study found that an average of 27 days was lost per depressed employee annually (Kessler et al., 2006). This study calculated an annual individual loss of US$4,400 amounting to a national loss of US$36.6 billion per year. Patients with depression are reported to utilise healthcare services more than patients in the general medical setting. Depression is associated with increased impairment in occupational and interpersonal functioning in comparison with several common medical illnesses. Annual global deaths due to suicide are close to 800,000. About 50% of individuals who have committed suicide carried a primary diagnosis of depression. Depression leads to disruption of family stability resulting in separation or divorce.

Depression is a common illness affecting more than 120 million people globally (Lepine & Briley, 2011). Prevalence of depression varies from nation to nation, with France reportedly having the highest lifetime prevalence (21%) and Brazil the highest 12-month prevalence (10.4%) while China is reported to have the least lifetime (6.5%) and 12-month prevalences (3.8%). (Kessler & Bromet, 2013). A Sri Lankan epidemiological study conducted in Colombo in 2006/7 showed that the lifetime prevalence of depression is 11.2%, which is on par with global prevalence (Ball et al., 2010). A country-wide study done in 2007 estimated the overall prevalence of major depressive syndrome to be 2.1% and other depression, minor depression, bipolar disorders, and dysthymia, to be 7.1% (Institute of Research and Development, 2007).Other Sri Lankan studies have shown an even higher prevalence in certain segments of the population such as adolescents (21.3%) (Perera, Torabi, Jayawardana, & Pallethanna, 2006), people who live in war affected areas (22.2%) (Husain et al., 2011) internally displaced people due to war (15.3%) (Siriwardhana, Abas, Siribaddana, Sumathipala & Stewart, 2015), and families of international migrant workers (17.1%) (Siriwardhana, Wickramage, Siribaddana, et al.; 2015). Sri Lankan studies suggest that the consequences of depression include poverty, suicide, substance misuse and non-communicable medical problems

(Ball et al., 2010; Egede & Ellis, 2010). Those studies highlight significant deficits in available treatment interventions for depression in Sri Lanka (Ball et al., 2010; Husain et al., 2011; Perera et al., 2006).

Studies conducted in non-western societies including Sri Lanka suggest that symptoms of depression in those settings have primarily been somatic. Yet, psychological symptoms such as low mood, anhedonia, loss of zest in life, suicidal thoughts, poor concentration and anxiety or worry are also present in these patients. It is believed culture may have played a role in the presentations of depression being different (Ball et al., 2010).

Depression is a treatable illness and potentially preventable (Chen & Shan, 2019; Khan, Faucett, Lichtenberg, Kirsch & Brown, 2012). There are many efficacious treatments for depression including pharmacotherapy (Cipriani, Furukawa, Salanti, et al., 2018), electroconvulsive therapy (Pagnin D, de Queiroz, Pini & Cassano, 2004), psychotherapy (Cuijpers, Karyotaki, Reijnders, Purgato, & Barbui, 2018) and social interventions (De Silva, Cooper, Li, Lund & Patel, 2013). Mild to moderate depression can be treated with psychotherapy alone. A combination of antidepressant medication and psychological interventions are generally considered to be the most effective treatment for moderate to severe depression. Cognitive behavioural therapy (CBT) is one of the most widely practiced and effective forms of psychotherapy for depression. Referral pathways taken by patients with psychiatric illness suggest that they consult both traditional healers and western medical practitioners. Many patients with depression in Sri Lanka do not receive adequate treatment. This is particularly true for psychotherapies, at least partly due to the lack of culturally adapted therapy which is acceptable to patients and is effective and easily deliverable.

In Chapter 3 the prevalence, associated disability, presentation, causes, interventions and the treatment gap in depression both globally and locally are discussed.

Culturally modified psychotherapy

Despite the success of psychotherapy in depression, there is little evidence to suggest these treatments have been applied to non-Western populations. Modern healthcare relies heavily on evidence-based practice (EBP). However, it is increasingly recognised that many EBPs have not been developed or tested for effectiveness in different cultural contexts and the evidence base may be limited to certain socio-cultural settings (Griner & Smith, 2006; Hwang, 2009). This is even more important in mental health as culture has a profound impact on how people exhibit symptoms of mental illness, use coping mechanisms, social supports, and seek care or assistance. Gelso et al.

(2014) noted that the single most important reason both for the underutilisation of mental health services by ethnic minority clients and for the high dropout rates in the US is the inability of the service to provide culturally sensitive/responsive therapy to these clients. A meta-analytic review of culturally modified mental health interventions found them to be four times more effective than non-adapted, generic interventions (Griner & Smith, 2006; Rathod et al., 2018).

Mainstream psychotherapy has focused predominantly on the therapeutic needs of Europeans or Americans as it reflects the values of western culture, most notably a persistent bias toward individualism (Hall, 2001; Sue, Zane, Nagayama Hall, & Berger, 2009). Unlike western society, however, eastern cultures including Sri Lankan society are considered to be collectivistic in that they promote interdependence and cooperation (Obeysekere, 1985; Spencer et al., 1990). Therefore universalism, a concept suggesting that all interventions suit all cultural groups despite the specific cultural and historical contexts in which people live their lives ('one size fits all') has little value in psychotherapy as such interventions make little or no use of the cultural values, beliefs and aspirations of a society and its origin (Bhui & Morgan, 2007; Tseng, 2001). Similarly, the cultural generalisability of CBT, one of the most researched psychological interventions for depression, is questioned (Arnberg, Alaie, Parling, & Jonsson, 2013; Nakimuli-Mpungu et al., 2014; Patel, Simon, Chowdhary, Kaaya, & Araya, 2009; Rathod et al., 2018).

Therefore, it has been suggested that psychotherapy might need adaptation according to language, metaphors, therapeutic relationships, theoretical constructs, goals, methods, and cultural needs of a given society or country. Such therapies, which are known as culturally modified psychotherapy, are created by tailoring existing or mainstream psychotherapy to specific cultural contexts or making systematic changes to the protocol of existing psychotherapy to make the features of the therapy relevant to the culture of the target population. There is growing evidence to suggest that the outcome of culturally modified psychotherapies is superior to non-adapted psychotherapies (Benish, Quintana, & Wampold, 2011; Chowdhary et al., 2014; Rathod et al., 2018). Despite wide support for culturally sensitive practice, such psychotherapies are not commonly available (Butler, Chapman, Forman, & Beck, 2006; Kirmayer, 2015; Linardon, Fairburn, Fitzsimmons-Craft, Wilfley, & Brennan, 2017). In fact, most culturally modified psychotherapies available have been developed and tested on ethnic minorities living in western societies such as the US and UK rather than on those living in non-western countries (Chowdhary et al., 2014; Rathod et al., 2018).

Several theoretical frameworks have been developed to guide therapy modification. One of the most widely used theoretical frameworks was proposed by Hwang (2009). He proposed the Formative

Method for Adapting Psychotherapy (FMAP) consisting of five phases. Rathod (2010) and Naeem (2019) found success in developing culturally appropriate CBT for psychosis and depression, respectively, in the South Asian population, utilising these strategies.

Very little research on culturally sensitive psychotherapies has been conducted in Sri Lanka. No studies have been conducted on culturally modified psychotherapy for depression in Sri Lanka.

In Chapter 4 the concept of culturally modified therapy, various ways of modifying therapy, evidence for effectiveness, methods of modifying the therapy and evidence for the same from Sri Lanka are discussed.

1.2 Rationale of the study

Armed with this knowledge I set forth with the task of developing a culturally appropriate CBT manual that will meet the needs of Sri Lankan patients with depression and then went on to pilot test the effectiveness of modified CBT in Colombo, Sri Lanka. This is the first time culturally appropriate psychotherapy has been developed in Sri Lanka for depression which is an important public health issue in the country. To the best of our knowledge, there are no Sri Lankan studies on expectations and experiences of patients with depression and their carers, healthcare professionals, traditional healers and lay counsellors regarding the treatment of depression using psychotherapy. This knowledge is invaluable in understanding the needs and ground realities of treating patients with depression in Sri Lanka. As non-western practitioners form an important part of the mental health system in the country, understanding their experiences is vital in developing a meaningful treatment for Sri Lankans. Their experiences were studied in detail.

Pilot testing a new treatment model provides important information on the feasibility and possible adverse effects of the treatment. Conducting such an experiment in a state hospital reveals problems that may arise when such treatment is utilised in settings similar to where it would be used in the future if found successful. Our project was motivated by the tremendous need for effective psychotherapeutic treatments for depression in Sri Lanka. Not only will these findings be important for Sri Lanka they will be important for other Asian cultures as well due to the similarity between Sri Lankan and other Asian cultures.

1.3 Significance of the study

The significance of this study should be viewed in the context of the knowledge that despite the high prevalence and significant impairment caused by depression in Sri Lanka, it is inadequately treated (Perera, Torabi, Jayawardana & Pallethanna, 2006; Kathriarachchi, Seneviratne & Amarakoon 2019). It has been hypothesised that one of the reasons for this is the lack of culturally sensitive psychiatric care in Sri Lanka. This is further established by the popularity of traditional healing methods for mental illness despite lack of proven effectiveness and high cost.

Psychotherapy is an integral part of treatment for depression. Perera et al. (2006) discussed the virtual non-existence of psychotherapeutic interventions for depression. This may partly be due to a lack of acceptable and less time-consuming therapies suited to Sri Lanka. A culturally adapted, focused, short-term psychotherapeutic intervention that could be easily administered may improve the treatment gap and patient satisfaction. Successful implementation of such psychotherapy will have far reaching consequences of implementing similar interventions for other diseases, thereby changing the landscape of mental health treatment in Sri Lanka.

1.4 Research questions

Therefore, the following research questions were formulated:

1. What are the views of Sri Lankan patients with depression and their carers about the components and delivery of suitable psychotherapy for depression in Sri Lanka?

2. What do Sri Lankan psychiatrists and psychotherapists consider as necessary modifications of cognitive behavioural therapy (CBT) for depression to make it more suitable for the Sri Lankan context?

3. What are Sri Lankan traditional healers' and other non-western mental health practitioners' views about the components and delivery of suitable psychotherapy for depression in Sri Lanka?

4. Are there particular cultural beliefs that influence how depression is viewed in Sri Lanka?

5. What are the helpful and not-so-helpful strategies in providing CBT for depression in Sri Lanka?

6. What are the specific cultural adaptations to the existing CBT manual for depression?

7. Is the modified CBT treatment for depression in Sri Lanka acceptable to patients?

8. Can the modified CBT treatment for depression in Sri Lanka be delivered with ease by healthcare professionals?

9. Are there any obstacles to delivering modified CBT for depression in Sri Lanka?

10. Will Sri Lankan patients see an improvement in symptoms with modified CBT for depression?

11. Can the modified CBT be incorporated into mainstream Sri Lankan clinical practice?

1.5 Research hypothesis

The main research hypothesis was that the existing CBT manual for depression can be modified to suit the Sri Lankan context by incorporating views of Sri Lankan patients, carers, psychiatrists, psychologists, traditional healers and non-Western health care practitioners and that this modified CBT is acceptable to Sri Lankan patients as a treatment method, is feasible for Sri Lankan clinicians to administer and can be incorporated into mainstream clinical practice in Sri Lanka.

1.6 Research process and results

In order to answer the research questions and test the research hypothesis, this study was conducted in two phases. The findings of the first phase informed the second phase. The overarching objective of Phase 1 was to explore the expectations and views of Sri Lankan patients with depression, as well as of their carers, healthcare professionals, traditional healers and lay counsellors, regarding how psychotherapy for depression can be better delivered in Sri Lanka. Phase 1 of the study adopted a mixed methodology with a view of modifying the existing CBT manual for depression to make it more culturally appropriate for Sri Lanka. In Phase 1 I conducted semi-structured interviews with all the stakeholders mentioned to generate knowledge on cultural values, beliefs and attitudes regarding psychotherapy for depression in Sri Lanka. Information gathered in this phase was used to develop the culturally adapted manual used in the second phase.

The objective of Phase 2 was to evaluate the feasibility and adverse events of a modified CBT for patients with depression in Sri Lanka. This phase was conducted using an experimental prospective study design for adult patients receiving outpatient treatment for unipolar depressive disorder at Colombo North Teaching Hospital, Ragama, Sri Lanka.

Research methodology, data analysis and the ethical perspective are discussed in Chapter 5.

A total of 45 participants including patients with depression, carers, psychiatrists, psychologists and alternative healers participated in Phase 1 of the study. The findings revealed that somatic symptoms are a common presentation of depression in Sri Lanka, antidepressants are the predominant treatment, and that the Sri Lankan general public has little knowledge about psychotherapy. Further, behavioural techniques are preferred over cognitive techniques, a more directive style is preferred in psychotherapy, and family can be involved in the therapy. Based on the findings of the discussions, the CBT manual was modified to make it shorter with 6 sessions and each session lasting for 30 minutes. The modified CBT manual is more didactic and directive with increased emphasis on education about CBT, addressing physical/somatic symptoms of depression, activity scheduling and problem-solving skills. This manual placed less emphasis on Socratic questioning and core beliefs.

In Phase 2, 12 patients were treated using the modified CBT manual and 11 patients completed the therapy. There was a significant improvement in depressive symptoms and functionality at the completion of the therapy and follow-up. Following the therapy, an improvement in treatment compliance was noted. All patients believed that psychotherapy was useful, practical and able to give them something different to treatment as usual. All the clinicians reported modified CBT as being ‘feasible’ and ‘easily deliverable’.

The results of Phase 1 and 2 of the study are discussed in Chapter 6.

The findings of the study suggest that the form of psychotherapy which has been developed is easily delivered in a culturally sensitive, acceptable and effective manner, resulting in increased treatment retention, increased satisfaction with treatment, reduction of symptomsand reduced cost of treatment. This study contributes to the growing evidence pointing to the need for adaptation of evidence based interventions and the efficacy and acceptability of culturally adapted CBT as a treatment option for depression.

The findings of my study with reference to previous studies and the wider context are discussed in Chapter 7.

1.7 Translating research findings into clinical practice

The finding of modified CBT being acceptable, deliverable and probably effective needs to be applied in Sri Lankan clinical practice. In order to address the question of how these findings can be applied in Sri Lankan clinical practice and to bridge the gap between research findings and clinical practice, I established a dedicated psychotherapy clinic to utilise the modified CBT to see how best it can be integrated into Sri Lankan clinical practice. The first of its kind, this dedicated psychotherapy clinic also provided organised and accessible services to patients and served as a training center for medical postgraduate trainees and clinical psychology trainees.

In Chapter 8 I discuss how establishing a psychotherapy clinic has translated the research finding into clinical practice.

1.8 Definition and initial operationalisation of terms

1.8.1 Depression

Depression is a common, yet serious mental illness that has a profound negative impact on thoughts, emotions and behaviours (McCarter, 2008). Depression symptoms can vary from mild to severe and can include:

- Feeling sad (having a depressed mood) or being irritable most of the time
- Loss of / reduced interest or pleasure in activities once enjoyed
- Loss of / reduced energy or increased fatigue
- Trouble sleeping or sleeping too much
- Disturbances in appetite — weight loss or gain unrelated to dieting
- Lack of self-confidence, feeling worthless/hopeless or guilty
- Difficulty thinking, concentrating or making decisions
- Increase in purposeless physical activity such as pacing or slowed movements and speech
- Thoughts of death or suicide

- It is not unusual for these patients to present with bodily symptoms such as headaches andabdominal pain in oriental cultures such as Sri Lanka.

These symptoms must continue for at least two weeks for a diagnosis of depression. Depression can result in a variety of emotional and physical problems and can decrease a person's ability to function at work and home.

Adverse incidents in life such as failure at an exam, loss of a job, the breakup of a relationship or death of a loved one will result in feelings of sadness or grief. While these experiences may be described as being 'depressed', being sad is different from the illness of depression.

Depression can affect anyone, even people who live in ideal conditions. Depression can develop at any time during life, but on average, first appears during the late teens to mid-20s. Women are more likely than men to experience depression (Albert, 2015).

Depression can be developed due to many reasons including the derangement of neurochemicals in the brain, genetic factors, personality and adverse environmental conditions.

Fortunately, depression is a treatable illness.

1.8.2 Cognitive Behavioural Therapy

Cognitive behavioural therapy (CBT) is a short-term, goal-oriented psychotherapy treatment that focuses on the here-and-now and takes a collaborative approach. It aims to change patterns of thinking or behaviour that are behind people's difficulties, and so change the way they feel. It is used to help treat a wide range of psychiatric and non-psychiatric conditions including depression, anxiety, substance misuse, relationship issues, eating disorders and pain related diseases. It is one of the most evidenced-based psychotherapies for depression (David, Cristea & Hofmann, 2018).

One of the important advantages of CBT over many other psychotherapies, particularly more established therapies such as psychodynamic therapy, is that it is relatively short (David, Cristea & Hofmann, 2018). Typically, it takes 4-10 months where the patients attend weekly sessions with each session lasting 50 minutes long. In the therapy, the client and therapist work collaboratively to understand the problems and to find solutions to address those problems. This therapy aims to socialise patients to a set of more adaptive and beneficial principles that they can use whenever they require. These principles are expected to make sustainable changes in the patient which would

ideally last a lifetime.

CBT is best conceptualised as a combination of cognitive and behavioural therapy. Psychotherapy underlines the importance of personal meanings attributed to things and how childhood has influenced thinking patterns and the system of rules and beliefs that govern our life. Behavioural therapy is about the relationship between problems, behaviour and thoughts. Many cognitive behavioural therapists personalise and customise CBT to the specific needs and background/culture of each patient.

1.8.3 Culture

Different people have described culture differently. Triandis (1980) defines the culture as a collection of physical factors such as environmental features including roads and buildings well as the subjective aspects of the world such as myths, values and attitudes. However, Fernando (2010) suggests that while the term culture refers to all features of a person's environment, it is more applicable to the non-material aspects of environment that is in common with other individuals forming a social group. Reber et al. (2009) have adopted a narrower definition, as 'the system of information that codes how people in an organised group, society or nation interact with their social and physical environment'. In contrast to Triandis and Fernando, Reber suggests that culture is only a cognitive construct without physical manifestations. The last definition is more in line with the description of culture by anthropologists. The anthropological description of the culture suggests that it is the basic difference between humans and animals and it has three components namely artefacts, ideas and knowledge. Similarly, Kroeber and Kluckhohn (1952) defined culture as "patterns, explicit and implicit, of and for behaviour acquired and transmitted by symbols ... including their embodiment in artefacts; the essential core of culture consists of traditional ... ideas and especially their attached values; culture systems may, on the one hand, be considered as products of action, on the other, as conditional elements of future action". Going along the same line, Rohner (1984) has defined culture as "highly variable systems of meanings, which are learned and shared by a people or an identifiable segment of a population". Cultural elements of psychology include "social norms, roles, beliefs and values such as familial roles, gender roles, communication styles, affective styles, values of authority or personal control, individualism, collectivism and spirituality among others". These elements may shape how individuals express and understand their experience of distress, influence help seeking behaviour as well as how they respond to a particular intervention.

These definitions underline the fact that people create cultural ideas and practices, and that these cultural ideas and practices, in turn, create people. Thus, culture and mind mutually constitute each

other, or "make each other up" (Shweder & Sullivan, 1993). The role of culture in mental health has been a debate between ‘etic’ and ‘emic’ approaches that underscore biological universality or cultural diversity (Patel, 2001). The ‘etic’ approach is based on the assumption that symptoms, causes and treatment of mental illnesses are similar around the globe irrespective of the setting and culture. This approach advocates the same treatment in western and non-western settings without significant changes. The ‘emic’ approach suggests considering the significant role played by culture in the causes and manifestation of mental illness thereby changing the treatment to suit the cultural context.

1.8.4 Traditional healers

Traditional medicine has been a part of Sri Lanka for many centuries, and it continues to play an important role in health services. Traditional medicine in Sri Lanka is of Indian (Ayurveda, Sidda), Arabic-Islamic (Unani) and indigenous (Desiya Chikitsa) origin (Arseculeratne, 2002). Traditional medicine is often described as 'holistic' as it is mostly based on local knowledge, beliefs, religion and traditional culture. Traditional healers are people who practise forms of traditional medicine. They may be Ayurvedic practitioners, Unani practitioners, lay counsellors, spiritual or religious advisors, or shamans. They use alternative medication including herbal, mineral and food, different forms of counselling or traditional healing ceremonies to treat people. Those treatment methods and their understanding of illnesses are more aligned with local cultural beliefs when compared to Western medical thinking or treatment.

1.8.5 Mental health professionals/practitioners

Mental health professionals are defined as individuals who have gained specialised training and skills in the nature and treatment of mental illness. Mental health professionals include psychiatrists, psychologists, psychiatric social workers and members of other related disciplines.

1.8.6 *Thovil*

Thovil is a healing ritual or exorcism performed in Sri Lanka to ward off evil spirits and illness. Some Sri Lankans, particularly those from rural areas, believe that certain health conditions like mental illnesses are caused by spirits (Moodley & Ocampo, 2014). To chase the bad influences

caused by spirits or demons away, a *thovil* ceremony is conducted with the exorcist wearing a demonic mask and dancing to the tune of loud local drums. This is done to make the patient go into a trance and/or possession state during the ceremony. Various rituals such as chanting and offerings are performed to appease the spirits/demons. *Salu Paliya*, a ritual where the dancer acts like a clown to uplift the spirits of the patient and take away his fear, is performed soon afterwards. The exorcist also cleanses the house of the patient to provide cosmic relief.

CHAPTER 2

Sri Lanka

Chapter 2

Sri Lanka

2.1 Sri Lanka

Sri Lanka is an island country, smaller than Tasmania, located just south of India with a population of 22 million, equal to that of Australia. The nation's population is predominantly rural, agriculture-oriented, multi-ethnic and multi-religious. According to the 2012 census, the majority are Sinhalese (74.8%), followed by Sri Lankan Tamils (11.2%), Sri Lankan Moors (9.2%) and Indian Tamils (4.2%). The predominant religion is Buddhism (70.2%) while Hinduism (12.6%), Islam (9.7%) and Christianity (7.4%) make up the other major religions (Department of Census and Statistics, 2015) Sinhala and Tamil are the most commonly used languages and English is also widely used, in urban parts of the country. While Sri Lanka is home to many ethnicities, religions and languages, the countrymen share common cultural values and ideals. The nation boasts rich cultural traditions dating back to 600BC, influenced by a Buddhist heritage, agricultural economy, close links with India and colonial occupation (Gunawardena, 2005). Cultural values have remained largely unchanged though there has been a degree of transformation with globalisation (Liston, 1999).

For administrative purposes, Sri Lanka is divided into nine provinces and 25 districts. While historically the people who lived in these administrative regions were distinct, due to internal migration and various other factors, the distinction is blurred at present. Some of the districts and provinces, such as Colombo district and the Western Province, are densely populated when compared to other areas (i.e. Monaragala district and Uva Province). Though more than 50% of the Sri Lankan population lives in the three urban provinces of Central, Southern and Western, the majority of people live in rural areas (urban: rural ratio = 1: 4.4) (Ministry of Finance and Planning, 2012). Poverty is significantly greater in rural than in urban regions (Ministry of Finance and Planning, 2012). Sri Lanka has one of the fastest ageing populations in the world. Although only12.3% of the population is over 60 years old, it is predicted that one-fifth of Sri Lankans will be aged over 60 by 2025 (World Health Organization, 2006).

Sri Lanka is a low middle-income (LMI) country with a per capita gross domestic product in 2016 of $3,835 (World Health Organization, 2019). The country has seen a transition from a rural based agricultural economy to an urbanised economy focused on manufacturing and services. Since the civil war ended in 2009, the Sri Lankan economy has grown at a healthy rate of 6.2% a year. However, the growth has been less pronounced in the last four years. Sri Lanka's social indicators compare favourably with other LMI countries and rank best in South Asia. The national poverty headcount ratio too has improved remarkably in recent years, from 15.3% in 2006 to 6.7% in 2013 (World Health Organization, 2019).

The value for health expenditure (percentage of total health expenditure) in Sri Lanka was 56.06 as of 2014. From 1995 to 2014, this indicator reached a maximum value of 57.18 in 2013 and a minimum value of 38.0 in 2012. Public health expenditure (percentage of government expenditure) in Sri Lanka was 11.17 as of 2014. Its highest value over the past 19 years was 11.52 in 2013, while its lowest value was 5.30 in 1995 (Index Mundi, 2016).

The total health expenditure, including public and private health expenditure, on preventive and curative services was 3.5% of its GDP in 2014 (World Health Organization, 2019). Its highest value over the past 19 years was 4.28 in 2004, while its lowest value was 3.21 in 2012.

This is much lower than the health expenditure in developed countries where around 10% of GDP is being spent on health. In 2015-16, Australia's health expenditure was more than 10% of GDP (World Health Organization, 2019). Despite relatively low levels of health expenditure, Sri Lanka's health indicators are almost comparable to developed countries (Ministry of Health, 2016). Universal healthcare and effective preventive health systems are largely responsible for the favourable indicators.

While it is difficult to calculate an exact proportion of the health budget spent on mental health in the country, Sri Lanka National Health Accounts 2013 suggests that only 1.2% of the combined health expenditure is spent on mental health (Health Economics Cell, 2016). A significant proportion of this budget is allocated to the specialised mental health hospital. According to a World Health Organization report, the average healthcare spending on mental health in low- and middle-income countries including Sri Lanka (1%-2%) is considerably lower than that of high-income countries (5%) (World Health Organization, 2013). The report also points out that the allocated funding does not match the disease burden of mental illness which may be due to the stigma

attached to mental illness and the less significance with which mental health is viewed. The report criticised the unequal funding allocation favouring large mental health hospitals rather than mental health promotion or prevention of illness (World Health Organization, 2013).

2.2 The Sri Lankan healthcare system

Universal healthcare, which has long been a national priority, extends free healthcare to all Sri Lankans (Jones, 2015; Ministry of Health, 2016). This has been a long held tradition from the time of the ancient kings of Sri Lanka who considered the health and sanitation of the citizens an important duty they bore (Jones, 2015; Uragoda, 1987). During British colonial rule this was further established by the introduction of free healthcare services through western medical institutions (Jones, 2015; Uragoda, 1987). The Sri Lankan healthcare setup is also distinctive in that an individual can choose to go to a hospital, a general practitioner or directly to see a specialist with no referral from a third party (Ministry of Health, 2016).

At present, universal healthcare is provided through the public healthcare system which is predominantly delivered by government run hospitals, from the tertiary to primary level, spread across the country. There are 21 large and well-equipped hospitals functioning as tertiary referral centres for large regions or the whole country (Ministry of Health, 2016). Further, each of the nine provinces of Sri Lanka is covered with at least one tertiary care hospital or provincial general hospital (Ministry of Health, 2017). All 25 districts of Sri Lanka have at least one big district general hospital. In addition, there are numerous base hospitals, divisional hospitals and primary care units spread across Sri Lanka (Ministry of Health, 2017). Outpatient departments (OPD) in public hospitals function as a primary care health centre as well as an emergency department. While inpatient care is provided through the wards of these hospitals, ongoing outpatient care is provided through clinics. Most of the medicine, laboratory and radiology investigations are provided free of charge at these institutions.

While the public sector dominates Sri Lanka's healthcare system, the private health sector plays a very important role which has been growing at a rapid rate (Rannan-Eliya, 2006). The private health sector comprises of several large hospitals and a number of medium and small sized hospitals that are situated in major cities and main towns of Sri Lanka. Outpatient care in the private sector is provided by many 'channeling centres', outpatient clinics conducted by specialists and large numbers of general practitioners conducting day and night clinic services (Rannan-Eliya, 2006).

These ambulatory care services, particularly the clinics by general practitioners, are more widespread than private hospitals.

Both public and private healthcare systems in Sri Lanka are largely based on western or allopathic healthcare introduced by the colonial powers of Portuguese, Dutch and British that ruled Sri Lanka from 1505 to 1948 (Jones, 2015; Uragoda, 1987). Traditional systems of healthcare including Ayurveda have been used for well over 2,000 years in Sri Lanka. These systems, having evolved over many years, are heavily influenced by cultural, religious and social factors (Uragoda, 1987) (Uragoda, 1987). Though these systems are not very popular at present, Sri Lankans were the first in the world to develop the concept of a hospital and establish a highly scientific public healthcare system using indigenous healthcare techniques (Uragoda, 1987). Modern public ayurvedic hospitals were re-established in Sri Lanka in the last 75 years when state run ayurvedic training institutes were established in the 1950s (Jones, 2015). Apart from the practitioners trained at these institutes and working in state ayurvedic hospitals who are recognised officially as ayurvedic medical practitioners, there are numerous other practitioners using variations of traditional Ayurveda and often practicing out of their homes. In certain areas such as mental health, due to cultural sensitivities and stigma, folk systems based on exorcism, astrology and various religious rites remain the first choice for some Sri Lankans.

2.3 Sri Lankan mental health care

Low and middle income countries such as Sri Lanka have fewer mental health professionals including psychiatrists, mental health nurses, psychologists and social workers. Compared with the global average of 3.96 psychiatrists per 100,000 people, China reported 1.55 psychiatrists per 100 000 of the population (Ministry of Health of the People's Republic of China, 2012). The corresponding ratios in the most populous developing countries of Asia and Africa, i.e. India, Pakistan, Nigeria and Ethiopia, are 0.301, 0.185, 0.06 and 0.04, respectively (World Health Organization, 2011). Chad, Eritrea and Liberia, with national populations of 9, 4.2 and 3.5 million, respectively, have just 1 psychiatrist for the whole country, whereas Rwanda, Afghanistan and Togo have 2 (Gadit & Khalid, 2002; World Health Organization, 2005).

There are less than 100 psychiatrists in Sri Lanka for a population of 22 million (Kathriarachchi, Seneviratne & Amarakoon 2019). They are unevenly distributed, with a disproportionate number practising in the country’s largest cities of Colombo, Kandy and Galle. There are also about 100

diploma holders of mental health and medical officers of mental health (MoMH) who have undergone a short course of training - a 12-month diploma in psychiatry and a 1-month course in psychiatry. MoMH, a more community-based post, is a recent addition to the mental health service in Sri Lanka. The MoMH system is not well established and services are poorly utilised.

The shortage of auxiliary psychiatric personnel - trained psychiatric nurses, social workers, clinical psychologists - is even more marked. There are no specialised psychiatric nurses, but the 800 nurses attached to psychiatric units are provided with ad hoc and occasional training programmes in psychiatry. There are only three clinical psychologists employed in the government sector and are attached to university units (Jenkins, Mendis, Cooray, & Cooray, 2012). Further, 57 occupational therapists, 20 psychosocial workers (PSWs) and 60 assistant PSWs work in mental health units of public hospitals (Jenkins et al., 2012).

The allopathic mental health care system was first introduced in Sri Lanka by the British in the 1840s (Fernando & Weerakody, 2009). The first purpose-built psychiatry hospital in Sri Lanka was opened in 1926 and it is currently being upgraded and remodeled as the National Institute of Mental Health (NIMH) (Minas, Mendis, & Hall, 2017). Even at present, statutory mental health services are based mainly on NIMH. About a decade ago, most resources for mental health care were confined to the Western Province, with three mental hospitals in the surroundings of Colombo, including NIMH. Improvement of mental health human resources, the strategy of reducing the capacity of the centralised mental health institutions, and the establishment of district based mental health services have contributed to more countrywide mental health services. At present, all districts except for Mullaitivu, have a consultant psychiatrist. While some districts do not have inpatient psychiatry units, all the districts excepting one have regular outpatient clinics.

The education of psychiatrists is largely if not solely based on western biomedical models. Services for mental health problems in the statutory sector are informed by western (allopathic) medicine, although government supported indigenous medical centres have been developed in some areas.

In most psychiatry outpatient clinics at public hospitals, 20-30 patients are seen by one doctor in a single session (3 to 4 hours). Usually, the doctor has only 3-6 minutes for each patient. In private specialist outpatient clinics, which are operated by consultant psychiatrists, the psychiatrists may spend about 10–15 minutes with a patient. Sri Lankan psychiatric care relies heavily on biomedical treatments such as psychotropic medications and electroconvulsive treatment. Some Sri Lankan patients and families look for quick, dramatic improvement and prefer biomedical treatment.

Psychotherapy plays a less important role in the Sri Lankan mental health system. There are no psychologists attached to public hospitals. Psychotherapy is predominantly provided by doctors but in a less organised manner. There is only one dedicated psychotherapy clinic in the Sri Lankan public healthcare system, begun in 2017. There are few clinical psychologists who work in the private sector and their services are still underutilised.

Allopathic mental health treatment and alternative forms of treatment including Ayurveda exist side by side in Sri Lanka, sometimes with a considerable degree of overlap. With mental health problems, more than with any other conditions, many people opt for alternative forms of treatment in preference to western allopathic medicine. Ayurveda currently recognises nine branches including "*mãnasika roga vedakama*" which can be translated as 'psychiatry' (Fernando & Weerakody, 2009). The extent to which people seek ayurvedic treatment for mental health problems in Sri Lanka is unknown.

It is not uncommon for Sri Lankans with mental health problems to consult and obtain help from a variety of traditional healers apart from western medical or ayurvedic medical practitioners. Traditional healers include specialists in exorcising and other forms of healing as well as astrologers who provide 'astrological counselling'. Vogt described three forms of healing rituals for mental illnesses commonly used in Sri Lanka: (a) *pirith* (translating to protection from Sinhala) - the recitation or chanting of the word of the Buddha believed to 'protect one from all directions', (b) *pooja* (offering ceremony) - a ritual act of generosity towards religious dignitaries, Buddha, gods or the less fortunate, and (c) *thovil* - a public healing ritual held in the house of a patient that involves dancing and drumming. *Thovil* may involve a *pooja* to the gods (Fernando & Weerakody, 2009). It is believed that spirituality is important in all forms of traditional healing and is often central to the explanatory system of the healer. Sri Lankan patients with mental illnesses utilise different forms of medicine and healing rituals without experiencing any conflict, one merging into the other.

2.4 Sri Lankan culture and mental health

Understanding of mental health is largely influenced by the meanings people give to their experiences, which are culturally determined (Fernando & Weerakody, 2009). Psychological states are interpreted through our perceptions of self, place in the world and beliefs about health, wellbeing and illness, which in turn are shaped by culture. Therefore, culture plays a major role in mental health.

Sri Lankan culture remains collectivistic, where interdependence, conformity and interpersonal harmony are highly valued (Spencer, 1995). The family forms the focal point of the Sri Lankan social structure. Therefore, family support is more accessible in Sri Lankan cultures than most western cultures (Fernando & Weerakody, 2009). The family will play a pivotal role in the health of an individual. Sri Lankan families are far more involved in caring for its members and resultantly suffer greater illness burdens. They are more intimate with the patient and capable of greater therapeutic participation than in the West. Neki (1992) pointed out that the concepts of confidentiality and privacy have very little relevance in the Indian socio-cultural setting and argued for greater family involvement in treatment. Those concepts are equally important in the Sri Lankan context.

Sri Lanka's culture also revolves around religion. The Sri Lankan identity is decisively shaped by its Buddhist heritage, followed by Hinduism, which are the majority religions of the country. Buddhists and Hindus share many foundational beliefs that have influenced Sri Lankan thinking for centuries (Deegalla, 2006). Both of these religions preach moderation and restraint. While Buddhism recommends the middle path, Hinduism advocates for disciplined behaviour. Further, both religions are based on karma, rebirth and the pathway to escape the cycle of rebirth including nirvana in Buddhism. Many of the followers of these religions believe in gods, spirits and demons. Religious perspectives such as karma or fatalism, a notion that all events are predetermined and therefore inevitable, lead some to believe that life including illness cannot be manipulated, leading to poor help-seeking. Research has shown that even when help was sought, patients - particularly individuals from rural communities - preferred a traditional healer who could explain the illness adhering to cultural beliefs (Fernando & Weerakody, 2009).

Many Sri Lankans believe in astrology, the belief that there is a connection between celestial bodies and personal destiny. The notion of fatalism or karma runs in parallel to astrology, which may partly explain its historical popularity in Sri Lanka. Many patients in the country may attempt to understand their mental illness through astrological explanations and this may lead to delays in presenting for treatment.

Culture not only influences the motivation to seek help but also impacts how mental illness is experienced. Psychological distress or symptoms are sometimes expressed differently in varied cultures. Sri Lankan patients may express distress as bodily symptoms such as headaches (Fernando & Weerakody, 2009).

The other overarching barrier to help-seeking behaviour in Sri Lanka is the stigma associated with mental illness. Available Sri Lankan literature suggest stigma not only affects the individual with mental illness but also the family, making it difficult for their siblings to get married, for example. It is also suggested that mental health professionals are also subject to stigma.

Sri Lanka and many other non-western countries can boast increased involvement of the family in the care of the mentally ill, thereby sharing the burden, and more inclusive approaches to the employment of the mentally ill (Koschorke et al., 2014). Although Sri Lankan statistics are not available, in neighbouring India, almost all (over 90%) individuals with mental illness live with their families (Thara, Henrietta, Joseph, Rajkumar, & Eaton, 1994). In Sri Lanka families play a pivotal role in both illness related decisions such as treatment seeking and treatment compliance and life decisions such as marriage and employment, of the mentally ill. The Sri Lankan mental health system utilises this strength by involving family members in treatment to enhance and ensure treatment and involving them in rehabilitation to promote social integration. Such involvement reduces the need for community mental health clinicians such as case managers who are not available in Sri Lanka. Yet the involvement of the family in the care of the mentally ill is not without its drawbacks. Such involvement may make the family feel distressed about the burden of care and may restrict their ability to engage in other activities including gainful employment (Rathod et al., 2017).

CHAPTER 3

Depression

Chapter 3

Depression

Depression has always been a serious health problem. Historical documents throughout the ages starting from ancient Mesopotamian texts in the second millennium BC, confirms the long-standing existence of depression and continuous struggles to address this common condition. Depression is characterised by pervasive low mood, irritability, decreased energy, loss of interest and lack of enjoyment in activities that were pleasurable before, feelings of worthlessness, hopelessness, helplessness and guilt, changes in appetite, weight loss or weight gain, sleep disturbances, changes in psychomotor activity, indecisiveness, or distracted attention (McCarter, 2008). Patients with depression may also present with somatic complaints particularly in non-Western contexts (Rajapakse and Sivapalasingham, 2011) which is discussed in detail under the presentation of depression in Sri Lanka.

Psychiatry taxonomies make a distinction between sadness and clinical diagnosis of depression. All the psychiatry classifications require a constellation of symptoms for one to diagnose depression. All the classifications agree on pervasive low mood, lack of enjoyment and reduced energy levels as the cardinal features of depressive disorder and require all three features should be present for the diagnosis of major depression or severe depression. These symptoms were, in fact, present in almost every patient with major depressive disorder with a prevalence of 100%, 99.4% and 99.1% for sad mood, lack of enjoyment and reduced enjoyment respectively (Ten Have et al., 2017). Psychiatry classification systems stipulate a minimum of 2 weeks duration for the diagnosis of depressive episode. However, the median episode duration was 6 months, the mean duration was 10.7 months, and 12% had not recovered at 36 months (Ten Have et al., 2017). Diagnostic and Statistical Manual of Mental Disorders (DSM) also requires a functional impairment due to depressive symptoms for the diagnosis of depressive disorder (American Psychiatric Association, 2013). A study done on patients with the depressive disorder at the start of antidepressant therapies found these patients to have marked functional impairment with a mean Sheehan Disability Score of 19.2±6.8, overall work impairment of 53.5%±27.9%; and overall activity impairment, of 61.1%±24.8% (Hammer-Helmich et al., 2018). Presentations with depression may be compounded by self harm thoughts, self harm acts and may even lead to completed suicide. Studies suggest that depression is the commonest psychiatric illness associated with self harm with a risk ratio of 14.4%. A study conducted among depressed patients in Saudi Arabia reported the prevalence of suicide ideation and attempted suicide in the previous week as high as 47.2% and 36.6% respectively.

3.1 Depression as a global problem

Depression is not only a serious mental illness that is different from the usual transient mood fluctuations and negative emotional reactions to the vicissitudes of life it is a recurrent disorder with a recurrence rate of 60% in 5 years, 67% in 10 years and 85% in 15 years (Hardeveld et al., 2010).

The Global Burden of Disease Study 2010 revealed depression to be the second leading cause of disability, accounting for 63 million years lived with disability (YLDs) and 9.6% of all YLDs (Prince et al., 2007; Vos et al., 2012). Depression is associated with poor quality of life, diminished role functioning, increased incidence of co-occurring medical problems and higher mortality (Spijker et al., 2004; Ustun et al., 2004). Depression was ranked as the fourth leading cause of disability worldwide and is projected to be the second leading cause by 2020 (Murray & Lopez, 1996). Depression is linked with decreased productivity in the workplace and increased absenteeism from work, increased unemployment and decreased annual salary (Judd et al., 2000; Reddy, 2010). In a 5-year study conducted in the US, one-third (33%) of depressed patients reported new unemployment. Another US study found that an average of 27 days was lost per depressed employee (Kessler et al., 2006). This study calculated an annual individual loss of US$4,400 per depressed employee amounting to a national loss of US$36.6 billion per year. Patients with depression reported using healthcare services more than patients in the general medical setting. Depression is associated with higher impairment in occupational and interpersonal functioning in comparison with several common medical illnesses. Annual global deaths due to suicide are close to 800,000. About 50% of individuals who have committed suicide carried a primary diagnosis of depression. Depression leads to disruption of family stability resulting in separation or divorce. The association between depression and divorce is bidirectional. In India, nearly a quarter (23%) of depressed patients report health difficulties severe enough to keep them bedridden (Reddy, 2010).

A prospective study of 10 years found that psychosocial disability in depression is associated with the degree of depressive symptom severity (Judd et al., 2000). This study also noted that the associated disability became greater with each stepwise increment in depressive symptom severity from asymptomatic to severe depression.

Depression is a common illness affecting more than 120 million people globally (Lepine & Briley, 2011). The prevalence of depression varies from nation to nation, with France reported having the highest lifetime prevalence (21%) and Brazil the highest 12-month prevalence (10.4%), while China

is reported to have the least lifetime prevalence (6.5%) and 12-month prevalence (3.8%) (Kessler & Bromet, 2013).

De Vaus, Hornsey, Kuppens, & Bastian (2018) argued that the lower prevalence in Eastern countries is not due to reporting bias but because of the fundamental differences in worldview between Eastern and Western cultures. It has been suggested that the people in Western cultures see the world analytically by dividing the world into mutually exclusive categories such as evil vs. good, others vs self, and sadness vs happiness. Western cultures are individualistic cultures where they view their thoughts, emotions and actions independently from others and broader context. On the other hand, Eastern cultures approach the world in a holistic and interdependent manner. De Vaus et al. (2018) argued that therefore people from Eastern cultures believe emotions such as happiness and sadness can co-occur and try not to avoid sad feelings at all costs. Eastern cultures accept emotions and self constantly change and if one feels sad or depressed that it will change with time. Easterners view emotions as emerging from the situation they're in rather than from within themselves thereby emotions can be changed by altering the context. De Vaus et al. (2018) conclude that people of Eastern cultures tend to find negative experiences are less threatening because they believe negative emotions don't preclude positive emotions and negative emotions are only temporary and can be changed. Therefore, pervasive sadness, a cardinal feature of depression is less common occurring in Eastern cultures.

It is important to note that cross cultural studies found that other aspects of descriptive epidemiology such as the age of onset, socio-demographic correlates and wide range of adverse effects of major depression are quite consistent across countries (Kessler & Bromet, 2013; Kessler & Ustun, 2004, 2008)

3.2 The Sri Lankan situation

A Sri Lankan epidemiological study conducted in Colombo in 2006/7 showed the lifetime prevalence of depression to be 11.2%, on par with global prevalence (Ball et al., 2010). This study demonstrated significant functional impairment to be linked with depression and a clear association between poverty and depression (OR=1.76, 95%CI 1.30-2.36). A country-wide study done in 2007 estimated the overall prevalence of major depressive syndrome at 2.1% and other depression; minor depression, bipolar disorders, and dysthymia at 7.1% (Institute of Research and Development, 2007).Perera et al. (2006) found depressive symptoms in 57.7% of adolescents in Sri Lanka, a considerably higher rate than the 15-45% reported in the US. A significant proportion of adolescents,

21.3%, reported ‘greater depressive symptoms’ thereby being at high risk of developing depression. Perera et al. (2006) also showed that those who have depressive disorders were more likely to use psychoactive substances and to suicide (p=0.001). A higher prevalence of depression (17.1%) than the normative Sri Lankan population was recorded among families of international migrant workers (Siriwardhana, Wickramage, Siribaddana, et al.; 2015).

Sri Lanka remained in the grip of a civil war for 26 years, until 2009. This war resulted in widespread personal and socioeconomic hardships and losses to the entire nation. A study conducted in northern Sri Lanka (where active combat took place) in the post-war period recorded significant depressive symptoms in 22.2% of adults (Husain et al., 2011). A study on internally displaced people due to war reported a prevalence of 15.3% (Siriwardhana, Abas, Siribaddana, Sumathipala & Stewart, 2015). This high rate of depressive symptoms was attributed to war related factors such as repeated losses, internal displacement and ongoing psychosocial stressors. Those studies demonstrate that depression is a major health issue in Sri Lanka, particularly in the context of the protracted civil war. Consequences of depression include poverty - the single most important social problem, suicides -with Sri Lanka having one of the highest rates in the world, difficulty in resettlement – a major issue in the North and East, and substance misuse and noncommunicable medical problems which are reaching epidemic proportions in the country (Ball et al., 2010; Egede & Ellis, 2010). Those studies highlight significant deficits in available treatment interventions for depression in Sri Lanka (Husain et al., 2011; Perera et al., 2006).

3.3 Presentation of depression in Sri Lanka

Some authors argue that depression is a multidimensional condition, with symptoms manifested in different aspects including emotional/affective symptoms (low mood, irritability, anxiety), somatic symptoms (lethargy, tiredness, disturbed sleep and disturbed appetite), self-perception or existential symptoms (worthlessness), interpersonal relation function (helplessness and bitterness) and suicidality (difficulty in finding the purpose of life, suicidal ideation) (Zhu, 2018). Research suggests that there is a distinction in how depression is manifested in non-western and western countries. The concept of depression in western societies is highly influenced by mainstream western cultural ideals of "positive emotions and feeling good about the self” (Chentsova-Dutton, Tsai, & Gotlib, 2010). Therefore, low mood or reduced positive affect and reduced self-esteem are the main features of depression found in western countries. Lewis-Fernandez & Kleinmen (1994) pointed out that depression will be perceived as “internal disturbances” in western countries and as “interpersonal

disturbances" in non-western countries. This is due to the promotion of individualistic values in western societies and interdependency in non-western countries. The same authors also argue that the expression of depression in western societies has been influenced by a dualistic view of mind-body relations. As a result, people with depression in western and non-western societies may present with either primarily psychological or primarily somatic complaints. This may have a direct implication on treatment seeking behaviour: the depressed individual in the West may seek primarily psychotherapeutic or primarily pharmacological therapies whereas an individual in a non-western country may seek help from non-mental health services and traditional healing methods. For example, in China the concept of neurasthenia, commonly understood as "neurological weakness,", is popular. This weakness is believed to be in the channels carrying vital energy, or qi due to the interaction between an inherited neurotic tendency and environmental stress (Zhu, 2018). Many patients in China sought treatment for self-diagnosed neurasthenia from physicians as well as from other practitioners.

A study comparing patients with depression in the US and South Korea reported that Korean patients were comparatively more likely to express symptoms related to low energy and difficulty in concentration than low mood and suicidal thoughts (Lee & Farran, 2004). Anthropological studies suggest that there is a greater tendency for Chinese with depression to report somatic symptoms when compared to patients from the West (Kleinman, 1977). Studies investigating the psychosocial functioning of patients with depression revealed that in the US, social life is the most impacted domain, followed by family and work/school lives, while in Asia, work/school life is the most impacted, followed by social and family lives. The discrepancy may reflect cultural differences between Asia and the West regarding functional priorities.

In addition to depressive symptoms, insomnia, obsession and compulsion, and pain may be clinically significant in this population. Still, pain does not seem to have a significant impact on a patient's quality of life. As mentioned previously, depression related symptoms appear to be most disruptive to work / school life for Asian patients when compared to family or social life. Given that patients perceived family to be a leading source of social support, family members may play an important role in helping this population. Further studies in these areas are warranted.

Cross-cultural researches suggest that the endorsement of positive and negative affect varies across culture (Iwata & Buka, 2002; Iwata & Higuchi, 2000). Iwata & Buka (2002) reported that native Japanese students tended to report less positive affect than their Caucasian American counterparts, while their negative affect scores were comparable to those of Caucasian Americans. This cultural

difference in the endorsement of positive affect was found in another group of native Japanese college students: Japanese students endorsed fewer anxiety-absent items from Spielberger's State-trait anxiety inventory than American students (Iwata & Higuchi, 2000). These differences may be attributed to cultural variation in the normative emotional expression: an individual's positive emotions and open expression may be encouraged and rewarded in individualistic cultures, while an individual's balance and control of emotional expression may be encouraged and rewarded in collectivistic cultures in order to maintain group harmony (Markus & Kitayama, 1991) although the reduced positive effect on depressive and anxiety measures has been reported for native Japanese samples, reduced positive effect has not yet been reported in Japanese-American samples. Thus, the positive affect scale, in particular, may be a sensitive measure to examine in a Japanese-American sample to assess whether cultural values observed in native Japanese samples influence depressive symptoms similarly in a collectivistic subcommunity within an individualistic majority culture.

There is a dearth of studies investigating the presentation of depression among Sri Lankan patients. Ball et al (2010) reported that while 94% and 91% of patients with depression endorsed classic symptoms of depression such as 'depressed mood' and 'loss of interest', psychomotor symptoms were also relatively common among patients. The study found that disturbances of appetite and sleep are common symptoms of depression in Sri Lanka, in addition to low energy, poor concentration and suicidal thoughts. However, guilt laden thoughts were a rare manifestation. Ball et al (2010) reported that the presentation of depression is largely similar between Sri Lankan males and females with the exception of males experiencing more hypersomnia and females experiencing suicidal thoughts.

Rajapakse and Sivapalasingham (2011), who studied the symptom profiles of 144 Sri Lankan patients with depression presenting to a psychiatry clinic at a teaching hospital reported that 31.2% of patients presented with prominent somatic symptoms. The most commonly reported somatic complaints were headache (44.4%), burning sensation of the body (17.7%), body and backaches (28.8%), and chest pain (13.3%). They argue that the proportion of depressed patients with somatic symptoms could be higher, as considering the nature of their presenting complaints they are more likely to present to services other than a psychiatry clinic. When they present to medical clinics, hospital outpatient departments and general practitioners, the underlying diagnosis of depression could be missed as they are unlikely to volunteer depressive symptomology such as suicidal ideation (Sumathipala et al., 2008). This study showed that 39.6% of patients expressed suicidal ideation at presentation while 28.5% had a history of previous deliberate self-harm. Most of these patients attempted self-harm within the 3 months before the presentation to psychiatric services. Among

patients with severe depression, 7.6 % reported auditory hallucinations and 10.4% had delusional beliefs, most commonly delusions of infidelity or persecution.

3.4 Causes of depression in Sri Lanka

Depression is a multifactorial disorder with no single identifiable aetiological factor. Yet, there is clear evidence to show that several biological, social, economic, environmental and cultural factors contribute to the development of depression (Saveanu & Nemeroff, 2012). Culture plays a significant aetiological role in depression. Cultural beliefs, cultural attitudes, cultural interpretations and cultural symptom thresholds are important as aetiological factors of depression. How distress and depression are expressed and experienced will be different in different cultures. The nature of social relationships differs from culture to culture and such social relationships are important as aetiological factors of depression. Change of traditional social fabric with globalization and urbanization leading to loss of family and social support systems in cultures like Sri Lanka and living in cities like Colombo with high population density may contribute to the development of depression. Further adverse economic conditions and experience of conflict may be relevant for depression in Sri Lanka.

Ball et al (2010) found that standards of living were independently associated with depression, especially among men. Low financial status, poor occupational status with reduced income and poor characteristics of the home environment like poor toilet facilities had a specific association with depression. Males in Sri Lanka are generally the main breadwinners of the family and are responsible for the quality of housing. Therefore, poor housing is a reflection of unemployment or less than full-time work. However, depression was linked to women who worked full-time when they experienced low standards of living. Ball et al (2010) argued that in economically deprived women work may be "a mark of low status and an indicator of stress where it is a material necessity". The authors also noted that urban dwelling was a risk factor for depression in men only, which may be a reflection of different social or economic pressures on men in heavily urbanised areas.

Rajapakse and Sivapalasingham (2011) found that most depressed patients were females, married and unemployed, with over a quarter of patients having a family history of mental illness. Anandakumar et al (2016), who studied depression in patients seeking medical advice for other illnesses in an outpatient department, found that pain related presenting complaints were significantly associated with depression.

A study on the association of previous trauma and depression in Sri Lanka revealed that physical and mental trauma is associated with the development of depression. Psychoactive substance abuse, alcohol, in particular, has shown an association with depression among people in Sri Lanka. While alcohol is associated with an increased prevalence of depression among users, the prevalence of depression among spouses of men who use alcohol is markedly higher ((Ariyasinghe, Abeysinghe, Siriwardhana, & Dassanayake, 2015). A study on depression among older people in Sri Lanka found that low socioeconomic status, low perceived social support and more than two self-reported illnesses were associated with depression (Khaltar et al., 2017).

3.5 Treatment of depression

Depression is a treatable illness and potentially preventable. There are many efficacious treatments for depression which include pharmacotherapy, electroconvulsive therapy, psychotherapy and social interventions. Psychological interventions alone for people with mild to moderate depression and a combination of antidepressant medication and psychological interventions for moderate or severe depression are considered to be the most effective treatment. Despite the severity of depression, treatment will include problem solving skills and lifestyle changes such as stress management, exercise and not using alcohol or other drugs. Cognitive behavioural therapy (CBT) is one of the most widely practiced and effective forms of psychotherapy for depression.

Patel et al (2009) proposed a package of care - a combination of treatments aimed at improving recognition and management to achieve optimal outcomes - for depression in low to middle income countries which included psychoeducation, generic antidepressants and problem-solving techniques. The Common Elements Intervention Approach (CETA) (Murray et al., 2014) which utilises the most frequently used elements from multiple evidence based treatments, has shown promising results in non-western countries. Studies from Iraq, Thailand, Myanmar and Ethiopia demonstrated the clear effectiveness (effect sizes >1) of this approach on symptoms of depression, trauma and anxiety (Bolton et al., 2014; Weiss et al., 2015). In these studies, CETA used effective elements of CBT which were delivered by specially trained paraprofessionals. Thus, these studies also suggest that paraprofessionals can be used in delivering simplified psychotherapy with an apprenticeship model of training and ongoing supervision and that CBT elements are effective in treating multiple conditions including depression.

WHO study (Kohn, Saxena, Levav, & Saraceno, 2004) reported the treatment gap in depression to be 56.3% and identified it as one of the biggest challenges in addressing the illness burden. In other words, the majority of patients with depression did not receive adequate care for depression. The authors mentioned that it is likely that the gap reported here is an underestimate due to the unavailability of community-based data from developing countries where services are scarcer. Abeysinghe and Gunnel (2008) who conducted psychological autopsies of 372 suicides occurring in three rural districts of Sri Lanka during August-October 1997 reported most of the patients who committed suicide were untreated although they had an underlying psychiatric illness.

Culture may play a pivotal role in determining in treatment-seeking or help-seeking behaviour in depression. In Eastern cultures, it is not unusual to consult traditional practitioners from their own culture for treatment of "illness" and Western-trained allopathic physicians for treating "disease". If distress or emotional disturbances are not considered within the area of disease, people with depression may not seek mental health treatment for depressive symptoms. It is more likely to interpret the distress is due to depression and accept the diagnosis of depression more readily, therefore more people living in those settings are willing to seek psychiatry treatment for same. However, depression is associated with stigma in Eastern cultures and the people less likely to accept the diagnosis. Therefore, the treatment for depression may be actively resisted in non-Western cultures.

Cultures also determine what treatments are more acceptable to its people. For example, electroconvulsive therapy is not acceptable to many individuals in Western cultures and Western antidepressant medications may not be acceptable to some Easterners. People who live in the USA demonstrated differences in beliefs and attitudes, and preferences for treatment in depression depending on their ethnicity (Cooper et al., 2003). African Americans found antidepressants to be less acceptable than white Americans. Hispanics found antidepressant medication less acceptable than white Americans but found counseling acceptable than white persons.

Referral pathways taken by patients presenting to psychiatry services in cross-cultural settings were evaluated by the International Pathways to Care Study which examined the referral pathways taken by patients referred to mental health services in 11 countries, including 7 non-western countries in Asia, Africa and Latin America (Gater et al., 1991). It found that the commonest route of referral to mental health services was the general medical practitioner based in a family practice setting or a hospital outpatient clinic setting. However, this study has been criticised due to the small and unrepresentative nature of the selected population. A more representative study from Zimbabwe

reported that excepting patients with an acute illness, most patients sought treatment from more than one care provider (Patel, Simunyu, & Gwanzura, 1997). Over 75% of those who sought treatment had consulted both allopathic and traditional care providers, most often in that order. This is in agreement with the cultural concepts of illness, considering it to be a 'normal' illness at the onset with treatment sought from an allopathic practitioner. If the treatment does not result in the desired outcome, assistance may be sought from a traditional healer.

A majority of participants in a study conducted in Uganda, Liberia and Nepal reported the hospital as their main source of care. Traditional healers placed last in the hierarchy as a care option in Liberia and Nepal, while placing second after the hospital in Uganda. Poor supply of psychotropic medicines, inadequate mental health clinicians, negative attitudes of healthcare workers, and family were identified as the systemic barriers to access to mental health care (Kisa et al., 2016).

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A Sri Lankan study investigated the pathways to care of mentally ill patients by conducting a cross sectional study among 120 attendees of the psychiatry clinic of the National Hospital of Sri Lanka (Gomez, Gunarathna, Gunarathna, Gnanapragasam, & Hanwella, 2017). It found that over 50% of the participants sought western medical psychiatric care as their first help-seeking behaviour. As the authors did not disclose the psychiatric diagnoses of the participants, it is unclear how many of them had depression. The great majority (73%) of participants believed that their symptoms were due to a mental illness while only a minority believed them to be due to physical health issues (16.7%) or supernatural causes (15%). Most participants (53.1%) consulted a psychiatrist at the beginning, while 17.8% consulted a western medicine practitioner other than a psychiatrist and 16% sought help from a traditional or faith healer. Participants reported psychiatric biomedical care to be significantly more beneficial than other care options. It is interesting to note that the average time to present to mental health treatment was less than one month. Recommendation from family and society and identifying that the symptoms were due to mental illness, were the key factors in determining help-seeking behaviour. While these findings suggest that mentally ill patients presenting to a tertiary care hospital in Colombo are likely to seek psychiatric care early, the sample of participants was not representative.

3.6 Psychotherapy for depression in non-western settings

In non-western countries, psychotherapies are not commonly practiced due to a lack of resources including time and inadequate training of healthcare professionals in psychotherapy (Rathod et al., 2017). Culture influences psychotherapy in non-western cultures. For example, South Asians believe in karma and superstitions such as astrology and thereby tend to look for the sources of problems outside the self. Therefore psychotherapy, which looks inwards to find solutions may not sit well with South Asian belief systems. Further, Asians generally believe that verbal expression and overt display of emotion is undesirable as it damages relationships. Therefore, therapies which require patients to participate in the exploration of thoughts and feelings may not be very popular in these cultures.

Religious and political ideologies have negatively influenced psychotherapy at least in some countries. Rathod et al (2017) pointed out that until recently literature on Freud's theories of psychoanalysis was not permitted in Saudi Arabia for religious reasons, perhaps because of a misunderstanding of those theories. They argued that even relatively neutral theories like CBT have not been accepted as culturally attuned. Rathod et al (2017) highlight some non-western cultural beliefs which are incompatible with CBT, including 'our destiny is fixed and based on our previous good or bad deeds', people do not have free will and are controlled by high power, the individual must abide by the rules and values of their family or community to have a meaningful and conflict-free life, females will always need support from a stronger individual'. As much as 82% of participants in a cross-sectional study among students in India reported that CBT principles did not agree with their cultural or familial values (46%) or religious beliefs (40%) (Scorzelli & Reinke-Scorzelli, 1994).

A meta-analysis by Singla et al (2017) found that psychotherapies in non-western countries were commonly delivered by community health workers or peers in primary care settings, comprised of fewer sessions, and were conducted as individual therapy. These therapies included common elements like therapeutic engagement and specific techniques in cognitive, behavioural, emotional and interpersonal domains. The pooled effect size of 27 studies included was 0.49 (95% CI: 0.36–0.62). Most of these studies were based on CBT principles. The findings of this meta-analysis suggest that psychological treatments in non-western countries can be shorter and simpler and thereby delivered by paraprofessionals. This implies that the psychotherapies could be and should be modified to suit the context of non-western countries (Singla et al., 2017).

Meanwhile, a meta-analysis by Cuijpers et al (2018)found that the effect size of psychotherapies for depression in non-western countries was larger (g=1.10; 95% CI: 0.91-1.30) than that for western

countries, even after adjusting for publication bias (g=0.73; 95% CI: 0.51-0.96). The authors speculated that this finding may be due to a true difference indicating that psychotherapies for depression in these settings are indeed more effective, or due to the treatment as usual which is used as the control being quite substandard in these countries, or due to the poor methodological rigour of the studies. CBT was revealed to demonstrate a larger effect size than interpersonal therapy and problem-solving therapy.

This meta-analysis did not find an association of specific adaptation of treatment to the context where it was conducted with better outcomes. However, the authors mention that this finding should be considered with caution as the psychotherapeutic interventions were not described in detail and thus it cannot be excluded that the interventions were adapted but not mentioned in the paper (Cuijpers et al., 2018).

3.7 Cognitive behavioural therapy (CBT) for depression

Several metanalyses (Biesheuvel-Leliefeld et al., 2015, DeRubeis, Siegle, & Hollon, 2008; Hollon et al., 2005) concluded that CBT is effective in the acute phase of depression and has a lower relapse/recurrence rate of the depression when compared to treatment with antidepressants. CBT is a clinically effective and cost-effective intervention in the treatment of depression (Wiles et al, 2016). A meta-analysis conducted by Tolin (2010) demonstrated the superiority of CBT over alternative psychological therapies among patients with depressive disorders (k=21, d=0.26, CI=0.10–0.41). Although this conclusion was questioned by a later metanalysis that found no clear evidence to support the superiority of CBT over other therapies (Cuijpers, Berking, Andersson, Quigley, Kleiboer & Dobson, 2013; Cuijpers, Cristea, Karyotaki, Reijnders & Huibers, 2016), treatment guidelines continue to recommend CBT should be considered a first-line psychosocial treatment for depressive disorders (Malhi, Bassett, Boyce, et al, 2015).

CBT for depression is based on the principle that a person's mood is directly related to his or her patterns of thought. Negative, dysfunctional thinking affects a person's mood, sense of self, behaviour, and even physical state. The goal of cognitive behavioural therapy is to help a person learn to recognise negative patterns of thought, evaluate their validity and replace them with healthier ways of thinking. At the same time, therapists who practice CBT aim to help their patients change patterns of behaviour that result from dysfunctional thinking. Negative thoughts and behaviour predispose an individual to depression and make it nearly impossible to escape its downward spiral. When patterns of thought and behaviour are changed, so is mood.

Cognitive behavioural therapy emphasises a 'here-and-now' approach, defining the problem, identifying goals and measurements, including attainment of goals. These are often met through homework assignments in which the patient and the therapist work together to craft an assignment to encourage patients to practice the techniques learned, in between sessions. Effective cognitive behavioural therapy is dependent on the guiding role of the therapist, active involvement of the patient, and a close and trusting collaboration between therapist and patient. In addition to goals for the treatment, each session should have a specific agenda which would be achieved through specific techniques and concepts that are discussed during each session. CBT is a time limited therapy and typically treatment with CBT for depression lasts 8 to 16 sessions. CBT is also a structured therapy that is often delivered with a manualised script. The manuals are designed to guide the therapists by detailing basic steps, techniques and issues related to the therapeutic process.

3.8 Barriers to treatment of depression in Sri Lanka

Despite its higher prevalence, the significant impairment caused by it and the economic burden, depression is undertreated in Sri Lanka. Two studies on psychological autopsies of suicides in Sri Lanka reported that a significant number of victims had suffered from depression, but none had received psychiatric care (Abeyasinghe & Gunnell, 2008; Samaraweera, Sumathipala, Siribaddana, Sivayogan, & Bhugra, 2008). It is important to note that on many occasions individuals or their families did not seek psychiatric help even after self-harm attempts. One could hypothesize several reasons for this startling finding including stigma, lack of easy access to psychiatric care and lack of cultural sensitivity to psychiatric care in Sri Lanka. The country has only a few studies assessing stigma or views regarding mental health (Fernando, Deane, & McLeod, 2010; Fernando, Deane, McLeod, & Davis, 2017; Liyanage, Rowel, Hewawitharana, de Silva & Dissanayake, 2018; Samarasekara, Davies, & Siribaddana, 2012). Three of those studies were conducted among doctors, clinicians and medical students (Fernando et al., 2010; Liyanage et al., 2018; Samarasekara et al., 2012) and one among carers (Fernando et al., 2017). The studies on stigma have highlighted very high rates of stigma towards depression with up to 62% of people believing that depression is a sign of personal weakness and that patients can be blamed. Those surveys further emphasised the importance of specific interventions that modify negative attitudes towards mental illnesses including depression to address these issues. An international cross-sectional survey involving people with major depressive disorder in 35 countries including Sri Lanka (Lasalvia, Zoppei, Van Bortel, Bonetto, Cristofalo, Wahlbeck, et al, 2013) reported that a vast majority (79%) experienced discrimination due to the diagnosis of depression, with negative impact on social relations (37%)

employment (25%) and education (20%). This study also showed that experiencing discrimination was associated with concealing the diagnosis.

Although there is a severe dearth of Sri Lankan literature about help-seeking behaviour amongst people with mental illness, the available literature suggests traditional healing methods are the first choice for mental illness amongst most, despite a lack of proven effectiveness and high cost. Vogt (1999) further speculated that the popularity of *pirith, pooja* or *thovil* as treatment options for depression may be due to the lesser stigma and greater cultural appropriateness of the methods. Samarasekara & Siribaddana (2012) noted that a lack of cultural relevance has led to poor use of existing mental health services, making traditional healing rituals a popular treatment option for psychiatric conditions in rural and suburban Sri Lanka.

There are no studies in Sri Lanka regarding the treatment of depression. Perera et al. (2006) discussed the virtual non-existence of psychotherapeutic interventions for depression. Studies conducted in neighbouring India report an epidemic proportion of people with untreated depression (Mendenhall, Narayanan, & Prabhakaran, 2012). Psychiatrists in India have identified psychotherapy as a necessity but have not been able to provide it due to a larger workload and lack of culturally appropriate therapy and trained therapists (Manickam, 2010). A patient satisfaction survey conducted among psychiatric service users in India found that patients are dissatisfied with the provision of non-biological treatment (Holikatti et al., 2012). It has been suggested that appropriate psychotherapeutic intervention will significantly improve patients' satisfaction. A culturally adapted, focused, short-term psychotherapeutic intervention that could be administered by auxiliary psychiatric personnel may improve the treatment gap and patient satisfaction.

3.9 Use of psychotherapy in Sri Lanka

Psychotherapy is a therapeutic interaction between a trained professional and a patient, family, couple or group which aims to increase the sense of wellbeing of the individual/s. This objective may be achieved using various techniques including communication, understanding associations, experiential relationship building, exploring subconscious tensions, focusing on relationships, modulating emotions and changing maladaptive thoughts and behaviours. Psychotherapy is identified as a major component of treatment or the sole treatment for a wide variety of mental health issues including depression. However, psychotherapy is not commonly practiced or available in Sri Lanka. In 1985, de Silva and Samarasinghe highlighted the severe shortage of trained personnel in psychotherapy as the main reason. Unfortunately, there has been very little improvement in the

situation over the last three decades. The country has very few trained clinical psychologists. Psychiatrists are compelled to rely on pharmacological and other physical treatments to cope with a large number of patients, rather than devoting time to more time consuming and long-term psychological therapies. The wide use of indigenous healing practices for psychiatric presentations in Sri Lanka indicates the demand for non-biological mental health treatment. However, high cost, lack of proven efficacy, anti-medical views of practitioners and inconsistent and unregulated practice are major drawbacks of indigenous healing practices. The authors commented that more culturally appropriate and effective psychotherapeutic interventions would make it easier to deliver and utilise this form of treatment further. Research regarding psychotherapy is rarely published in Sri Lanka and most of those that have been published would be discussed in detail under section 4.3.

3.10 Is CBT a better suited psychotherapy for Sri Lanka?

There are many forms of psychotherapy, based on varied theoretical foundations using different techniques of delivery. Sri Lankan society is characterised by deeply ingrained traditions and belief systems despite modernisation. Psychotherapies which are consistent with these traditions and beliefs expected to be more suitable for the Sri Lankan context. Patients from the Indian subcontinent and Sri Lanka are more likely to expect and accept dependent relationships, less ready to seek intrapsychic explanations, more inclined to discard ego-bounds and involve their therapists in a student- teacher relationship. Sri Lankan people regard professionals as authority figures who are knowledgeable, and respected. Thus it may be more acceptable to patients, and more clinically effective, to adopt an instructive and didactic style of therapy. A facilitative client-focused approach to counselling does not conform to the image of a traditional cultural healer and taking this approach may negatively impact the engagement of the client into a therapeutic relationship.

Therefore, psychotherapies with a high emphasis on interpretation such as psychoanalysis and psychodynamic psychotherapy may be alien to the Sri Lankan context. Psychotherapies which give high importance to autonomy such as client-centered therapy, Gestalt therapy and existential therapy may have little value in the country's socio-cultural setting. Psychotherapies with equal therapist-client relationships such as psychoanalysis or humanistic therapies are likely to have little acceptance in Sri Lankan society.

Buddhism is the majority religion and arguably the most defining influence on belief systems in Sri Lanka. Beck, who developed CBT, believed that even though Buddhism and cognitive-behavioral therapy (CBT) were developed thousands of years apart and in different hemispheres, they have

many things in common (Beck, 2010). One of the most defining premises of CBT is the notion that one can change the content of their thoughts. In turn, this can change the person's feelings or emotions. This is called the "cognitive model." Thought-emotion fusion is well described in Buddhism. Other similarities between CBT and Buddhism, such as thought monitoring and the pragmatic approach to behaviour modification, make CBT less alien to the Sri Lankan population than some other forms of psychotherapy, such as psychoanalytic therapy. Demonstrable efficacy and the direct interaction between the therapist and the patient using the "teacher-disciple" paradigm are other reasons why CBT may be a suitable approach in Sri Lanka. Naeem, Waheed, Gobbi, Ayub and Kingdon (2011), Rossello and Bernal (1999) and Hwang (2009) pointed out that the relatively fixed structure, 'here-and-now' orientation, techniques to solve problems and more active interventions used in CBT may intrinsically appeal to oriental cultural traditions including Sri Lankan society.

CHAPTER 4

Culturally modified psychotherapy

Chapter 4

Culturally modified psychotherapy

4.1 Culturally modified psychotherapy

Culture impacts how people exhibit symptoms of mental illness and use coping mechanisms, social supports, and how people seek care or assistance (Gelso et al., 2014). Help-seeking behaviours and types of mental health services utilised vary by culture. Cultural factors also impact mental health care providers. These factors influence how consumers are diagnosed and treated (Hwang, 2009). In addition to the culture of consumers, overall service delivery is impacted by the culture of both providers and organisations. Lack of cultural competence can also contribute to barriers to engagement or continued utilisation of available mental health services. These barriers can include stigma perceived by consumers, conflicting ideas about what constitutes mental wellbeing, and culture based help-seeking behaviours. Elimination of barriers to care and improved access to existing healthcare are thought to increase service utilisation and improve outcomes (Hwang, 2009).

Modern healthcare relies heavily on evidence based practice (EBP), an approach to prevention or treatment that is backed by scientific evidence demonstrating positive outcomes in multiple research studies. However, it has been increasingly recognised that many EBPs have not been developed or tested for effectiveness in different cultural contexts and the evidence base may be limited to certain socio-cultural settings (Griner & Smith, 2006; Hwang, 2009). Cultural accommodation to an EBP involves modifying the way a practice is delivered so that it can be utilised within a particular culture or community, such as translating forms or using interpreters (Samuels, Schudrich, & Altschul, 2009). Cultural adaptation of an EBP involves reviewing and changing the structure of a programme or practice to more appropriately fit the needs and preferences of a particular cultural group or community (Samuels et al., 2009). At times both accommodations and adaptations to cultural groups are necessary to meet the needs of different cultures.

Gelso et al. (2014) noted that the single most important reason for both underutilisation of mental health services by ethnic minority clients and high dropout rates in the US is the inability to provide culturally sensitive/responsive therapy to the ethnic minority client (Gelso et al., 2014). A meta-analytic review of culturally adapted mental health interventions found culturally focused interventions to be four times more effective than non-adapted, generic interventions (Griner & Smith, 2006). The cultural adaptations included the inclusion of specific cultural values, therapist ethnic match, use of native language and changes to treatment duration. Despite increased awareness and enthusiasm about the benefits of culturally adapted mental health interventions, they are not widely available (Griner & Smith, 2006). This meta-analysis concluded that many culturally adapted mental health treatment methods may have not been included in the study as those have not been evaluated for effectiveness (Griner & Smith, 2006). Meanwhile, a meta-analysis conducted this year by Rathod et al. (2018) concluded that culturally modified therapies are indeed more effective.

Huey & Polo (2008) conducted a meta-analysis of 25 published randomised trials for ethnic minority youth. They concluded that none of the 25 studies could be considered well established therapies but were either probably or possibly efficacious. The authors noted the small number of studies and inconsistent quality as limitations. Sutton (2015), who evaluated 49 studies of treatment for Latinos living in the US, concluded that the type of cultural adaptation, treatment style and format had little influence on the effectiveness of culturally adapted interventions.

4.2 Psychotherapy in different cultural contexts

Historically, psychotherapy has focused predominantly on the therapeutic needs of upper and middle class Europeans or Americans. Mainstream psychotherapy continues to reflect the values of western culture, most notably a persistent bias toward individualism (Hall, 2001; Sue et al., 2009). Unlike western society, eastern cultures including Sri Lankan society are considered to be collectivistic in that they promote interdependence and cooperation (Obeysekere, 1985; Spencer et al., 1990). Therefore, universalism, a concept suggesting all interventions suit all cultural groups despite specific cultural and historical contexts in which people live their lives (‘one size fits all’) holds little value for psychotherapies as such interventions make use of the cultural values, beliefs and aspirations of a society and its origin (Bhui & Morgan, 2007; Tseng, 2001). It has been further suggested that cultural differences can influence the process of psychotherapy because of differences in the manifestation of symptoms, coping styles, values, family and community support, and willingness to seek treatment (Bhui & Morgan, 2007; Gelso et al., 2014; Nasser, 2004; Tseng, 2001).

CBT has become established as one of the most researched psychological interventions for depression (American Psychiatric Association, 2010; Butler et al., 2006; Cuijpers et al., 2018; Guven & Gokce, 2018; Ijaz et al., 2018; National Institute for Health and Care Excellence (NICE), 2009; Purgato et al., 2018). However, the cultural generalisability of the evidence is questioned (Arnberg et al., 2013; Nakimuli-Mpungu et al., 2014; Patel et al., 2009; Rathod et al., 2018). Most of the evidence for CBT comes from the western world (Cuijpers et al., 2018; Tolin, 2010). This is illustrated by the fact that all 10 studies included in a meta-analysis by Tolin (2010) on the effectiveness of CBT in treating depressive illnesses were conducted in western settings. A handful of the published data has included findings from ethnic minority groups who were however still living in western societies (Chowdhary et al., 2014; Hall, 2001; Sue et al., 2009). Most other empirically based psychotherapeutic treatments that are in practice have not been researched in different cultural settings (Alvidrez, Azocar, & Miranda, 1996; Casas, 1998; Constantine, Miville, & Kindaichi, 2008; Tseng, 2001). Thus it has been suggested that therapy may require adaptation according to language, metaphors, therapeutic relationship, theoretical constructs, goals, methods, and the cultural needs of a given society or country (Bernal & Scharron-del-Rio, 2001; Chowdhary et al., 2014; Laungani, 2004; Rathod et al., 2018; Scorzelli & Reinke-Scorzelli, 1994; Sue & Sue, 2000).

4.3 Modifying psychotherapy

4.3.1 Culturally modified psychotherapies

As discussed above, most psychological treatments such as CBT have been developed in western countries and are embedded with western ideals, values and norms. Bernal & Scharroon-Del-Rio (2001) state that psychotherapy itself is a cultural phenomenon and ethnic cultural concepts play a key role in the treatment process. It has been pointed out that existing psychotherapies may not represent the cultural background, thinking style or belief systems of the non-western population. It has been further suggested that cultural differences can influence the process of psychotherapy because of differences in the manifestation of symptoms, coping styles, values, family and community support, and willingness to seek treatment. Therefore, it has been suggested that therapy may require adaptation according to language, metaphors, therapeutic relationship, theoretical constructs, goals, methods, and cultural needs of a given society or country.

Known as culturally modified psychotherapy, they use existing or mainstream psychotherapy tailored to specific cultural contexts or make systematic changes to the protocol of an existing psychotherapy to make features of the therapy relevant to the culture of the target population. Whaley & Davis (2007) described culturally modified therapy as "any modification to an evidence based treatment that involves changes in the approach to service delivery, in the nature of the therapeutic relationship, or in components of the treatment itself to accommodate the cultural beliefs, attitudes and behaviours of the target population". Various other terminologies such as 'culturally adapted', 'culturally sensitive', 'culturally appropriate', 'culturally relevant', 'culturally anchored', 'culturally competent', 'culturally responsive', 'culturally congruent' and 'culturally informed' have been used to describe similar psychotherapies. Some authors have argued that different terminologies may describe the variability and gradation in the relationship between culture and psychotherapy (Kalibatseva & Leong, 2014). For example, the term 'culturally embedded' suggests the strongest relationship between culture and modified therapy, so much so that the psychotherapy is considered an integral part of the culture, whereas 'culturally adapted' implies changes have been made to existing treatment to make the characteristics of the treatment more suitable to that culture.

Sue et al. (2009) discuss the characteristics of culturally competent psychotherapists practising in a western country. While the context is different, most of these characteristics are still applicable to culturally modified psychotherapies in a non-western country. They state that beliefs, knowledge and skills related to culture should be embedded in culturally modified therapy.

Specific culturally adapted psychotherapy programmes found to be effective (Griner & Smith, 2006; Hodge, Jackson, & Vaughn, 2010; Rathod et al., 2018). There is growing evidence to suggest that the outcome of culturally modified psychotherapies are superior to non-adapted psychotherapies (Benish et al., 2011; Chowdhary et al., 2014; Rathod et al., 2018). Three studies conducted in California, USA, between 1991 and 2003, with modified psychotherapy for ethnic minorities using native language, therapist ethnic match and content modification according to cultural values showed those interventions had lower premature treatment failure rates (OR 6.32) and significantly improved symptoms control (Flaskerud & Liu, 1991; Kohn, Oden, Munoz, Robinson, & Leavitt, 2002; Miranda, Azocar, Organista, Dwyer, & Areane, 2003). Since then this has been replicated elsewhere (Chowdhary et al., 2014; Rathod et al., 2018).

Chowdhary et al. (2014) systematically reviewed the literature on adaptations of evidence based generic interventions for depression for ethnic minorities in western countries and for any population

in non-western countries to describe the effectiveness of the cultural adaptations. The authors describe the following adaptations in the 20 studies they included in the systematic review. Chowdhary et al. (2014) concluded that almost all studies (90%) reported the effectiveness of a culturally adapted intervention in depression using depressive symptoms as the primary outcome measurement, measured using depression rating scales over a period ranging from 2 weeks to 18 months post-treatment. This meta-analysis' pooled weighted standard mean difference showed a statistically significant benefit in favour of the culturally adapted intervention over the differing control conditions [SMD = −0.72]. This indicates that culturally adapted psychotherapies are efficacious.

Rojas-Garcia et al. (2015) found in their meta-analysis that culturally modified therapies are more effective for depression in low socioeconomic status populations. Benish et al. (2011) compared 21 culturally modified treatments for a wide range of psychiatric disorders including anxiety disorders, psychoses and behavioral disorders and across age groups against the unmodified generic treatment. They found a modest effect size (d = 0.32) in favour of culturally modified therapies. Chowdhary et al. (2014) identified that two studies (of the 20 studies included in the systematic review) were conducted as head-to-head studies comparing the effectiveness of the culturally modified treatment for depression against the unmodified generic treatment (Crespo, 2006; Kohn et al., 2002). Both studies reported greater effectiveness of the modified psychotherapy when compared to the unmodified version.

Despite wide support for the culturally sensitive practice, such psychotherapies are not commonly available (Butler et al., 2006; Kirmayer, 2015; Linardon et al., 2017). Most of the available culturally modified psychotherapies have been developed and tested on ethnic minorities living in western societies such as in the US and UK rather than on those living in non-western countries (Chowdhary et al., 2014; Rathod et al., 2018). Those adaptations are at least partly geared to address discrimination and marginalisation, and the unique set of problems faced by ethnic minorities living in foreign countries (Chowdhary et al., 2014; Rathod et al., 2018).

However, if existing interventions are sufficiently effective in different cultures, then adapting interventions to enhance cultural fit is unnecessary. Modified therapy risk losing the connection to the generic treatment, which is the evidence based treatment. Changes to the original therapy can decrease intervention fidelity and thereby effectiveness. Therefore, a modified therapy should be reasonably similar to the generic version, yet adapted enough to be more acceptable, deliverable and effective.

4.3.2. Overview of modification to adapt treatment

The Centre of Excellence in Culturally Competent Mental Health in the US identified 4 phases in the cultural modification process once a clinical need has been established: 1) Working with stakeholders, 2) Selecting an Evidence Based Generic Psychotherapy (EBP), 3) Modifying EBPs, and 4) Implementation Issues. The initial step includes identifying stakeholders, forming a working group, and gathering and discussing information required for treatment modification through a collaborative process. It further highlights the importance of identifying EBPs which have basic cultural compatibility, determining the components of EBP to modify, the process of modification, clear documentation of modifications, and assessing the suitability and effectiveness of the modifications. It emphasises the necessity of organisational and individual readiness to implement successful modified treatment.

4.3.3 Modification of psychotherapy

A few theoretical frameworks have been developed to guide therapy modification. Bernal, Bonilla & Bellido proposed the Ecological Validity Framework which comprises adapting 8 different dimensions including language, persons, metaphors, content, concepts, goals, methods, and context in developing culturally sensitive treatment. Culturally relevant forms of communication and expression of experience/distress such as lingo and sayings are considered under language and metaphors; persons describe patient-therapist dynamics including what is expected in the therapeutic relationship; and content refers to taking the patient's norms, values and interpersonal styles into consideration. Treatment, treatment goals and treatment methods should also align with the patient's culture. Context such as available support and religiosity is considered in the assessment and treatment. Few studies used the Ecological Validity Framework and interpersonal therapy for depression in Haiti and Puerto Rica.

Resnicow et al described interventions adapted at 'surface structure' and those adapted at 'deep structure'. Surface structure interventions are concerned with matching observable characteristics, such as people and language, while deep structure interventions engage with cultural, social, environmental and psychological forces that influence healthy behaviour such as religious and cultural values, beliefs, aspirations and goals.

Other authorities have used different terminologies to describe similar frameworks. They describe using a top-down, bottom-up or integrative approach to modify mainstream therapies. In this framework, top-down refers to cultural adaptations to an existing therapy to make it sound and look

more compatible to the target population. Those changes may include using the language of the particular population and changing the therapeutic relationship to a certain degree. These types of adaptations are equivalent to Resnicow et al.'s (1999) surface adaptations. On the other hand, bottom-up modifications refer to deep adaptations that consider contextual factors that determine conceptualisation and behaviour which involve collaboration with the target population in the form of focus group discussion or research study. An integrative approach refers to the use of both top-down and bottom-up modifications.

Leong & Lee (2006) proposed the Cultural Accommodation Model of psychotherapy comprising 3 steps: "(a) identifying the cultural gaps or cultural blind spots in an existing theory that restricts the cultural validity of the theory, (b) selecting current culturally specific concepts and models from cross-cultural and ethnic minority psychology to fill in the cultural gaps and accommodate the theory to racial and ethnic minorities and culturally diverse populations, and (c) testing the culturally accommodated theory to determine if it has incremental validity above and beyond the culturally unaccommodated theory" (Leong & Serafica, 2001). The Cultural Accommodation Model highlights the importance of using person-environment interaction rather than focusing only on the person and ignoring cultural context variables in the lives of these culturally diverse individuals (Leong & Kalibatseva, 2011).

Hwang (2009) argued that bottom- or ground-up community based approaches may supplement theoretically driven approaches to cultural adaptation by confirming theory related adaptations. He also suggested that such an approach may generate ideas that more theory driven approaches leave out and provide more specificity in the adaptations. Therefore Hwang proposed the Formative Method for Adapting Psychotherapy (FMAP) which consists of 5 phases: (a) generating knowledge and collaborating with stakeholders, (b) integrating generated information with theory and empirical and clinical knowledge, (c) reviewing the initial culturally adapted clinical intervention with stakeholders and revising the culturally adapted intervention, (d) testing the culturally adapted intervention, and (e) finalising the culturally adapted intervention. Netto et al (2010)identified 5 principles for guiding the development of interventions for ethnic minorities after a systematic review: (i) use community resources to publicise the intervention and increase accessibility, (ii) identify and address barriers to access and participation, (iii) develop communication strategies which are sensitive to language use and information requirements, (iv) work within cultural or religious values that either promote or hinder behavioural change and (v) accommodate varying degrees of cultural identification. Rathod et al. (2010) and Naeem. Ayub, Gobbi, & Kingdon (2009) used the following steps in modifying CBT to suit cultural contexts: a) information gathering, b)

preliminary adaptation, c) preliminary adaptation test, and d) adaptation refinement. Rathod and Naeem found these strategies successful in developing culturally appropriate CBT for psychosis and depression, respectively.

Chowdhary et al. (2014) systematically reviewed the literature on adaptations of evidence based generic interventions for depression for ethnic minorities in western countries and for any population in non-western countries to describe the nature of the cultural adaptations. The authors describe the following adaptations in the 20 studies they included in the systematic review.

They reported that language adaptations were found in most (75%) of the studies. These modifications were more than merely using the native language or the literal translation. Those adaptations included the use of everyday conversational and more acceptable expressions instead of technical and rather undesirable terms. For example, they used ‘therapeutic exercise’ instead of ‘homework’. They also used conceptually equivalent idioms of depression. The use of culturally relevant metaphors was reported in 30% of the studies, which included using culturally appropriate tools, materials, symbols and idioms. For example, the therapist used folk stories or religious stories to explain the patient's situation and symptoms and use the mood ladder to evaluate mood.

The systematic review found changes to methods such as focusing on less sophisticated, yet effective components were described in half (50%) of the studies. Dropping treatment elements which were culturally alien or less appropriate such as tasks involving writing has been described under adaptation to the method. Changes in the treatment to make it more suitable to social contexts were reported in two-thirds of the studies. Such modifications were focused on facilitating treatment delivery, acceptability and accessibility. These included involving family members in therapy, flexibility in scheduling sessions or delivering the treatment in a more accessible and less stigmatising setting.

Chowdhary et al. (2014) reported that addition or incorporation of cultural practices or focusing specifically on culturally relevant issues such as assertiveness training occurred in 40% of the studies. Specific focus on interpersonal issues and placing more emphasis on spirituality were among those modifications. Depicting mental health concepts in a more culturally comprehensible manner and thereby increasing the service utilisation was described in 30% of the studies. These included the somatic conceptualisation of depression thereby reducing the stigma attached to it.

The authors of the review found that therapist adaptations were also found in many (70%) of the studies. Therapist adaptation was aimed at increasing the acceptability and credibility of the therapist to the patient through shared beliefs, customs and experiences. Treatment modifications under therapist adaptation included changes in how the therapist conducted therapy, such as having a less-directive style emphasising the therapeutic nature of the interaction between therapist and patient. Chowdhary et al. (2014) revealed that changes to treatment goals to make them more culturally aligned were seen only in 20% of the studies. Having goals such as the wellbeing of the family over individual health and community advocacy was also described under this section.

Considering the reduction in symptoms associated with the models used by Rathod et al. (2010) and Naeem et al. (2009) in modifying CBT to suit Indian and Pakistani cultural contexts along with the high user satisfaction and low dropout rates reported by Rathod et al. (2013), this study was based on designs on those models and the very closely related FMAP proposed by Hwang (2009) to modify psychotherapy for Asian cultural contexts. I have incorporated some of the principles identified by Netto et al. (2010), particularly with identifying and addressing the barriers in service utilisation, in my study design, given the significant stigma towards mental health issues in Sri Lanka. Information regarding the necessary cultural modifications would be gathered around the themes that were generated after studying previous relevant studies which are collated in Table 1.

4.4 What makes culturally modified therapy more effective?

Culturally modified therapies work better in certain conditions and circumstances and when specific therapeutic elements are incorporated in the treatment. Different studies have described different moderating factors.

Smith, Rodríguez & Bernal (2011) in their meta-analysis pointed out that culturally modified treatment may have different effects on different ethnic groups and treatments are more effective when it is focused on a single ethnic group. The study reported that culturally modified treatment is more effective for Asian Americans when compared to African Americans [d=0.47], Latinos [d=0.47], and Native Americans [d=0.22]). They also reported that treatment focused on a specific cultural group was more effective [d=0.51] than treatment provided for mixed cultural groups [d=0.18]). Rojas-Garcia et al. (2015) replicated this finding, reporting that culturally modified treatment was twice as effective with Asian Americans compared with other ethnic minority groups in the US.

Rojas-Garcia et al. (2015), who conducted a meta-analysis of treatment for depression in low socioeconomic status populations (19 studies), identified individual therapy (cf group-administered interventions), therapy delivered in hospitals/clinics and at home, therapy based on psychoeducation, and interpersonal therapy to be more effective than other modified therapies.

Table 1

Themes of cultural modification of psychotherapy

Assessment	**Changes necessary in assessment and formulation**
Commonly used techniques	Degree of emphasis on changing negative thinking patterns and positive reframing (focusing on changing one's way of thinking is less in line with clients' goals of solving their problems. Too much emphasis on cognitive biases and changing negative thinking patterns may alienate the client, whereas a positive reframing to helping the client think more effectively and healthily is more congruent with their goals) Increase emphasis on problem-solving and behavioural activation Increase emphasis on resolving social conflicts and relationship problems. (The primary problems of many clients from collectivistic cultural backgrounds tend to be such issues)

	Importance of simplification and consolidation of topics into the basics when several variations of similar categories exist vs. discussing several different techniques
Style of therapy	Degree of collaborative vs. instructional style and importance of direct advice when presenting themselves as experts. (Consistent with respect for authority figures in collectivistic traditions where caregivers are experts who can help resolve their problems)
Flexibility	Need for increased flexibility in the ordering of sessions and also in the speed at which you move through them
Dynamic sizing	Differentiation of emic (culture-specific) and etic (culture-general) constructs when providing therapy - when to individualise and when to generalise
Homework	Selection of culturally appropriate homework assignments; encouragement to attend even if they were unable to complete their homework; use of different terminology such as exercise, practice or strengthening rather than homework.
Somatic complaints	Highlighting the importance of physical symptoms and their association with thoughts and mood; acknowledging the interrelationship of mind and body consistent with the holistic emphasis in Sri Lankan culture; inclusion of physical complaints in the thought diary as a separate column
Attendance and premature dropouts	Addressing premature dropouts, education about the healthy termination of the therapeutic alliance, and the importance of educating the client about the course of therapy (e.g., what their experience is going to be like the first few weeks, several weeks thereafter, and in the long run)
Involvement of family	Presence of family members during sessions, active assistance from the family in completion of homework, and limitations in family involvement
Translations of terminology	Translations of cognitive therapy terminology such as cognitive errors

Cultural metaphors	Folktales and *Jataka* Stories (instructional stories of Lord Buddha's past lives) often convey a message or a moral to be emulated by others
Beliefs about illness	Discuss how to overcome beliefs such as ‘depression is due to fate or bad astrological periods’
Experience with faith healers	Identify how interactions with faith healers affect psychotherapy delivery and outcome
indfulness and other Buddhist / religious values	Discuss how existing knowledge about mindfulness in the community can be incorporated into practice along with the utilisation of specific religious value systems
Goal setting	Increased emphasis on goal setting and markers of treatment progress that is periodically reviewed. This helps reduce the ambiguity of therapy and is consistent with the problem focused nature of clients seeking treatment. Clients who are less comfortable being in therapy find frequent reminders of the goals that they have achieved to be confirmation that attendance is beneficial
Number and length of sessions	Discuss what would be practical, acceptable and achievable durations for sessions and the necessity to adjust the number of sessions accordingly

Degnan et al. (2018) reported that interventions were more effective when participants attended with relatives versus alone. More than one meta-analysis identified the older age of the patient as a predictor of the effect of culturally modified therapy (Griner & Smith, 2006; Smith et al., 2011).

Benish et al. (2011) concluded, in the meta-analysis of culturally adapted therapies vs. unadapted therapies (59 studies), the illness myth as the sole moderator of superior outcomes via culturally adapted psychotherapy (d = 0.21). The illness myth is a particular form of modification involving the explanation of illness known in an anthropological context as the illness myth of universal healing practices. van Loon et al. (2013) found that culturally modified therapy for depression and anxiety for adult outpatients is more effective when such therapies are combined with a focus on patients’ cultural values, beliefs and symptom presentation.

Meta-analyses conducted by Huey & Polo (2008), Hodge et al. (2010) and Sutton (2015) found no moderating effect for type of cultural modification, diagnosis, illness severity, ethnicity or immigration status of the patient.

4.5 Modification of psychotherapy in Sri Lanka

Very little research has been conducted on culturally sensitive psychotherapies in Sri Lanka. Sumathipala, Hewege, Hanwella, & Mann (2000) conducted a randomised controlled trial using modified CBT for medically unexplained complaints. The cultural modifications utilised were shorter sessions, active involvement of a carer and stronger emphasis on psychoeducation. Although the first study showed a significant reduction in symptoms and distress with modified CBT, a subsequent study (Sumathipala et al., 2008) showed CBT provided after a short course of training on culturally modified therapy was no more efficacious than structured care (the latter included the same number of appointments of similar duration and maintenance of diaries to record symptoms but the physicians did not receive training in CBT nor was there any requirement to adhere to manualised interventions). Samaraweera et al. (2008) demonstrated in a pilot study of modified CBT for suicidal ideation that suicidal intent eased more than in the treatment as usual group in Sri Lanka. However, the cultural modifications used in that study were not elaborated. De Zoysa published 3 case reports (de Zoysa, 2010, 2011, 2013) on the modification of CBT using Buddhist mindfulness meditation to address depressive and anxiety symptoms in the Sri Lankan context. Three techniques of mindfulness practice - awareness of daily activities, awareness of postures/gestures, and awareness of inhalation and exhalation of the breath - were used with good effect. No studies have been conducted on culturally modified psychotherapy for depression in Sri Lanka. A summary of the study methods and results are collated in Table 2.

The severe dearth of experienced specialist mental health professionals such as psychiatrists and clinical psychologists in Sri Lanka is the main barrier to effective mental health care. Development of a culturally relevant psychotherapeutic model with a comprehensive manual may enable other mental health professionals with less experience, a greater number of whom are available in the health service, also practice psychotherapeutic interventions effectively and thereby reach out to a larger proportion of mental health service users (Kakuma et al., 2011).

4.6 Significance of culturally modified therapy in Sri Lanka

Obeysekara pointed out that some Sri Lankans do not consider depressive symptoms or distress due to those symptoms as a disease but as something else, for example, religion. He argues that in Western culture, depressive affects are not given cultural meaning due to rationalisation, but in cultures such as Sri Lankan, the same experience is interpreted with different cultural explanations. In other words, these “symptoms in western societies exist in a free-floating manner and are not anchored to a cultural aetiology and are therefore identifiable and conducive as an illness, whereas in

oriental societies these features may be locked into larger cultural and philosophical issues of existence and the problem of meaning". Therefore, treatment should be sensitive to such conceptualisations to ensure higher utilisation, lower dropout and better efficacy.

In this backdrop, psychiatric services being developed in Sri Lanka should be sensitive to the cultural values and practices of its society. They should consider the current behaviour of the Sri Lankan people in seeking help for mental health. Hence culturally modified psychotherapies will play a vital role in the Sri Lankan mental health system.

Table 2

Psychotherapeutic studies in Sri Lanka

Study	Mental disorder	Setting	Study design	Intervention	Sample size	Outcome
Sumathipala et al. (2000)	Medically unexplained symptoms	General outpatient clinic, Colombo Sri Lanka	RCT	Intervention group received 6, 30 min sessions of modified CBT for 3 months. The control group received standard clinical care – outpatient appointments with doctors	34 in each group	Two interventions were compared at 3 months. 24 in the treatment and 21 in the control groups completed assessments. Differences in number of complaints 6.1 and 3.8 ($p= 0.001$), GHQ 10.4 and 6.3 ($p=0.04$), Bradford Somatic Inventory score 15.6 and 132 ($p<$ 0-01), visits 7.9 and 3.1 ($p = 0.004$).
Sumathipala et al. (2008)	Medically unexplained symptoms	General outpatient clinic,	RCT	Intervention group received 6, 30 min	75 in each group	Two interventions were compared at 3 months, 6 months, 9 months and 12 months. No significant

		Colombo Sri Lanka		sessions of modified CBT by primary care physicians after a short course of training. The control group received standard clinical care – outpatient appointments with doctors		difference was observed in the number of complaints. GHQ, Bradford Somatic Inventory score or the number of visits at 3 months, 6 months, 9 months and 12 months.
Samaraweera et al. (2008)	Suicidal ideation	Primary care settings, Colombo, Sri Lanka	RCT	3-6 sessions of structured, culturally adapted (adaptations not elaborated) CBT. Control group received treatment as usual which did not include structured CBT	5 in each group	Two interventions were compared at 3 months. Difference in Beck's Suicidal Intent Score 11.2 and 0.2 (*p =0.002*) and in GHQ 22.0 and 10.8 (*p* =?)
de Zoysa (2013)	Obsessive compulsive disorder	Outpatient, Colombo, Sri Lanka	Case study	Seven 20-50 min sessions of mindfulness based CBT based on	1	Clinical remission

				Buddhist principles such as the body scan technique, awareness of daily activities, and awareness of postures and gestures		
de Zoysa (2010)	Mixed anxiety and depressive disorder	Outpatient, Colombo, Sri Lanka	Case study	7, 30-50 min sessions of mindfulness based CBT based on Buddhist principles such as awareness of daily activities and awareness of breathing	1	Clinical remission
de Zoysa (2011)	Major Depressive disorder with somatic symptoms	Outpatient, Colombo, Sri Lanka	Case study	6 sessions of CBT based on Buddhist principles such as mindful acceptance of thoughts and breathing meditations	1	Clinical remission

CHAPTER 5

Methodology

Chapter 5

Methodology

5.1 Methodology

This study was conducted in two phases. It has to be conducted in two phases due to the sequential nature of the study. The findings of the first phase informed the second phase. In this thesis, the two phases will be discussed separately.

5.2 Objectives of Phase 1 of the study

5.2.1 General objective

The most important objective of Phase 1 was to explore the expectations and views of Sri Lankan patients with depression, and their carers, healthcare professionals, traditional healers and lay counsellors regarding the best form psychotherapy for depression should take in Sri Lanka.

5.2.2 Specific objectives

1. To gain a meaningful understanding of the views and expectations of patients with depression and their carers in Sri Lanka, on suitable psychotherapy for depression in Sri Lanka
2. To elicit those cultural influences, values and attitudes that shape a Sri Lankan patient's degree of participation and responsiveness to psychotherapy for depression
3. To elicit from psychiatrists / psychiatry trainees and psychotherapists in Sri Lanka their experiences and views on how CBT for depression can be modified to make it more suitable to the Sri Lankan context
4. To elicit from traditional healers and religious and community leaders in Sri Lanka, their views on psychotherapy for depression suitable to Sri Lanka
5. To identify strategies relevant to CBT for depression that mental health practitioners and traditional healers identify as being supportive or not, for Sri Lankan patients
6. To analyse the data collated to make culturally specific adaptations to the existing CBT manual for depression.
7. To review this preliminary culturally adapted CBT manual with the above mentioned stakeholders and revise accordingly

Ethics approvals were obtained from the Ethics Committees of the University of Melbourne and the University of Kelaniya. Details are given in section 5.11

5.3 Study design of Phase 1

Phase 1 of the study adopted a mixed methodology informed by an ethnographic approach to modify the existing CBT manual for depression to make it more culturally appropriate for Sri Lanka. In Phase 1 we conducted semi-structured interviews with all stakeholders to generate knowledge on cultural values, beliefs and attitudes regarding psychotherapy for depression in Sri Lanka. The following categories were selected with a purposive sampling method.

The Formative Method for Adapting Psychotherapy (FMAP) with 5 phases, namely (a) generating knowledge and collaborating with stakeholders, (b) integrating generated information with theory and empirical and clinical knowledge, (c) reviewing the initial culturally adapted clinical intervention with stakeholders and revising the culturally adapted intervention, (d) testing the culturally adapted intervention, and (e) finalising the culturally adapted intervention, was used in adapting the existing CBT manual (Hwang, 2009). All 8 different dimensions, namely language, persons, metaphors, content, concepts, goals, methods and context described in the Ecological Validity Framework were considered when modifying the manual (Bernal, Bonilla, & Bellido, 1995). Following areas described by Naeem et al. (2019) were also considered in the modification

- Awareness of relevant issues and preparation for therapy
- Assessment and engagement
- Modifications in therapy techniques
- Adjustments in the process of psychotherapy including changes in the health care system
- Awareness of relevant cultural issues, including areas related to culture, religion and spirituality

Further, both surface and deep structure modifications described by Resnicow et al. (1999) were taken into consideration when modifying the CBT manual.

5.4 Study participants of Phase 1

Four groups of participants were included in this study. We selected these groups after studying previous studies. We believed these four groups truly represent the stakeholders- service recipients

or patients, service providers or psychotherapists both psychiatrists and psychologists, those who have intimate knowledge of patients or their carers and those who have intimate knowledge about the cultural issues pertaining to mental health or traditional healers.

5.4.1 Group 1 - Sri Lankan patients with depression

Individuals aged 18 to 60 years, receiving outpatient or inpatient treatment for major depressive disorder at Colombo North Teaching Hospital in Ragama, Sri Lanka.
Teenagers and older persons were not included as depression in adolescence and old age can be different (Bryant, 2010; Thapar, Collishaw, Pine, & Thapar, 2012).

5.4.2 Group 2 - Sri Lankan carers of patients with depression

Individuals aged 18 to 70 years caring for adult outpatients or inpatients receiving treatment for major depressive disorder at Colombo North Teaching Hospital in Ragama, Sri Lanka. In societies like Sri Lanka, family plays a greater role in caring for mentally ill individuals. They have a definite influence on treatment seeking behaviour and treatment preferences of patients (Chadda, 2014).

5.4.3 Group 3 - Sri Lankan care professionals

Consultant psychiatrists, psychiatry advanced trainees (post-MD), clinical psychologists and final year clinical psychology students who practice or study in the Colombo and Gampaha districts in Sri Lanka. In developing countries like Sri Lanka nurses and other allied health clinicians play a less significant role in delivering psychological therapies (World Health Organization, 2007). Doctors and psychologist are the only two professional categories who provide formal psychotherapy in Sri Lanka

5.4.4. Group 4 - Sri Lankan traditional healers and lay counsellors including religious leaders

Traditional / faith healers who treat patients with psychiatric symptoms and Buddhist, Catholic, Christian, Hindu and Muslim religious dignitaries who practice and reside in the Colombo and Gampaha districts in Sri Lanka.

The reciprocal interaction between culture and religion is well documented (Beyers, 2017). Religion is not only determined by culture, religion also influences culture. Therefore, religion and culture are interwoven. Comparative importance of traditional healers in Sri Lanka may have diminished with the introduction of the Allopathic Western Medical system, but they are still consulted for mental health issues on a wide scale and are readily available, affordable and trusted (Jones & Liyanage,

2018). This is particularly true for rural areas of Sri Lanka. Traditional healing methods are socially acceptable to communities and are therefore carry less stigma. Therefore religious dignitaries and traditional healers are considered to the custodians of indigenous knowledge on culture and health (Mathibela, Egan, Du Plessis, & Potgieter, 2015).

5.5 Recruitment of participants for Phase 1 of the study

5.5.1. Inclusion criteria

Groups 1 and 2 - Sri Lankan patients with depression and carers of patients with depression

- Individuals receiving outpatient or inpatient treatment for major depressive disorder and carers of such patients at Colombo North Teaching Hospital in Ragama or its satellite clinics in Kandana and Ja Ela
- Have the capacity to consent and understand the interview

Group 3 - Sri Lankan consultant psychiatrists, psychiatry trainees, psychotherapists

- Consultant psychiatrists, psychiatry trainees (medical doctors in the psychiatry training programme), medical officers of mental health (MOMH), clinical psychologists and clinical psychology students who practice or study in the Colombo and Gampaha districts

Group 4 - Sri Lankan traditional healers and lay counsellors including religious leaders

- Traditional / faith healers who treat patients with psychiatric symptoms and Buddhist, Catholic, Christian, Hindu and Muslim religious dignitaries who practice and reside in the Colombo and Gampaha districts.

5.5.2. Exclusion criteria

All 3 groups

- Inability to communicate in Sinhala as the interviews are conducted in Sinhala

Group 1

- Patients whose treating psychiatrists / clinicians believed that the interview of this study would distress them

5.6 Recruitment procedure

5.6.1 Groups 1 and 2

Initially, the treating doctors identified eligible patients and carers who accompanied patients to the clinic / ward as per the inclusion and exclusion criteria described above. Carers of the patients who were recruited for the study were not recruited depending on their suitability and their personal preference. Any patient or carer who might get distressed by the interview was excluded. This was ascertained by the psychiatrist treating the patient before approaching the potential participant. The treating doctors described the study to the eligible patients / carers. The purpose of the study, what it involved and ethical aspects such as confidentiality and non-obligatory participation in the study were explained to the patients / carers. Recruitment of the patients and their carers were conducted by non-clinical research assistants who were not involved in the treatment of the patient. Research assistants were pre-intern medical graduates who had basic training in principles of conducting research ethically and accurately. They were supervised and monitored by the student researcher.

Student researcher (AR) works as a psychiatrist at Colombo North Teaching Hospital, Ragama and patients under his direct care were not recruited.

5.6.2 Groups 3 and 4

The list of names of psychiatrists / psychiatry trainees, medical officers of mental health and psychologists working in the Colombo and Gampaha districts, along with their contact details were gathered from the Ministry of Health. A list of traditional / faith healers who treat patients with psychiatric symptoms and Buddhist, Catholic, Christian, Hindu and Muslim religious dignitaries who practice and reside in the Colombo and Gampaha districts were gathered through religious and societal leaders. Participants of Group 3 (healthcare professionals) and Group 4 (traditional healers and lay counsellors) were identified by the student researcher depending on whether they provided psychological treatment for depression, place of practice (urban vs. semi-urban), age, gender and experience, to ensure a representative sample. They were contacted by the student researcher to explain the study to them and invite them to participate in the same. During recruitment, the fact that participation was non-obligatory and that their decision to participate or not would have no future bearing was emphasised to the trainee psychiatrists and psychologists.

5.7 Sample size of Phase 1

The number of participants required from each stakeholder group was decided after reviewing similar studies. Those studies found 8-12 participants from each stakeholder group adequate to gather the necessary information. It was observed that all areas were covered with sufficient depth with 8-12 participants from each group (Naeem et al., 2009; Rathod et al., 2010).
More participants were recruited from Group 3 as it was felt that they could contribute the most to generating knowledge.

5.8 Data collection in Phase 1

Stakeholders were interviewed to generate knowledge on cultural values, beliefs and attitudes regarding psychotherapy for depression in Sri Lanka. The areas explored with each group and the specific questionnaire guides that were used (see Appendices) are mentioned below. Interviews with patients and carers were held at Colombo North Teaching Hospital, Ragama at a mutually convenient time. The hospital was selected as the patients either attended the hospital for outpatient clinics or treated at the hospital as an inpatient. Their carers either accompanied them to the hospital or visited them in the hospital. Interviews with healthcare professionals and traditional healers were held at their workplaces at a pre-arranged time. These interviews were held at their workplaces as many of them found it practically inconvenient to come to the hospital.

Group 1 - Patients were interviewed regarding their presenting symptoms, help-seeking behaviours, attribution styles, acceptability of psychotherapy / counselling, obstacles in delivery and acceptance of these forms of therapy. Cultural factors related to psychotherapy and their experience with psychotherapy or counselling were explored.

Group 2 - Carers were interviewed regarding their patients' presenting symptoms, help-seeking behaviour, attribution styles, acceptability of psychotherapy / counselling, obstacles in delivery and acceptance of these forms of therapy. Cultural factors related to psychotherapy and their experience with psychotherapy or counselling were also explored.

Patients and carers were asked about their symptoms, with particular reference to somatic symptoms understand the symptoms pattern of depression. Somatic symptoms were explored to know how much emphasis should be placed on somatic symptoms in psychotherapy. Their pathway to treatment was explored to understand whether they came directly to Allopathic treatment or first sought alternative treatment. When there was a delay in seeking treatment reasons for the same was explored in detail to understand the reason for it including stigma, poor mental health literacy, treatment not being culturally acceptable, advice from someone, etc. If they have sought traditional treatment, the reason for it and their experience of it was explored. This was to understand whether psychotherapy treatment could learn from it. At times patients and carers were not very knowledgeable about psychotherapy. In such cases, it was explained to them the concept of psychotherapy. It was noted that after explanation, patients and carers were able to provide more elaborative answers. Even when they have not had psychotherapy before, they were asked about their opinion on psychotherapy.

Group 3 - Healthcare professionals were interviewed regarding their experiences and attitudes towards providing therapy, especially CBT, to depressed patients. In particular, issues around necessary cultural modifications, barriers to therapy, helpful and unhelpful techniques, and factors that influence the outcome of therapy were explored.

First, whether they deliver psychotherapy and CBT in their routine practice was discussed. Psychotherapeutic principles as well as psychotherapy in its entirety were discussed as many Sri Lankan doctors may not find time to do the psychotherapy in its full form. This was to have an idea about their familiarity and expertise in psychotherapy and CBT. Their opinion on the effectiveness of psychotherapy /CBT was discussed. Their assessment of psychotherapy against other treatments was explored. The discussion was focused on whether the clinicians believe CBT for depression can be used in Sri Lanka in its original form or whether it should be modified. Clinicians' view about the suitability of individual core components of CBT including behavioural activation and cognitive restructuring and peripheral components such as problem solving, and mindfulness was discussed. In addition to the alternations to content or component of CBT, necessary changes to the process such as length of the therapy, the involvement of family and whether it should be more instructional, or collaborative were discussed. Specific strategies to make it more relevant to Sri Lankan patients such as using folk stories explaining CBT techniques were discussed.

Group 4 - Traditional healers were interviewed about their experiences in providing treatment to patients with psychiatric symptoms and depressive symptoms in particular, helpful and unhelpful techniques, and factors that influence the outcome of therapy.

First, whether they see patients with psychiatric ailments was established. Then the symptoms of those patients and details of treatment they deliver were discussed. The therapeutic principles of their practice were explored at length. Parallels between their practice and Western psychotherapy such as homework assignments were discussed. Their opinion on the effectiveness of allopathic treatment psychotherapy, in particular, was explored. What CBT was explained to them. Then the discussion was focused on how CBT can be more culturally relevant using their experience.

The above mentioned themes were selected upon studying previously conducted relevant studies (Hwang, 2009; Interian & Diaz-Martinez, 2007; Naeem et al., 2009; Netto et al., 2010; Rathod et al., 2010).

The principle of 'emergent design' was followed when respondents raised issues that required further exploration or verification. These points were then tested appropriately with subsequent participants. While most of the interview questions were ‘explorative’ and ‘interpretive’, some were ‘ideal’ and ‘hypothetical’ (Merriam & Tisdell, 2015).

5.9 Data analysis in Phase 1

All individual interviews were audio-recorded and transcribed. Transcripts were coded and anonymised. All interviews, those with patients, carers and traditional healers, in particular, were conducted in Sinhala. The interviews with healthcare professionals however were conducted in English. The interviewer (AR) is fluent in both languages. Two bilingual Sri Lankan mental health professionals translated the transcripts of interviews conducted in Sinhala into English. Each person translated the full transcripts independently and subsequently met to decide on a consensus of the translation. Both conceptual and linguistic equivalence were considered during the translation process. If there were significant discrepancies in the two translated versions, another bilingual mental health clinician performed back-translation of the transcripts independently to identify the more suitable translation. Notes were taken on non-verbal communication and behaviour.

The data was analysed by systematic content and question analysis by identifying emerging categories and themes (Krueger & Casey, 2014; Morse & Field, 1996; Simons, Lathlean, & Squire,

2008). Data analysis of stage 1 of the study was done in three stages; namely, the reduction or breakdown of the text, the exploration of the text; and the integration of the exploration (Attride-Stirling, 2001). We attempted to accomplish a more abstract level of analysis at each stage.

The first step in our analysis, reduction of the data, was done by dissecting the text into manageable and meaningful text segments. This was done with the use of a coding framework based both on the questions used in the semi structured questionnaire salient issues that arise in the text itself. Questions used in the questionnaire were driven by the theoretical interests guiding the research questions. English transcripts were perused to identify the most salient constructs in the discussions and a limited number of discrete, yet meaningful codes were developed. The codes had explicit definitions avoiding those being interchangeable. The transcripts were then dissected, classified and organized according to these codes.

Identifying categories from coded segments were done by perusing the text segments in each code, and extracting the common, prominent or significant themes in the segments. This was done by the student researcher (AR) though re- reading the text segments within the context of the codes under which they have been classified. Re-reading enabled the student researcher to identify underlying patterns and structures which in turn assisted in formulating categories. The selected categories were refined further to develop themes which were discrete yet inclusive to capture a set of ideas contained in a large amount of data. This reduced the data into a more manageable set of significant themes that concisely summaries the text into something that can be used to modify the mainstream CBT.

The objective of the analysis is to summarise the salient themes which are clear or emerging in the exploration. Recognizing and describing them succinctly and explicitly makes the modification of CBT more compelling in turn more effective.

5.10 Formation of the modified manual of Phase 1

The culturally adapted manual was compiled using the analysed data. Analysed data was used in developing the modified CBT manual after studying similar studies (Naeem et al., 2011; White et al., 2010). After completion of the manual, additional interviews and focus groups were conducted with mental health clinicians, particularly with those who practice CBT. Initial impressions and feedback were used to refine and finalise the manual before the second stage.

The manual was not translated to Sinhala as the psychotherapists who use the manual preferred it to be in English. Initially manual describes the therapeutic relationship of CBT and its applicability in the Sri Lankan context. After discussing generic components in the therapeutic relationship, the MCBT manual how specifically it should change to make it more suitable for the Sri Lankan context. For example "It is even more important in Sri Lankan context to explain the therapeutic nature of the relationship between the therapist and the patient considering that Sri Lankan patients are not familiar with psychotherapy" or "In carrying out CBT with Sri Lankan patients the therapist may be required to adopt a more didactic role and instructional style. This is in the context of social structures and expectations of patients. Sri Lanka has a more hierarchal society than the Western world and patients expect doctors / health care professionals to guide them. Therefore, a more instructional style could be adopted without being coercive or dismissive. The treatment methods and approach should still be tailored to patients considering their presentations, problems and needs….."

This manual discusses the therapeutic strategies that are given lesser significance than in generic CBT manual such as Socratic questioning. This also discusses how cognitive formulation will be different from its normal form. It states that while it is essential to have a formulation, detailed and more sophisticated formulation may neither be feasible nor useful in MCBT.

It discusses six sessions in detail. Examples in the form dialogues between a Sri Lankan patient called Dharshanie and Sri Lankan therapist is given to guide and inform the therapist how each of those components is introduced to the patient and delivered. It also gives examples of how certain culturally appropriate examples are used to describe concepts related to CBT. It uses some popular sayings in Sri Lanka, well known religious teachings in the country and Sri Lankan folk stories to exemplify the CBT concepts. The manual also discusses what common potential treatment obstacles in the Sri Lankan context and how to address those issues in a culturally sensitive manner.

The manual gives a clear and elaborate description of monitoring, assessing and addressing somatic or physical symptoms which are common in Sri Lankan patients. As this is not included in the original CBT manual this described with clear examples and dialogues. Likewise, clear scripts with Sri Lankan examples are given to guide the relaxation techniques, mindfulness and problem solving techniques. In the end, there are handouts and worksheets that can be given to Sri Lankan patients.

In summary modifications of the manual included guidance on culturally sensitive psychotherapy assessment and culturally sensitive engagement with the patient and technical adjustments of CBT to suit the Sri Lankan cultural context. Extensive knowledge about local cultural, religious and spiritual

beliefs could not be included in the therapy manual due to obvious reasons including the sheer volume of information.

5.11 Ethical aspects of Phase 1 of the study

5.11.1 Approval

Ethics approvals were obtained from the Ethics Committees of the University of Melbourne and the University of Kelaniya. Permission was obtained from the Director of Colombo North Teaching Hospital to conduct the study at the hospital. Written informed consent was obtained from participants using a patient information leaflet and consent form (see Appendices).

5.12 Debriefing

Patients and carers were checked on by a member of the team treating them following participation in the study to ensure they were not distressed.

5.13 Benefits compared to potential harm

Phase 1 of the study assisted in developing culturally relevant psychotherapy (CBT) for depression in Sri Lanka which would improve treatment provision for depression in Sri Lanka. This also provides important insights into cultural beliefs, values and ideals which would help to improve mental health care provision in Sri Lanka in general. Participants of the study, particularly the patients, carers and healthcare professionals, would benefit from both development of culturally adapted CBT and improvement in healthcare provision. Other possible benefits for patients and carers include this study serving as an educational session regarding all treatment options that are available for depression, especially psychotherapy.

We excluded any patient or carer who was likely to get distressed by the interview. Considering the vulnerability of patients, face-to-face semi-structured individual interviews with participants were conducted. The interviews were conducted at a time and place convenient to the participants.

5.14 Managing the dependant relationship

Patients and their carers were recruited by non-clinical research assistants who were not involved in the treatment of the patients. Research assistants were used as the initial point of contact to ensure voluntary participation uninfluenced by the doctor-patient relationship. The fact that participation was non-obligatory was emphasised along with the fact that their decision to participate or not would have no future bearing. The student researcher (AR) works as a psychiatrist at Colombo North Teaching Hospital, Ragama and inpatients under his direct care were not recruited.

The psychiatry and psychology trainees were approached by the student researcher. The student researcher was not directly involved in examinations to be undertaken by these trainees. The fact that participation was non-obligatory and that a participant's decision to participate or not would have no future bearing was emphasised at the time of obtaining consent.

5.15 Data protection

Confidentiality of the data will be ensured by safe storage in locked cabinets at the Department of Psychiatry, the University of Kelaniya, Sri Lanka for paper records / audio tapes and by password protection of electronic documents in the computers of the Department of Psychiatry, the University of Kelaniya with exclusive access to student researchers. The paper and audio data will be stored safely in locked cabinets at the University of Kelaniya for 7 years. Only researchers will have exclusive access to the data.

5.16 Objectives of Phase 2 of the study

5.16.1 General objective

This phase was aimed at evaluating the feasibility and adverse events of a modified CBT for patients with depression in Sri Lanka.

5.16.2 Specific objectives

- Explore whether the modified CBT treatment for depression in Sri Lanka is acceptable to the patients.
- Evaluate whether modified CBT treatment for depression in Sri Lanka is deliverable with ease by the healthcare professionals.
- Examine the obstacles in delivering the modified CBT for depression in Sri Lanka.
- Examine whether Sri Lankan patients show improvement in symptoms with the modified CBT for depression.

5.17 Study design of Phase 2

In Phase 2, a pilot study was conducted using an experimental prospective study design to evaluate the feasibility and possible adverse events of a modified CBT for adult patients receiving outpatient treatment for unipolar depressive disorder at Colombo North Teaching Hospital, Ragama, Sri Lanka.

5.18 Study participants of Phase 2

Patients were recruited from the psychiatry outpatient clinic at Colombo North Teaching Hospital, Ragama, Sri Lanka.

5.18.1 Inclusion criteria

- Patients with unipolar depression aged 18 to 60 years, satisfying DSM-V criteria for major depression and scoring at least 20 on the 24-item Hamilton Rating Scale for Depression (HRSD) and 9 on the Sinhalese version of the Beck Depression Inventory II (BDI)
- Patients who have received treatment for depression for at least 6 months
- Patients who have the capacity to understand the study and give informed consent

5.18.2 Exclusion criteria

- Patients with a history of bipolar disorder, cyclothymia, schizoaffective disorder, persistent antisocial behaviour or repeated self-harm, borderline personality disorder, learning disability (estimated IQ <70) or organic brain damage
- Patients currently receiving formal psychotherapy or those who have previously received CBT for more than 5 sessions
- Severe illness that has affected mental capacity or ability to participate in the study
- Unable to communicate in Sinhalese
- Patients who, in the opinion of the treating psychiatrist or clinician, would become distressed by the intervention considering their clinical and personality profile

5.19 Sample size and selection in Phase 2

Twelve patients were selected by convenience sampling. Twelve patients made allowance for two participants potentially dropping out of the study to make the eventual target of 10 participants. The number of participants for the study was decided after studying previous pilot and feasibility studies (Billingham, Whitehead, & Julious, 2013). Those studies found 10 participants as being adequate to gather the necessary information.

5.20 Recruitment of participants for Phase 2 of the study

The student researcher trained the doctors working at the psychiatry clinic on how to identify eligible participants as per inclusion / exclusion criteria. Those doctors were asked to identify the patients with moderate or severe depression rather than focusing on rating scale scores. They were given a paper with inclusion / exclusion criteria just before the clinic commenced as a reminder. Accordingly, treating doctors identified eligible patients by reviewing the medical records at the beginning of the clinic and assessing current clinical status during the patient review. These doctors briefly described the study to the eligible patients during a regular clinic session. The purpose of the study and what it involves, the confidential nature of the information provided, and the non-obligatory nature of participation were explained to the patient. If they were willing to consider participation in the study, they were asked to speak with the research assistants responsible for recruitment. The research assistants had a recruitment table away from the patient consultation area yet within the psychiatry clinic. This table was placed in a clinic room with adequate privacy for the patients. The research assistants were available to speak with potential study participants at the times when clinics were conducted, during the recruitment stage. The details of the identified patients were given to research assistants at the end of the clinic. If they had not already come to the recruitment table, they were contacted via telephone / letter inviting them to come and meet the research assistants at a mutually convenient time.

When the patient came to the recruitment table, the research assistants verbally explained to the patient the purpose of the study and what participation involved. If patients were happy to consider participation, written information (see Appendices) was provided. The fact that participation was non-obligatory was emphasised. It was also explained to potential patients that their decision to participate or not will have no bearing on care provided by the treating team to the patients. Potential participants were interviewed by research assistants who administered the Hamilton Depression Rating Scale. Participants were requested to complete the Sinhalese Beck Depression Inventory II to ascertain the fulfilment of inclusion criteria. If the patient was happy to participate and fulfilled the inclusion criteria requirement as per HDRS and BDI, written consent was obtained.

Patients under the care of the student researcher, who works as a consultant psychiatrist at Colombo North Teaching Hospital, Ragama where the study was conducted, were not recruited for the study.

5.21 Study process of Phase 2

The period of the study comprised of 10 weeks of treatment and 6 months of follow-up after completion of the treatment. The treatment stage involved 10 weeks of modified CBT therapy, during which participants received treatment as usual (medication and clinical management including psychoeducation, social interventions and supportive therapy such as appropriate reassurance, instilling hope and allowing them to ventilate emotions) and additional modified, culturally relevant CBT - at 6 fortnightly sessions. Each CBT session was 30 minutes long. The sessions were conducted on mutually convenient days for the therapist and participants.

The modified CBT was delivered by three trained clinical psychologists and a consultant psychiatrist (student researcher) according to the modified CBT manual prepared in Phase 1 of the study. The student researcher, the author of the manual, trained the clinical psychologists in delivering the modified CBT and provided them with regular supervision to ensure the sessions were conducted according to the manual. CBT sessions were audio recorded with the consent of the patient. These audio recordings were used to ensure the intervention was conducted according to the modified CBT manual.

Treatment as usual including psychoeducation and supportive therapy was provided by the treating psychiatrists and his/her team. Treatment as usual sessions occurred throughout the treatment and follow-up stage on a weekly, fortnightly or monthly basis depending on the clinical requirement as decided by the treatment team. Usually, it was monthly sessions lasting for 5-15 minutes. Participants were given the choice to inform their treating team that they were receiving CBT.

5.22 Data collection in Phase 2

Participants were assessed at baseline, 10 weeks (completion of treatment), and 6 months (16 weeks after completion of treatment) by an independent assessor. Assessors were pre-intern medical officers. The knowledge and skills required to perform focused psychiatric evaluations and assessments in this study were provided to them. They were trained in administering the HRSD and Global Assessment Functioning (GAF) scale by the student researcher.

Baseline assessments included history of present episode, previous history and recent treatment, as well as HRSD, BDI and GAF scores. The baseline assessment included filling the questionnaire and structured interview, which took about 30 minutes.

The rating scales used in the assessments are translated and validated for use in the Sri Lankan context (Rodrigo, Kuruppuarachchi, & Pathmeswaran, 2015; Suraweera, 2013). HRSD is an interviewer-administered depression rating scale and BDI is a self-administered rating scale and therefore concurrent use of both scales is complementary and increases sensitivity (Beck, Steer, & Garbin, 1988; Williams, 1988). The GAF score provides a measurement of functionality / impact of the illness whereas HRSD and BDI measure the symptomatology and severity (Grootenboer et al., 2012).

In subsequent assessments HRSD, BDI and GAF scores were recorded by the independent assessor. Details of allopathic and traditional mental health treatment received from the initial assessment were recorded. This included psychotropic medication and their changes and reasons for it, ECT and traditional healing methods. Treatment adherence with medication was assessed through self-report on a 5-point scale. Details of self-harm and hospitalisation were also recorded. The subsequent assessment included filling the questionnaire and structured interview which took about 30 minutes.

The semi-structured individual interviews were conducted with patients who were provided the modified CBT soon after they completed the last session and clinicians who provided the modified CBT soon after they had completed therapy with all the patients. Interviews with patients were focused on the acceptability of the modified CBT, obstacles to treatment, and benefits and drawbacks of the therapy in general and of specific components. Clinicians' interviews were focused on the perceived efficacy of the modified CBT, obstacles to delivery, benefits and drawbacks of the therapy in general and of specific components.

All individual interviews were audio-recorded, and transcribed. Transcripts were coded and anonymised. All the interviews, especially with patients, were conducted in Sinhala. All of the interviews with clinical psychologists were conducted in English. The interviewer (AR) is fluent in both languages. Two bilingual Sri Lankan mental health professionals translated the transcripts of interviews conducted in Sinhala into English. Each person translated the full transcripts independently and subsequently met to decide on a consensus of the translation. Both conceptual and linguistic equivalence were considered during the translation process. If significant discrepancies were found in the two translated versions, another bilingual mental health clinician performed back-

translation of the English versions of the transcripts independently in order to identify the more suitable translation. Notes were taken on non-verbal communication and behaviour.

5.23 Data analysis in Phase 2

Paired t-tests were conducted to examine the significance of the HRSD, GAF and BDI from baseline to the endpoint on two occasions: baseline to 10 weeks and baseline to 6 months. Paired t-tests were also conducted to examine the significance of the HRSD, GAF, BDI from week 10 to 6 months. Secondary outcome measures such as discontinuation of treatment, hospitalisation and self-harm were also compared using paired t-tests. If the variances were unequal, the Satterthwaite-Welch correction was used. (SPSS- version 16 was used in the analysis.)

5.24 Ethical aspects of Phase 2 of the study

5.24.1 Approval

Ethics approvals were obtained from the Ethics Committees of the University of Melbourne and the University of Kelaniya. Permission was obtained from the Director of Colombo North Teaching Hospital, Ragama, Sri Lanka to conduct the study at the hospital. Written informed consent was obtained from participants using the patient information leaflet and consent form.

5.25 Debriefing

Research assistants who conducted the assessments were trained to detect distress and advised to stop the assessment in the event of emotional distress in the participants. Clinical psychologists are well trained in detecting emotional distress and were able to use their clinical psychology training to alter / modify / stop the CBT sessions.

If participants got distressed, the student researcher who was in the vicinity was notified immediately. The student researcher (AR), a psychiatrist, was able to assess the participant and determine whether the participant required urgent treatment or support services and make arrangements to ensure these were provided if necessary. The research team then contacted the relevant treating team of the participant and referred him / her for appropriate help.

Three clinical psychologists trained in managing distressed clients using psychoeducation, appropriate reassurance, allowing them to ventilate their emotions and by demonstrating relaxation methods, worked with the student researcher. If participants got distressed due to research study assessments / sessions, they were given the option of opting out of the study.

5.26 Benefits compared to potential harm

We excluded any patient who would have got distressed or was unable to participate in this study. This was done at two stages. First, the treating psychiatrist was asked not to select patients with acute exacerbation of illness. If the treating team felt that psychotherapy or assessments may make their mental state worse due to the patients' personality profile, preferences or beliefs, they were excluded. Second, if the research assistants felt during the recruitment proceedings that the potential participant was likely to get distressed, as evidenced by their behaviour and interactions during the recruitment process, they too were excluded after carefully explaining to them why they would not be recruited.

Assessments took about 30 minutes. Sensitive areas, such as suicidal ideation, were explored during the assessment. Participants were made aware that sensitive areas will be explored and that the modified CBT explored negative cognitions which may rarely be distressing to participants. However, the modified CBT was generally not expected to cause any significant distress to the patients considering the nature of the questions in the assessments and the modified CBT, as well as the experience / training of those who conducted the sessions.

Treatment as usual including supportive therapy, medication and education was also not expected to cause distress.

This phase of the study was useful in evaluating the feasibility of culturally relevant psychotherapy (CBT) for depression in Sri Lanka and provided an opportunity to improve the acceptability and efficacy of psychological treatment for depression in Sri Lanka.

Other possible benefits for patients included modified CBT sessions in the study serving as a treatment for depression. Assessments may have served as educational sessions too. After the participation in the assessments, the researcher answered any queries that the patients had and clarified any doubts about depression and its treatment.

5.27 Managing the dependant relationship

Patients and their carers were recruited by non-clinical research assistants uninvolved in treating the patient. Research assistants were used as the initial point of contact to ensure voluntary participation uninfluenced by the doctor-patient relationship. The fact that participation is non-obligatory was emphasised along with the fact that their decision to participate or not would have no bearing on their future care.

The student researcher works as a consultant psychiatrist at Colombo North Teaching Hospital, Ragama where the study was conducted. However, patients under the care of the student researcher were not recruited for the study. Therefore, the student researcher and his team were not involved in the treatment of the participants.

The three clinical psychologists who conducted the modified CBT sessions were external clinicians uninvolved in the care of the patients treated at Colombo North Teaching Hospital, Ragama. There are no psychologists attached to this hospital**.**

5.28 Conflicts of interest

The student researcher developed the modified CBT manual. However, he did not divulge this to participants to minimise bias. Data was de-identified and the student researcher sought the assistance of an independent person in data interpretation to minimise the bias.

5.29 Data protection

The confidentiality of the data is ensured by safe storage in locked cabinets in the Department of Psychiatry, University of Kelaniya, Sri Lanka for paper records and audio tapes, and by password protection of electronic documents in the computers of the same. The paper and audio data will be stored safely for 7 years, after which they will be destroyed. Researchers will have exclusive access to data.

Chapter 6

Results

Chapter 6

6.1 Results

6.1.1 Results of Phase 1

6.1.1.1 Demographic details of the participants

A total of 45 persons participated in the first phase of the study: 9 patients with depression, 8 carers, 20 healthcare professionals comprising 14 psychiatrists and 6 psychologists, and 8 alternative healers (Table 1).

Most of the patients (77%) were female and the average age was 34 (ranging from 24 to 58 years). Both male patients and 2 of the 7 female patients were employed. Two were single, 1 was separated and the others were married. All except one identified a person/s who cared for them. A majority (56%) identified their spouse as the main carer while others named a parent. All 8 patients who identified as having a carer/s reported being supported emotionally by the carer/s, with 6 receiving support with treatment and 5 receiving financial support. While 3 patients presented with their first episode of depression, other people had experienced depressive episodes before, although some were untreated. On average, their first symptoms had developed 3.9 years previously (ranging from 0.5 to 14 years). Most of the carers, 6 of 8, were females and 4 were mothers, 2 were wives and 2 were husbands of the patients. On average, they had been caring for the patients for 3 years.

Out of 14 medical professionals, 9 were consultant general adult psychiatrists, 4 were senior registrars in general adult psychiatry (advance trainees in psychiatry) and 1 was a child and adolescent psychiatrist. The average age of this group was 44 years and psychiatrists have been working in mental health for 14 years on average whereas senior registrars have been working in mental health for 4 years. Clinical psychologists were younger with an average of 26 years and they have been in the field of clinical psychology for 4 years.

Traditional healers were comprised of 3 lay counsellors, 2 astrologers, a soothsayer, a shaman and an ayurvedic practitioner. Their average age and duration they have been in their roles were 52 years and 11 years.

6.1.1.2 Content analysis of Phase 1

Some questions generated more interest than others (Table 4). Those led to spontaneous discussions rather than the brief or monosyllabic answers elicited by other questions.

Content analysis was done at two levels: descriptive (what data was) and interpretive (what data meant) (Bengtsson, 2016; Simons et al., 2008). Descriptive coding and process coding were used to document and categorise the breadth of opinions. Coding was done manually and subsequently, codes were categorised to demonstrate broad representative themes. Most of these categories were as per the main questions or themes in the semi structured questionnaire. The main emergent categories were grouped into broader themes (Table 3).

Table 3

Participants of the study

Participants	Number
Patients with depression	
Outpatient	8
Inpatient	1
Subtotal	9
Carers	8
Healthcare professionals	
Psychiatrists / trainees in psychiatry	14
Psychologists / trainees in psychology	6
Subtotal	20
Traditional healers / lay counsellors	
Traditional healers	5
Lay counsellors	3
Subtotal	8

Total	45

Table 4

Questions used in Phase 1 which generated elaborate answers

Patient / Carer group "Have you / the patient had physical symptoms related to depression? What are they?" *Healthcare practitioners* "Do you believe psychotherapy is beneficial in Sri Lanka?" "Do you think / find placing more emphasis on physical symptoms, their association with thoughts and mood, and inclusion of physical complaints in the thought diary as a separate column is useful?" "What are your thoughts about the duration and number of sessions?" *Traditional healers / lay counsellors* Do you use mindfulness / meditation in your healing practices or lay counselling? Do you use folk tales / *Jataka* stories in your healing practices or lay counselling? Do you involve the client's family in your healing practices or lay counselling?

6.1.1.3 Patients and carers

Six of the 9 patients reported having somatic symptoms and the commonest physical symptoms were headache and burning sensation of the body, found in 4 patients. Patients who have had treatment for depression previously sought help, on average, 3 weeks from the onset of symptoms in this episode. All of them went directly to a western medical practitioner. However, the average time elapsed between the onset of symptoms and seeking help was 5.7 months in 3 patients with the first episode of depression. Two of them had sought astrological remedies before presenting to western medical treatment.

All the patients have been treated with antidepressants while 1 patient had had electroconvulsive therapy (ECT). While the vast majority of them reported antidepressants as the most beneficial

treatment, it was also the only treatment they had had. When they sought alternative treatment after being on western medical treatment, all of them did so while being on medical treatment.

Four of the 8 carers were mothers of the patients and two each were wives and husbands. Their mean age was 61 (ranging from 33 to 78 years). All of them reported supporting the patient with emotional support and treatment.

The responses of the patients and carers have been collated together as they were found to be similar. Only a few patients or carers (12%, 2/17) had direct experience of dedicated psychotherapy. Many patients and carers identified psychotherapy as a relatively alien concept. However, 14 of the 17 patients believed psychotherapy to be a useful treatment strategy when it was explained to them. They found it somewhat difficult to answer the question about their expectations about psychotherapies. However, the following were the main themes. They strongly felt that listening to the patient and understanding their problems is the most important component of non-pharmacological treatment.

"I believe the most important treatment is, even more than medications, listening and making us feel understood. That gives us faith in treatment and confidence in the doctor." (Patient 6)
"I guess talking therapy has to start with listening, listening with intention and interest" (Carer 1)

They wanted clinicians to advise them and endorsed a directive style of the therapeutic relationship. When advising, they wanted the clinicians to use relevant religious or local examples and stressed on the importance of instilling hope and reassuring them.

"Doctors need to tell us how we can get better. What we need to do. Asking our opinion about how to get better……Then we don't need therapy, we already know what we need to do" (Patient 3)
"The long-winded discussions with patients are not going to be of much use. It has to be short, sweet and to the point" (Carer 5)
"I guess there is lot psychotherapy can learn from religions , all the religions, religious stories such as Jataka Katha and folk stories" (Carer1)
"The worst thing about depression is how powerless we feel. We don't think we will get better, even when we have got better before. We need a lot of hope, reassurance and encouragement. That is very very important" (Patient 2)

While they understood the importance of homework, they felt it would be difficult to do it with other commitments. However, when explored further they said that a limited amount of homework may be feasible.

"We have enough homework to do", we can't do house chores because we lack energy and motivation. If you ask us to do therapy homework on top of that, we will feel worse, not better" (Patient 2)

"No, I get the point. We need to practice what we were taught in between seeing the doctor. If it is not too much we should be able to do it"(Patient 2)

"I guess homework is important, but it should not be a lot. With lots of other things to do at home and work, no time to do a lot of homework. If they can't do it, it will be demoralizing and may not go to talking therapy afterward" (Carer 1)

Both patients and carers felt the involvement of the family in psychotherapy would be important, yet not essential. They preferred a limited number of short sessions but were not clear on the frequency.

"I believe family helps us with to go through depression, it is not logical we involve them in treatment. They can tell things we don't see ourselves" (Patient 1)

"Family could be involved in this treatment, but only when necessary" (Patient 6)

"We as a family can help with treatment. But I have seen when I got involved with his (patient's) treatment uninvitedly it did harm than good. So, has to be careful" (Carer 4)

"When we talk to doctors for a few minutes, we get a lot out of it. I don't see why the therapy can't be like that. I know it will be for a bit longer than a few minutes……..I don't know how many minutes or how many sessions" (Patient 6)

"If therapy sessions are long, patients will lose focus. If patients have to attend many sessions, they will stop coming after a few sessions. So, it should be brief sessions and few sessions. I don't know whether that is doable" (Carer 5)

6.1.1.4 Healthcare professionals

Fourteen psychiatrists including 4 advanced trainees were interviewed. The majority of psychiatrists reported (71%, 10/14) using psychotherapeutic principles in their practice. They used psychotherapeutic techniques more for anxiety and depressive disorders and less for psychotic and bipolar affective disorders. Only one of the psychiatrists identified psychotherapy as the main form of treatment for depression and she was a child psychiatrist. Other psychiatrists identified antidepressants as the most effective treatment modality for depression in Sri Lankan patients and believed psychotherapy to be beneficial mainly as an adjunct to biological treatment for depression. They felt CBT and supportive psychotherapy to be the two most suitable psychotherapy forms for Sri Lanka with CBT being the most suitable psychotherapy for depression in Sri Lanka. While all 10 psychiatrists who used psychotherapy used CBT principles, 5 used supportive psychotherapy principles. Having to spend a lot of time on therapy was identified as the main obstacle to providing

psychotherapy by a majority of psychiatrists (64%, 9/14). Lack of adequate training was also considered to be an important contributory factor by many (50%, 7/14).

The responses of the psychiatrists and psychologists on the experiences and expectations of psychotherapy have been collated together as their responses were found to be similar. Most used activity scheduling / behavioural activation as the predominant CBT technique and felt it to be the most beneficial CBT technique as well.

"Behavioural activation is not difficult to explain to Sri Lankan patients, easy for them to follow, it works because they do it" (Psychiatrist 3)
"Activity scheduling is one of most effective interventions for Sri Lankan clients and treatment compliance for it is high" (Psychologist 1)

While some used cognitive techniques such as cognitive restructuring effectively, others did not find this very useful. Most healthcare professionals agreed that Sri Lankan patients found it difficult to differentiate thoughts from emotions. They believed this was partly due to the ambiguity of the language.

"In contrast to behavioural interventions, cognitive restructuring is difficult to explain, difficult to grasp, difficult to follow, so it does not work as well. In some patients, I should say it does not work at all" (Psychiatrist 3)
"Cognitive restructuring is a tricky task for many patients in Sri Lanka for several reasons. They get confused with thoughts and emotions. For example, they often say "I think sad" for feeling sad. They are either unwilling or unable to monitor thoughts. Challenging negative thoughts can be quite difficult with some" (Psychologist 1)

They also believed that as CBT was a non-familiar technique for patients, its premise and essential features need to be explained in detail at the beginning. Psychologists in particular stressed that the success of CBT would largely depend on it and therefore recommended spending considerable time to explain it, as an investment for the future.

"Sri Lankan patients are not accustomed to discussing their thoughts, feelings in detail with health care professionals. They are used to very brief chats with doctors. So, I have seen people get anxious and confused in therapy. So, it is very important to discuss what therapy is, how it is done and what therapeutic boundaries are at the beginning" (Psychologist 4)

They felt that when describing how to practice CBT techniques, it would be very useful to use Sri Lankan idioms and examples. Yet the use of religious literature may not be very helpful with the

younger population. They felt discussing local beliefs such as astrological explanations at the beginning is helpful in at least two ways: using it to explain the psychological phenomena as bias and adequately addressing these will clear any doubts the patient may have and help mitigate any obstacles these doubts could cause. Some believed that totally disregarding them as unscientific may harm the therapeutic relationship as it makes the patient lose faith in the therapist with loss of credibility in their eyes.

"We can use a lot of things from Sri Lankan culture to improvise psychotherapy such as CBT. For example, one thing many depressed people are worried about is endless suffering due to depression. In that case, we can use the notion of impermanence from Buddhism and time limited nature of a bad period from astrology." (Psychiatrist 4)

"I have seen some doctors trying to be very Western by disregarding or not acknowledging the cultural explanations for mental illness. I always think it is a stupid thing to do. Address them, you don't have to agree with all of them. Use it for therapeutic advantage. If you discard them as nonsense, then you are running the risk of your treatment discarded as nonsense for not understanding them and not respecting their precious cultural beliefs" (Psychiatrist 4)

All healthcare professionals believed CBT should be more instructional. While the psychiatrists felt firm about it, the psychologists were less so. Both groups believed it should be collaborative, individualised and tailored towards patients' needs. However, the therapist should take more of a leading role and delivery should be more didactic than the generic version. When discussed further, many agreed that depending on the patient, the therapist may adopt a more collaborative approach. However, healthcare professionals, predominantly psychiatrists, pointed out here that the therapeutic relationship is more of a teacher-disciple relationship and they look up to the clinicians for advice.

"Our patients come to us for help when they are distressed. They need help. We need to take the lead. So, psychotherapy should be directive. I am not talking about one-size fits all. You need to make it appropriate for the individual patient. But you need to take the lead. This customer and provider approach will not work here. It is counterproductive. They need to know that we know what we are doing. Asking what they think about their problems will undermine the trust in the clinician and will lead to poor therapeutic outcome. In the end it is about how they bond with the clinician. Sri Lankan patients are like students or children whereas Western patients are like consumers.' (Psychiatrist 4)

"Collaborative empiricism in CBT could be and should be modified for Sri Lankan concept. While it should be client centered, it should be clinician led, if you know what I meant. The therapist should inquire about patients' expectations. But I should mention, in my experience Sri Lankan patients are

not proactive in identifying therapeutic goals. The therapist must actively assist the client in identifying goals to therapy conclusion." (Psychologist 2)

Healthcare professionals, especially female clinicians, felt that boundaries of the therapeutic relationship should be clearly explained. As Sri Lankan patients are usually more accustomed to very didactic and brief interactions with clinicians, particularly doctors, they should understand the nature of the therapy and contact between clinician and patient, which is longer than normal doctor-patient contact.

"……. it is very important to discuss what therapy is, how it is done and what therapeutic boundaries are at the beginning. I have had experiences where the client interpreted my detailed discussions about his feelings and thoughts in the wrong way and misinterpreted my relationship with him. It has happened to a few of my female colleagues. So, I learned it the hard way, we need to be very explicit about the nature of the relationship" " (Psychologist 4)

Clinicians identified the importance of the support provided by family and the privilege Sri Lankan patients are privy to because of family support. At the same time, however, they also felt family problems were a significant issue for many Sri Lankan patients. "It is not to say that family is part of the problem, they are part of the solution most of the time, but we should be sensitive to the fact that patients may need some space of their own when they do therapy, so they can speak their mind." Therefore, family involvement was not considered to be essential. But it was suggested that the therapist should always ask whether they prefer to have a family member, while on the other hand there should be at least one or two sessions without the family member, even if they want the family member present. Most of the healthcare professionals interviewed agreed on this. However, psychologists felt more strongly that "family is not essential" when compared to psychiatrists.

"Family is a treasure we need to value and embrace in Sri Lankan culture. I involve them in treatment and therapy. It almost always pays off" (Psychiatrist 4)

"It is not to say that family is part of the problem, they are part of the solution most of the time, but we should be sensitive to the fact that patients may need some space of their own when they do therapy, so they can speak their mind." (Psychiatrist 3)

"I believe family involvement in therapy should be conditional. Sometimes when you ask patients whether they would like us to involve the family in the therapy, they say yes, because they think it is the right thing to do. I have a cautious approach towards the involvement in the family as I have noticed a fracture in the therapeutic relationship after doing so. But certainly, it has a place in many patients." (Psychologist 2)

Many clinicians believed that the quantity of homework should be less. Experience had shown that patients are either reluctant or unable to do homework. It was suggested that only essential homework be given. It is important to do at least two examples of the homework before they left the session. When they complete their homework, they should be praised highly. If they have not done their homework, patients should not be criticised but asked to complete it during the session. Some stated that it is better to not use the word homework but rather mention the specific task.

"Sri Lankan patients are unlikely to do CBT homework for their perceived or real incompetence in completing homework and their perceived or real difficulty in finding time to complete it. Therefore, psychiatrists or psychologists should not depend too much on homework. I understand homework necessary to make the patient his own therapist, so I believe in it, it should be done. Its compliance can be maximized by keeping the amount of homework at an optimal level and practicing the homework during the session. " (Psychiatrist 3)
"……I believe many Sri Lankans find the word Homework negative. Perhaps that comes from childhood and related to school homework. So, whenever I give homework, I use different terminologies such as 'practice in between sessions." (Psychologist 1)

All the clinicians agreed that a considerable number of Sri Lankan patients with depression present with somatic symptoms and in a significant minority, somatic symptoms were the index presentation. For some patients, the somatic symptoms caused the most amount of stress. Therefore, it should be addressed assertively and adequately. For those presenting with somatic symptoms, it is very important to have an additional column in the three-column list (of circumstance, mood and thought). Equal prominence should be given to physical symptoms as to thoughts.

"Many of our patients with depression presents with somatic symptoms such as the burning sensation of the body, headache, dryness of mouth, numbness of body, bloating sensation of the tummy, etc. These symptoms cause significant distress to them they want to get rid of those. In fact, in some patients, this is the main symptom. So, it makes sense to address these symptoms in psychotherapy" (Psychiatrist 4)
"What I think we could do is have a separate column for somatic symptoms in depressed patients who are presenting with prominent somatic symptoms. So, in addition to thought/ mood diary, we are monitoring somatic symptoms. We will look for the connection between thoughts and somatic symptoms. We do cognitive restructuring and activity scheduling to alleviate somatic symptoms." (Psychiatrist 7)

Healthcare professionals considered poor problem-solving to be a significant contributory factor or maintaining factor of depression in some people. For those individuals, problem-solving skills should be an essential component of the therapy.

Clinicians noted that mindfulness is a familiar concept for people who are religious or spiritual. While such people may embrace the idea and benefit from its practice, others, such as younger persons, may find it alien. Therefore, mindfulness should be introduced to suitable people, but not to all.

"I am all for mindfulness but with caution. Mindfulness will be a very useful tool for people with spiritual inclinations. It is a familiar concept for them, they believe in it, and will work in depression for them. But for some it is an alien concept, does not find it useful."(Psychologist 2)

As many psychiatrists noted, lack of time is one of the biggest obstacles for delivering psychotherapy. It was also felt that Sri Lankan patients may not appreciate or tolerate longer sessions or many sessions. Therefore, the consensus was that a session should be approximately 30 minutes in duration and the number of sessions is between 5 and 8. However, it was also noted that the first session may need to be longer as psychotherapeutic formulation and understanding the patient may take more time. Considering the practical realities of the life of Sri Lankan patients, weekly sessions may not be suitable and fortnightly sessions are considered more appropriate.

"Why I don't do psychotherapy is I don't have time. I am sure it is true for others as well. I don't think patients will want to come weekly and do therapy for 1 hour" (Psychiatrist 4)
"Therapy as a whole should be long enough to cover what we need to cover we have to cover; Therapy sessions should be long enough it is worth for patient to come for therapy. At the same time, it should be realistically possible for doctors or whoever doing it. What I believe 5-10 of 30 minutes sessions may be the way to go" (Psychiatrist 3)
"Patients have other commitments, so they may not be able to come weekly. The monthly is too long. Perhaps fortnightly sessions will be better suited for our patients" (Psychiatrist 6)
".....yes, shorter sessions. But the first session should be long enough for a good assessment, introduction to therapy and build rapport. So, I always have a longer first session" (Psychologist 2)

6.1.1.5 Alternative therapists

Alternative therapists were the most heterogeneous group of all. There were three lay counsellors (Buddhists priests who saw individuals with psychological problems regularly, one based in a suburban temple and the other two based in village temples), two astrologers (practitioners who study astrology and use it to tell people how astrology affects their health and mental health in particular), a soothsayer (a person who practices divination by communicating with supernatural powers to 'heal' people with psychological problems), a shaman (a person who performs *thovil* ceremonies to 'heal' individuals with mental health problems) and an ayurvedic practitioner who had a special interest in mental illnesses.

Their responses were also heterogeneous. However, all of them or almost all of them agreed on certain issues such as involvement of the family in therapy, benefits of meditation / mindfulness, use of folk stories / religious stories in therapy and the didactic nature of therapy. Further, all of them believed psychotherapy to be an integral part of mental health treatment.

"Family is their companion in the journey. Family is our companion in the quest for their health. There may be exceptions where involvement of family is not an option, but those are rare"
"Family is important in understanding the problem and solving the problem" (Alternative therapist 5)

"The real problem is with our reaction to what is happening around us not, what is happening around us per se. The mental reaction makes them mentally unwell. So, if we could teach them how to let it go they will be well or at least not unwell. That's where mindfulness comes in" (Alternative therapist 1)

"Sri Lankan literature is very rich in giving life advice through religious stories and folk stories. We grew up with them. They are part of us. So, if we can use it in treatment that will go a long way" (Alternative therapist 2)

"I don't know how the new generation thinks, not many come to me. But certainly, other people need to hear from us what to do. Straight-up advice. So, if we don't let that happen, I don't think they will be happy. So, you need to tell them what they need to do" (Alternative therapist 4)

6.1.1.6 The need for modified psychotherapy

All the alternate therapists acknowledged a distinct role for psychotherapy in managing patients with mental illnesses and the majority of them (75%, 6/8) had a favourable view about allopathic mental health treatment. None of the therapists had objected to their clients seeking allopathic treatment and in fact, 62.5% (5/8) regularly encouraged their patients to do so. Alternative therapists (62.5%, 5/8) expressed their concerns about allopathic practitioners ignoring the cultural dimensions of the illness.

Three patients (33%), 4 carers (50%), 4 medical practitioners (29%), and 4 alternative therapists (50%) did not believe in the usefulness of unmodified psychotherapy to treat depression in Sri Lanka. However, all of the patients, carers, medical practitioners, psychologists and alternative therapists believed culturally modified psychotherapy would be useful in treatment.

6.1.1.7 Codes, categories and themes derived from phase 1 of the study

In the phase1 of the study, 34 codes were derived based on specific theoretical interests and recurrent issues in the discussions regarding the treatment of depression, modification of CBT and obstacles for modification (Table 3). These codes were discrete enough to avoid redundancy and global enough to be meaningful. The codes were applied to the textual data to dissect it into meaningful and manageable chunks of text such as sentences or phrases.

The 34 codes were grouped into 10 categories by re-reading over 950 text segments in each code. These 10 categories were further reduced to more refined 8 themes which were inclusive yet discrete (Table 3). Categories and themes that were common through all categories thereby which are more common were given priority. However, it should be noted that this was not intended to give greater significance to themes on a quantitative basis. Yet, this approach allowed us to select common, homogenous, popular themes, which was important in modifying the CBT manual. But we also selected themes which are exclusively or mostly limited to one particular group of participants, for example, the theme of the therapeutic nature of the therapist-patient relationship in CBT which was exclusively discussed by the health care professionals.

6.1.1.8 Modifications to CBT manual

Information gathered through this process was used in modifying the CBT manual for depression to make it more suitable for Sri Lanka. The existing CBT manual, developed by Muñoz & Miranda (1996), comprised of 12 sessions each lasting for 50 minutes. The first 2 sessions are dedicated to assessment, the establishment of rapport and familiarisation with the cognitive behaviour therapy

model. Sessions 3 and 4 are mostly focused on mood monitoring and behavioural activation or activity scheduling. Sessions 5-8 are dedicated to thought monitoring and cognitive restructuring. Sessions 9-11 are concerned with the management of anxiety, sleep disturbance, interpersonal issues and more deep-seated thoughts and beliefs. The final session, session 12, focuses on revision and consolidation.

We have summarised the salient themes which were clear or emerging in the exploration. Recognizing and describing them succinctly and explicitly makes the modification of CBT more compelling in turn more effective. The initial draft of the manual was discussed with the selected psychiatrists and psychotherapists in order to refine the manual further. The main changes and features of the modified CBT manual are listed in Table 6. The summarised versions of the 6 sessions are given in Table 7.

Table 5

Codes, categories and themes identified in Phase 1 interviews

Codes	Categories	Themes
Antidepressants **ECT** **Psychotherapy** **Supportive psychotherapy** **CBT** **Attitude**	Depression treatment Psychotherapy for depression	Psychiatrists prefer biological treatment for depression. Yet psychotherapy is a useful adjunct treatment. Psychiatrists use treatment principles of supportive therapy and CBT. Patients thought of psychotherapy as useful
Familiarise **Investment** **Attrition** **Boundary**	Familiarising to CBT Therapeutic nature	Patients have difficulty in understanding the CBT model. Therefore, it is very important to familiarise them with the model at the outset to reduce dropout and failure rates. Spending adequate time to do this is a wise investment. Providing a clear explanation about the

		professional nature of the relationship is also important, particularly with female therapists and male patients
Confusion	Differentiating emotions from thoughts	It is difficult to differentiate thoughts from emotions. Take a few examples and explain. Do the thought / emotions exercises with them
Homework **Important** **Busy** **Get-it-done** **Co-therapist**	CBT homework Obstacles to homework How to overcome	Homework is important. Make an analogy of homework and taking medication at home. Without homework, CBT may not be effective. A family member, functioning as a co-therapist, can help with homework. If not done, still attend; do it during the session
Behavioural **Instructional** **Problem-solving** **Assertiveness** **Family** **Support** **Somatic** **Idioms** **Folk stories** **Astrological** **Mindfulness** **Religious** **Meritorious**	Useful components Cultural components	CBT needs to be more instructional while using behavioural strategies. Problem-solving skills and assertiveness skills are important. Assertiveness should be culturally appropriate. Family involvement is optional. Invite family with consent and if appropriate. Have a low threshold to involve them. Mobilise social support. Address somatic symptoms. The use of Sri Lankan idioms and examples is helpful. Use examples from local literature, religious beliefs, folk stories and *Jataka* stories. Don't disregard or dismiss cultural beliefs such as astrology. Mindfulness is beneficial but doesn't overplay it. Highlight the impermanent nature of bad times and the concept of equanimity and loving kindness. Include meritorious activities in activity scheduling.
Duration **Frequency** **Number**	How session can be conducted	The duration of a session could be 20-45 minutes. Fortnightly sessions generally; some weekly. 4 to 8 sessions would be adequate

Skills **Time** **Listening**	Why no psychotherapy	Sri Lankan psychiatrists need more training in psychotherapy. Lack of time is one of the main issues for not doing psychotherapy. Listening is lacking among doctors

Table 6

Main changes to the CBT manual

Duration – The duration of the first session is set for 45 minutes and the other sessions 30 minutes long, in comparison to the standard 50-minute long sessions in the original manual. Session 1 will be a focused yet comprehensive assessment. Table 5 explains the content of other sessions. Each session will be conducted along the lines of checking in with the patient about their current state, reviewing homework, setting the agenda for the session, the main tasks of the sessions, homework for the next 2 weeks, followed by the conclusion.

Number of sessions - The number of sessions is reduced to 6 from the 12-20 prescribed in the original manual by making them more didactic / directive, placing less emphasis on Socratic questioning and core beliefs and limiting the number of cognitive strategies to a few.

Style - A more didactic role and instructional style are to be adopted without being coercive or dismissive. Treatment methods and approaches will remain tailored to patients considering their presentations, problems and needs. The patient will be consulted on their treatment and the therapist show due respect to the patient's opinion in decision making. However, the therapist will decide, in consultation with the patient, the path to be taken. This will reduce time spent on therapy and make patients feel they are receiving expert help.

Directive - Less emphasis on formulation and Socratic questioning. The formulation will take place in the first session, or two and will be not as detailed as in the original CBT manual. Socratic questioning will be used but not as often as in the original CBT manual. The therapist will more often point out factors to the patient rather than use Socratic questioning to get the patient to understand. This will reduce time spent on therapy and the patient will feel therapy is more 'effective'.

Education - Explain the techniques and processes of CBT adequately to Sri Lankan patients and their families and make sure they understand it. Sri Lankan patients are not familiar with psychotherapy and explaining what it is and how it is done is imperative and cannot be taken for granted. Sri Lankan patients are not used to talking at length about their problems with clinicians. They should be made to understand the therapeutic nature of the interaction to avoid any misinterpretation of the interaction between the clinician and the patient.

Physical symptoms - More emphasis on monitoring physical symptoms just like with mood in selected patients. Many Sri Lankan patients present with somatic symptoms in relation to depression. Sometimes this can be their primary presentation. Therefore, it has to be addressed as much as thoughts and emotions are addressed in some patients. So much so that it warrants the addition of another column along with time / circumstances, mood and thoughts. Changes in physical symptoms should be demonstrated just as with mood when the thought changes.

Activity scheduling - Emphasise on activity scheduling at the expense of sophisticated cognitive techniques. Sri Lankans are more receptive to change in activity than to cognitive restructuring. They also find it easier than challenging their thoughts. More culturally appropriate activities should be suggested, such as visiting relatives, going to the temple and even almsgivings can be suggested to suitable patients.

Problem solving skills - Place more emphasis on problem-solving skills considering the presentations of patients with depression in Sri Lanka. Some or many patients present with depression due to not being able to solve problems. The concept of problem-solving is not introduced to Sri Lankans during their education and it is important to empower them with this skill. This can be introduced to suitable patients as an optional module in session 5 (see Table 5).

Mindfulness skills - Considering the religious and spiritual beliefs in Sri Lanka, mindfulness is incorporated in the modified CBT. Many Sri Lankans are accustomed to mindfulness and this has been identified as one of the important elements of modern CBT. Therefore, using this in CBT will make therapy more familiar and effective for Sri Lankan patients. It will be introduced later in the therapy.

Core beliefs - Due to time limitations and patient needs, core beliefs and intermediate rules would not be addressed. This may have an impact on the sustainability of the improvement achieved by

CBT. However, core beliefs are difficult to understand for Sri Lankan patients and time spent on it will not be useful. It will increase the length of the therapy to an unsustainable level.

Folk stories - CBT techniques will be explained with culturally appropriate examples such as folk stories and religious stories. This will make it easier for the patients to understand the therapy and recall it for a long time.

Homework - While therapists will encourage the patients to do their homework, patients will be strongly encouraged to continue with therapy irrespective of whether they complete the homework or not. Many of the patients are working and / or have to do household chores while attending therapy which may make it difficult for them to do homework formally at home. Doing homework is also somewhat of an alien concept for a typical adult Sri Lankan. However, the patient should be asked to come to therapy or they may not attend for not having completed their homework.

Table 7

Outline of sessions in the modified CBT manual

Session 1 – Assessment and familiarisation of the patient to the CBT model
Session 2 - Monitoring of mood, activity and somatic symptoms; activity scheduling
Session 3 - Monitoring of thoughts, identifying cognitive errors
Session 4 - Cognitive restructuring
Session 5 - Optional modules of relaxation techniques, problem-solving techniques, assertiveness
Session 6 - Consolidation of what was learned in previous sessions. Education on early warning signs

6.2 Results of Phase 2

Of the 12 patients recruited for Phase 2 of the study, only 11 completed the treatment. One patient was hospitalised with an exacerbation of depressive symptoms after 4 sessions and was lost to follow-up. Most of the patients (67%; 8/12) were females and the average age at baseline was 42 (ranging from 22 to 66 years). A majority (58%; 7/12) had experienced episodes of depression previously and the mean duration of treatment was 3.1 years. At the baseline, all were on antidepressant medication and 8 were on adjunct medications.

Table 8 presents the scores of the scales at baseline, post-treatment (10 weeks) and 6 months (26 weeks) follow-up. The table also presents changes to treatment and treatment adherence during the

study. Although the HRSD, BDI and GAF scores have improved significantly at both points with better scores at week 10, differences between the outcome scores at week 10 and 26 were not significant. Treatment compliance did not show any significant difference from baseline at the two assessment points.

Table 8

Assessment scores at baseline, week 10 and week 26

	Mean score at baseline (CI)	**Mean score at week 10 (CI)**	**Change from baseline at week 10**	**Mean score at week 26 (CI)**	**Change from baseline at week 26**
HRSD	26.3 (25-28.6)	21.4 (19.2-23.5)	4.9 (*p<0.01*)	22.2 (19.7-24.6)	4.1 (*p<0.05*)
BDI	22 (20.7-23.7)	17.9 (15.9-19.9)	4.1 (*p<0.05*)	18.5 (16-20.9)	3.7 (*p=0.05*)
GAF	51 (47.6-53.4)	60 (55.3-65.6)	9 (*p<0.01*)	58 (52.7-65.4)	7 (*p<0.05*)
TC	4.4 (4-4.8)	4.5 (4.1-5)	0.1 (*p=0.17*)	4.45 (4.1-4.7)	0.05 (*p=0.58)*

HRSD - Hamilton Rating Scale for Depression; BDI - Beck Depression Inventory II; GAF- Global Assessment of Function Scale; TC- Treatment Compliance on a 5-point Likert Scale, CI- Confidence Interval

6.2.1 Patients' and clinicians' perceptions and content analysis in Phase 2

All the patients believed that psychotherapy was useful and practical. The majority (73%, 8/11) reported that the psychotherapy was able to give them something significantly differently to treatment as usual. All the clinicians reported the modified CBT as being 'feasible' and 'easily deliverable'. Content analysis was done similar to Phase 1 of the study. Codes were categorised to demonstrate broad representative themes (Table 9).

Table 9

Codes, categories and themes identified in Phase 2 interviews

Codes	Categories	Themes
Assessment **Formulation** **Familiarisation**	Assessment and formulation	Assessment and formulation were not given adequate weightage. There should be a more explicit discussion about the assessment
	Training on familiarisation to CBT	Training on familiarisation to the CBT model should be more robust
Homework **In-sessions** **Leaflets**	Problems with homework	A more lenient approach to homework promotes patients' attendance. But then patients do homework during the session which reduces the time for other things. Patients find it difficult to do homework and require guidance and support. They did not receive much support from family members to do the homework. Therefore, a different and better approach may help. Eye-catching, easy-to-read leaflets given to patients as reading material at home could serve as useful reminders and attract more family support
	Improvement to leaflets	
Mindfulness **Assertiveness** **Activity scheduling** **Relaxation** **Somatic symptoms**	Not-so-helpful techniques	Mindfulness and assertiveness are not very beneficial. Therefore, less emphasis should be placed on those
	Helpful techniques	Activity scheduling, relaxation techniques and addressing physical symptoms are helpful and more focus should be placed on them
Duration **No of sessions** **Approach**	Advantages and disadvantages of the process	Duration and number of sessions keep clinicians and patients focused. Patients find duration and number practical and feasible. It makes clinicians time conscious thereby more task oriented and focused. At times it is stressful for the clinicians
		Patients were comfortable with the direct approach and it was easier to keep to time because of that

Satisfaction **Feasibility** **At the end**	Perceptions of patients Perceptions of clinicians	Patients were satisfied with the therapy. They felt it had done something medication could not or did not do. Clinicians felt it was feasible At the end of sessions, some patients felt empowered and that they had wrestled back control of their life. But others felt they will not know what to do

Chapter 7

Discussion

Chapter 7

7.1 Discussion

7.1.1 Methodological rigour of the study

Tobin and Begley identified a number of factors that would improve the methodological rigour in a mixed study. Appropriate study design, specific and inclusive audience and adequate sample size have been described as some of those factors.

In the first phase of the study, we were looking for insights on psychotherapy for depression in Sri Lankan contexts from service users and service providers. We selected semi-structured interview questions over close ended questions or focus group discussions for the first phase of the study. We conducted one-on-one interviews with study participants in-person. These interviews generally lasted for 30 minutes to 1 hour and allowed us to cover a wide range of topics and delve into specific areas depending on the initial response to the theme. We believed by this method we were able to get far richer responses as well as test out concepts that we simply can't acquire through close-ended questions. This method was preferred over focus groups as what we covered sensitive and personal topics which participants, especially patients and carers would have found difficult to discuss in a group setting. Considering the stigma attached to mental health in Sri Lanka, such topics are rarely discussed in groups. We also believed it was logistically too difficult to gather a study sample, especially clinicians and traditional healers, in one place considering their professional commitments.

In this phase of the study, we wanted to explore the insights of service users and service providers in Sri Lanka. In addition to the patients, we included carers as they play a pivotal role in mental health care in Sri Lanka. Carers not only play the carers role but also the role of a case manager in a Western Country by facilitating and coordinating treatment. In addition to allopathic mental health care professionals, we also included the traditional healers as they too play a significant role in mental health care provision in Sri Lanka as many people have sought treatment from them for mental health issues as suggested by studies on pathways of care. They are also widely considered as custodians of cultural knowledge of mental health treatment. Therefore, we believe we have been inclusive of the study population of the first phase of the study.

We recruited patients with a clear diagnosis of depression for at least 6 months, so they have adequate exposure to treatment options for depression. We recruited consultant psychiatrists, medical

specialists providing mental health care. They not only provide pharmacological as well as psychological treatment options for patients, but they are also responsible for overall treatment. A psychiatrist may opt to refer the patients for psychotherapies when they believe the patients will benefit from it and they are unable or unwilling to provide the same. Some patients will seek the opinion of psychiatrists before they go for psychotherapy. Therefore, their insight Senior registrars or advanced trainees in psychiatry are waiting to become consultant psychiatrists after 1-2 years of training. Senior registrars have completed all the examinations and have had at least 4 years of experience in psychiatry. Essentially, they are future psychiatrists who provide mental health care delivery for future generations of Sri Lanka. So, we have explored insights into the most important mental health care providers in Sri Lanka as well as futuristic care providers.

In the first phase of the study, the sample sizes of most groups were large enough to sufficiently describe the insights of that group on psychotherapy for depression in Sri Lanka and address the research themes we focused on. Except for the group of medical mental health care providers (psychiatrists and senior registrars in psychiatry), there was no repetitive data. We attained saturation in the groups of patients, carers, mental health care professionals (both medical and non-medical). We believed adding more participants to these groups would have not resulted in obtaining additional perspectives or information. However, we did not attain saturation in some research themes with the traditional healers' group. The Heterogenicity of this group as well as the smaller sample size may have contributed to this. The fact that we attained saturation in more than 50% of the research topics we discussed with this group and difficulty in finding study participants for this group prevented us from recruiting more people for the study.

Therefore, we believe the first phase of the study was methodologically sound with appropriate study design, inclusive yet specific audience and adequate sample size.

We conducted the 2nd phase of our study to evaluate the feasibility and acceptability of the Modified CBT manual we created in Phase 1. We conducted a pilot study in the 2nd phase. Eldridge, Lancaster, Campbell, Thabane, Hopewell, Coleman, & Bond (2016) made recommendations in relation to the design of pilot and feasibility studies. They identified several areas that are important for the methodology of these studies. Eldridge et al. (2016) stated that these studies should be designed to determine the acceptability of an intervention. The study protocol of the pilot should be designed to test the integrity of the study design for the future larger trial, such as RCT, by adopting a similar design to future study. The pilot study should be designed to gain initial estimates for sample size calculation, test data collection forms or questionnaires, to estimate rates of recruitment

and consent and to select the most appropriate primary outcome measure. We were able to achieve all those objectives through the design of the 2nd phase of the study.

In addition, as Bowen et al. (2009) suggested we were able to test the practicality (exploration of whether modified CBT can be delivered when resources, time or some combination thereof are constrained in some way), adaptation (exploration of further changes in contents or format of CBT to be appropriate in Sri Lankan context) and integration (assessment whether a new program or process could integrate into an existing system or infrastructure).

Our sample size was small and only 11 patients completed the 2nd phase of the study. There is no clear consensus about the required sample size for the pilot or feasibility studies. One of the simplest methods to apply are sample size rules of thumb. Julious (2005) suggests a minimum sample size of 12 subjects per study. However, many suggest basing sample size calculation on previous research studies. We recruited 12 patients for our pilot study after studying similar previous studies.

7.1.1.1 Strength and Limitations

We recruited the patients for a pilot study from the psychiatry outpatient clinic at Colombo North Teaching Hospital, Ragama, Sri Lanka. They had a confirmed diagnosis of depression at last for 6 months and severity ranged from moderate to severe. They have never been exposed to significant CBT in the past. We believed with previous exposure to psychotherapy participants may have had psychotherapeutic strategies in their rapporteur which may make the sample contaminated. We were conducting the intervention in Sinhalese and therefore had to exclude patients who were not conversant in Sinhalese. We wanted the test mCBT on patients with depressive disorder Therefore, we believe the patients we recruited were specific enough yet representative of the eventual target audience. Modified CBT was delivered by three clinical psychologists and a consultant psychiatrist with special training in psychotherapies including CBT. This was important to ensure the fidelity of CBT for the study. But we see this as a limitation as this may not be generalisable. Another major limitation of our 2nd phase of the study is not having a control arm with patients who are treated as usual. While this was keeping in line with our objectives of checking the acceptability of feasibility of Modified CBT for depression in Sri Lanka, the addition of such arm would have given us further information about recruitment, randomization and efficacy. As discussed before, a pilot study can be used to evaluate the feasibility of recruitment, randomization, retention, assessment procedures, new methods, and implementation of the novel intervention. We did not attempt to conclude the efficacy of this intervention through the pilot study. But the results we saw with the outcome measures were very encouraging. Although efficacy and effectiveness are usually not evaluated in a pilot study it

may give some indication of whether the new intervention will work (Leon, Davis, & Kraemer, 2011).

7.1.2 Encouraging results of the study

Historically, communicable diseases or infectious diseases such as malaria and polio were significant public health concerns in Sri Lanka (Karunathilake, 2012; World Health Organization, 2018). However, with the change of socioeconomic conditions and the improvement of certain health facilities in Sri Lanka, noncommunicable diseases are becoming more pertinent health issues. Sri Lanka has been able to successfully eradicate menacing infectious diseases such as polio and malaria; it was the 11th country in the world to eradicate polio and the second country in Southeast Asia to eliminate malaria (Abeyasinghe et al., 2012; Holmes et al., 2017). Conversely, Sri Lanka's struggle against noncommunicable diseases has been far less noteworthy (Mehta, 2016). We may be able to emulate the success against communicable diseases if we could find an effective, inexpensive and widely accepted treatment such as immunisation for noncommunicable diseases (Engelgau, Okamato, Navaratne, & Gopalan, 2009). The success of immunisation lies not only in it being inexpensive and widely available, but its ability to prevent future occurrences of the illness (Doherty, Buchy, Standaert, Giaquinto, & Prado-Cohrs, 2016).

The need for such treatment is very relevant to Sri Lanka considering the nation is facing the transition from communicable diseases to noncommunicable diseases with a relatively small resource base compared to many other countries experiencing this transition as they move towards high-income status (Karunathilake, 2012; World Health Organization, 2018). Lower gross domestic product (GDP) as well as lower health spending, which is only 4% of GDP, underscores this necessity even more (Health Economics Cell, 2016). The fact that mental illnesses are more prevalent among people with lower socioeconomic backgrounds too highlights the need for affordable and accessible treatment (Lund et al., 2010; Maselko et al., 2018). Further, mental illnesses such as depression are recurrent and treatment should preferably be able to manage the current symptoms as well as prevent future relapses (Ng, How, & Ng, 2017). Therefore, an inexpensive treatment, which is effective in symptom control as well as mitigating future relapses, would be ideal.

Yet, no treatment would be of any use, however effective and inexpensive it is, unless people are willing to utilise it. Mental health is laden with unique issues such as stigma and cultural relevance, particularly in a country like Sri Lanka (Fernando et al., 2010; Samarasekara et al., 2012). As mental health is a heavily value laden field, cultural aspects play a significant role not only in the

understanding of the disease but also in treatment utility (Malla, Joober, & Garcia, 2015). Unless people can relate to the treatment as their own, they may reject it. People may be able to relate to the treatment if it endorses cultural values and norms (Jimenez, Bartels, Cardenas, Dhaliwal, & Alegria, 2012). One of the reasons why people seek traditional treatment for mental illness is that they feel these therapies are much more attuned with their culture (Choudhry, Mani, Ming, & Khan, 2016). Therefore, in order to make people utilise inexpensive and effective treatments more, we should learn from traditional treatments which are sensitive to cultural values. Human resources are scarce in the field of mental health in Sri Lanka (Minas, 2015). Therefore, treatment should be easily deliverable by available health staff.

Considering the above factors, the ideal treatment for mental health in Sri Lanka should be inexpensive, easily deliverable, culturally sensitive and effective in symptom control and mitigating future relapses.

A considerable proportion of people with depression experience recurrences of the condition. Those people experience 7-8 recurrences during their lifetime (Burcusa & Iacono, 2007). We need long-term strategies to reduce the risk of relapse or recurrence of depression. Considering the debilitating nature of the depressive episodes every treatment guideline strongly recommends continued use of antidepressants from 6 months to over 2 years from the improvement of symptoms (Blier et al., 2007; Hansen et al., 2008). However, when people are in remission, they either forget or deliberately stop taking medication (Jung et al., 2016).

A number of studies including a systematic review and meta-analysis concluded that psychological interventions are superior to treatment as usual and not inferior to continued antidepressant medication in preventing relapses of depression (Biesheuvel-Leliefeld et al., 2015; DeRubeis, Siegle, & Hollon, 2008; Hollon et al., 2005; Jarrett, Minhajuddin, Gershenfeld, Friedman, & Thase, 2013). Biesheuvel-Leliefeld et al. (2015) further reported that the effectiveness of psychotherapies in preventing relapse was enhanced when the patient had received psychotherapy during the acute phase of the depression. CBT had the largest effect size. However, it is not very clear how long psychotherapy should be administered to obtain this result. Some studies included in these meta-analyses used a few sessions while others utilised many.

If one could achieve this feat, preventing or minimising relapses with psychotherapy consisting of fewer sessions, it would be a truly effective and inexpensive way to reduce the burden of the illness

considering the cost of antidepressant medications and high degree of non-compliance or partial non-compliance of medication once the acute phase is resolved.

Results of this feasibility study suggest that we have developed a psychotherapy that could be easily delivered in a culturally sensitive, acceptable and effective manner, resulting in the following possible benefits:

1. Increased retention in treatment (continuity of care)
2. Increased satisfaction with treatment
3. Decreased symptoms of major depressive disorder (MDD)
4. Increased ease of the delivery
5. Reduced cost of the treatment

7.1.3 More inclusive generation of knowledge

The favourable result is borne by the strengths of the research methodology. One of the main strengths of the research is generating knowledge to develop an intervention by in-depth interviews with all relevant collaborators. Most other studies have considered only patients and service providers as stakeholders (Naeem et al., 2011; Rathod et al., 2010). This study included carers and alternative therapists with due consideration for strong family relationships, involvement of the family in therapy and long held traditions of alternative therapies in Sri Lanka. Inclusion of those categories proved valuable with their unique insight into varied aspects, including the necessity for increasing activity and not rejecting cultural explanations of depression, but using those for therapeutic gains. The latter seems very important as at least 2 meta-analyses concluded that adapting the explanation of the client's illness was the sole if not an important moderator for the differences observed in mainstream vs. modified psychotherapy (Benish et al., 2011; van Loon et al., 2013). Their suggestions were incorporated in modifying CBT and this was found to be beneficial in the feasibility study.

7.1.4 Delay in seeking treatment

The study explored the time lag between the onset of symptoms and seeking treatment, as treatment delays are associated with many negative consequences. It has been found that treatment delays at the beginning of the illness are linked with more severe mental health disorders with frequent recurrences and treatment resistance (Wang et al., 2007). Further, such delays lead to undiagnosed and undertreated psychiatric disorders, which could result in failures in education, occupation and relationships (Kessler, Walters, & Forthofer, 1998; Reddy, 2010; Williams, Chung, & Muennig, 2017). If not treated at the onset of the illness, a single disorder like depression can often progress to

complex co-morbid disorders such as depression with substance misuse that is more difficult to treat (Kessler & Price, 1993). Delay in treatment initiation in depression is correlated with increased suicidality (Rihmer, 2001; Schwartz-Lifshitz, Zalsman, Giner, & Oquendo, 2012). The delay of 5.7 months in treatment seeking in the study population was much better than the delay reported for mood disorders in the WHO's World Mental Health Survey Initiative of 1-14 years (Wang et al., 2007). The WHO study reported that even in countries with advanced economies such as Netherlands (1 year), France (3 years) and the US (4 years), the delay was significant. In countries with similar socioeconomic backgrounds as Sri Lanka, the delay was between 6 years (Nigeria and Lebanon) and 14 years (Mexico). Though it appears that this patient sample was significantly quicker than the WHO study population in seeking treatment, a direct comparison between these two groups is difficult. There is a clear sampling bias in the study sample, being conveniently selected from a patient population receiving treatment at a hospital. Those who did not promptly seek help may have had mild and self-limiting illness whereas these patients had more severe debilitating depression which required early treatment. However, a study conducted in the US has shown that even people with severe and impairing disorders have substantial delays in initial treatment contact (Wang, Berglund, Olfson, & Kessler, 2004). The fact that psychological autopsies of suicide in Sri Lanka show a considerable delay in treatment seeking may suggest that our sample is not representative of the Sri Lankan population (Abeyasinghe & Gunnell, 2008; Samaraweera et al., 2008). An epidemiological study in Sri Lanka, similar to the WHO study, will confer clearer answers to this question.

Patients who had received prior psychiatric treatment in the study were found to have made prompt contact with mental health services, i.e. in 3 weeks. Gomez et al. (2017), who studied a group of patients with varying mental health disorders attending a psychiatric clinic of a different tertiary care hospital in Sri Lanka reported similar findings. They too found that 51.7% sought treatment within a month after the onset of symptoms, while only less than a quarter (24.2%) delayed by over 6 months.

7.1.5 Pathways to care

While all 3 patients experiencing their first episode of depression directly sought a western medical practitioner, 2 (67%) had sought astrological remedies before presenting for western medical treatment. Goldberg and Huxley (1980) in their seminal publication described a succession of filters individuals go through that determine whether people access specialist care. The authors pointed out that the individual's beliefs and attributions about symptoms of the illness are central to how they respond to the illness. Those beliefs and attributions inform whether they will seek help and the manner in which they present to services. There are two Sri Lankan studies which looked at

pathways of care for patients with mental illness (Gomez et al., 2017; Karandawala, 2004). Gomez et al. (2017) reported that 60.8% of patients with varying mental health disorders attending a psychiatry clinic of a tertiary care hospital in Sri Lanka perceived that their symptoms were caused by mental illness while 16.7% believed it was due to physical illness. Fifteen percent believed the symptoms were due to supernatural causes and 61% of that group sought traditional and faith healing methods. Another Sri Lankan study that explored help-seeking during the entire course of the illness reported that 51.9% of patients sought traditional help while 25.9% sought magico-religious remedies, and 9.1 % consulted ayurvedic practitioners (Karandawala, 2004). The small sample size and differing methodologies do not allow comparisons between our study and these. Yet, it is important to note that in all three studies, a significant number of patients sought traditional health remedies. Our study demonstrated that people seek both western and non-western treatment concurrently, suggesting that they believe in both belief systems. Therefore, incorporating useful and relevant elements of the traditional systems in the western system may increase the utility value of the latter in the Sri Lankan context.

7.1.6 Carer involvement

We found that a vast majority of the patients of Phase 1 identified a carer - spouse or parents - who supported them emotionally and / or financially and assisted them with treatment. All the carers in Phase 2 of the study reported supporting the patient with emotional support and treatment. Available literature in Sri Lanka regarding carers of the mentally ill concur with our findings; almost all the carers are family members and mostly female (Fernando et al., 2017). This may be due to the strong family ties in Sri Lankan society, and cultural expectation that the ill be looked after by family (Fernando, 2000; Kaluthanthri, 2014). This may present with the opportunity for Sri Lankan psychotherapists to have the patient's family members function as reliable co-therapists though this may make empowering the patient a challenging task at times.

Both patients and healthcare practitioners agreed on the vital role family members could play in therapy yet felt the participation of the family in therapy was not essential and should occur with conditions. In contrast, the carers and traditional practitioners felt more strongly about the involvement of the family in therapy. The importance of family ties is perhaps valued more by carers and traditional practitioners when compared to patients and healthcare professionals. Among the healthcare professionals, psychiatrists were in favour of the family taking part in therapy when compared to psychologists. This could be understood in the context of psychiatrists seeing patients at a time when they are more unwell and need the assistance of family compared to psychologists who see the patients when they are relatively well and independent.

Western literature predominantly discusses the involvement of the family in psychotherapy with children and youth rather than with adult patients (Haine-Schlagel, Brookman-Frazee, Fettes, Baker-Ericzen, & Garland, 2012; Manassis, 2005). When it comes to literature on culturally modified psychotherapies, the importance of family involvement in Latinos living in the US has been mentioned (Hall, Ibaraki, Huang, Marti, & Stice, 2016). However, the efficacy of their involvement has not been assessed. Both types of literature stress that involvement of family should only be implemented if it is considered a shared goal of all stakeholders, including the patient, family and therapist. It is interesting to note that irrespective of the variation in cultures, Sri Lankan patients and healthcare professionals expressed the same sentiment about involving family members in therapy.

7.1.7 Use of psychotherapy without the patient being aware

Most doctors reported providing psychotherapy in part or its entirety during their regular practice. However, it is interesting to note that all but 2 patients and carers reported ever having psychotherapeutic treatment even after a comprehensive explanation of varied components of psychotherapies. It is possible that the psychotherapeutic principles they used in the practice were well integrated with other treatment modalities, such as pharmacotherapy and education, so the patients may not have understood those as psychotherapy. The credibility of psychotherapy and its treatment outcomes are closely associated (Lambert & Barley, 2001; Mooney, Gibbons, Gallop, Mack, & Crits-Christoph, 2014; Sandell, Clinton, Frövenholt, & Bragesjö, 2011). The credibility of treatment can be defined as how much the patient believes that the treatment or intervention, in this case, psychotherapy appears appropriate, rational and useful (Borkovec & Nau, 1972). What patients expect from therapy as well as how they experience therapy will depend on the perceived credibility of therapy (Hardy, Barkham, Shapiro, Reynolds, & Rees, 1995; Newman & Fisher, 2010). If patients are unaware that they are receiving psychotherapy, the credibility of therapy is very low and consequently, experience and expectation of patients as well as actual treatment outcomes are poor. Therefore, psychiatrists' explanation of what they are doing when they are doing psychotherapy may go a long way in improving treatment outcomes.

Strong (1968) suggested that the therapist should establish treatment credibility thereby gaining influence which in turn may bring about the required change in the patients' thinking and action. The social influence theory essentially sees psychotherapy as an interpersonal influence process which changes patients' health (Greenberg, Constantino, & Bruce, 2006). In Sri Lanka, healthcare

professionals, doctors, in particular, have credibility by virtue of their position and may not require establishing treatment credibility to bring about changes in the patient.

It is interesting to explore the possible reasons for healthcare professionals keeping patients unaware when they practise psychotherapy. Healthcare professionals may be apprehensive of patients' reception as they are not very familiar with the concept. They may also consider that not taking the time to explain the techniques being used is a better use of the limited time they have with patients.

7.1.8 Lack of time for psychotherapy

It is not surprising that doctors highlighted a lack of time as the main obstacle to the provision of psychotherapy considering the lack of human resources in the mental health sector in Sri Lanka (Minas, 2015). In the present context of psychiatry in Sri Lanka, psychiatrists face mounting demands on their time. Increasing non-clinical duties such as administrative duties invade on time spent with patients.

It has been shown clearly that patients' and physicians' level of satisfaction is connected to their perception of the amount of time that they had with the doctor and they could spend with a patient respectively. The time duration that doctors spend with patients varies greatly between countries and specialty (Chen, Zou, & Shuster, 2017; Dugdale, Epstein, & Pantilat, 1999; Lin et al., 2001). Psychiatrists spend more time with the patient due to the nature of the patient's presentation and doctors in resource poor countries spend less time due to patient load. When the average time spent with each patient for family practitioners in the US was 20 minutes, Sri Lankan psychiatrists could spend only a few minutes with a patient (Lowes, 1995).

Studies have revealed that whenever physicians are able to spend a longer time with patients, they are more likely to do a better assessment and provide better treatment (Arora, 2003). Further, doctors engaged in activities that required time such as educating the patient when they were aware they had longer appointments with patients (Klitzman, 2007; Pomey, Ghadiri, Karazivan, Fernandez, & Clavel, 2015; Sampson et al., 2013). Therefore, doctors are less likely to engage in psychotherapy if they thought psychotherapy takes a long time. Briefer and shorter psychotherapies such as this modified therapy we developed may address this issue. It is interesting to note that Sri Lankan patients and carers too wanted shorter and fewer sessions reflecting their competing demands. Therefore, modified therapy with shorter sessions and fewer sessions will improve delivery by clinicians as well as utility by patients.

However, it is generally believed that a greater number of CBT sessions are associated with better outcomes, suggesting that the receipt of an adequate number of sessions is necessary for an adequate clinical response (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012). Lower doses of psychotherapy have been associated with poorer outcomes (Weersing & Weisz, 2002). The expectations of patients and the need for shorter therapy by therapists may explain the positive outcomes we saw with the modified CBT. While longer therapy may have been more effective as far as outcomes are concerned, it may not have been accepted by patients or delivered by therapists.

7.1.9 Lack of training in psychotherapy

Psychiatrists identified the lack of training in psychotherapy as one of the obstacles in providing such treatment. Lack of training may need to be addressed through a better emphasis on psychotherapy during basic and advanced postgraduate training in psychiatry. It is heartening to see that increased emphasis has been placed on psychotherapy in Sri Lankan psychiatry training over the last few years (Hanwella, 2011).

A 2-stage approach is generally advocated for therapists with the relevant background experience such as psychiatry trainees or junior psychiatrists (Beidas & Kendall, 2010; Sholomskas et al., 2005; Weissman et al., 2006). In the first stage, the components of therapy are taught in a didactic manner and then demonstrated practically. In the second stage, the trainee therapists provide the treatment under the supervision of an expert therapist. When the treatment is shorter, simpler and manualised, both stages of training become easier. Modified CBT for depression in Sri Lanka as a shorter and simpler therapy, when compared to generic CBT, may augur well for training psychiatrists in Sri Lanka. This therapy is being provided by psychiatry trainees at Colombo North Teaching Hospital, Ragama, Sri Lanka under the supervision of the student researcher.

7.1.10 Traditional healers and western medicine

Contrary to popular belief, most alternative therapists believed allopathic treatment to be beneficial and a majority even encouraged their clients to seek allopathic treatment. Patel (2011) described a similar phenomenon in Africa. However, the intent we have seen is much clearer than what was described by Patel. The selection bias of therapists who took part in our study may have played a part in this. Alternative therapists also believed they had a complementary role in managing mental health issues and therefore considered collaboration between allopathic medicine and alternative healing to be beneficial. The greatest obstacle to such collaboration has been the mutual suspicion between the two sectors and the concerns of the medical sector regarding the ‘unscientific’ and unorthodox practices of traditional healers (Mokgobi, 2014). The considerable diversity of alternative therapists will make it difficult to regulate their practice and identify more credible people

for collaboration. Therefore, incorporation of their helpful traditional and culturally relevant components into mainstream therapy appears to be the compromise (Krah, de Kruijf, & Ragno, 2018).

7.1.11 The modified CBT manual

It is difficult to compare the changes made to the CBT manual with previous studies as authors have been vague about how their treatments varied from the existing CBT manual (Chowdhary et al., 2014). However, available evidence suggests that the modified therapy is shorter and briefer than many other culturally modified therapies (Benuto & O'Donohue, 2015; Comas-Diaz, 2006). Most of those modified therapies were designed for cultural minorities in developed countries (Chowdhary et al., 2014; Rathod et al., 2010). Time and resources may be less of a problem in those settings compared to Sri Lanka, which may partly explain this difference. The risk that one may run when changing the treatment is whether it will affect CBT adversely, so much so that the efficacy of the generic version will be lost in the modified format (Lo & Fung, 2003). While Phase 2 of the study addressed this question to a certain extent by assessing symptom improvement, a head-to-head study of modified CBT vs. generic CBT would have answered this issue more thoroughly.

7.1.12 Treatment outcome of Phase 2

Patients who participated in Phase 2 of the study demonstrated clear improvements in their symptoms and functionality as suggested by improvements in HRSD, BDI and GAF scores. Those improvements are too significant to be ignored as being natural progression seen with treatment as usual in patients who were treated for a mean duration of 3.1 years. Further, the fact that those changes were more marked soon after the completion of therapy at week 10 when compared 6 months afterwards also gives credence to the possibility that improvements were due to the modified psychotherapy. On the other hand, this observation may question the sustainability of symptom resolution. However, it should be noted that a better response in the immediacy of treatment completion is a well-known phenomenon (Cuijpers et al., 2013). There was an improvement, though statistically not significant, in treatment compliance with the modified CBT. This would also confirm the widely held view that psychotherapies are not only supplementary but also complementary in treatment (Pampallona, Bollini, Tibaldi, Kupelnick, & Munizza, 2004). More significant symptom improvement may suggest mildly improved treatment compliance alone is not the reason for the previous occurrence. Symptom improvement is combined with the subjective acceptance of the therapy by the patients. It is important to note that all but one patient attended all therapy sessions.

7.1.13 Lessons learnt from Phase 2 of the study

Phase 2 study comments suggest that case formulation was not given adequate weightage. Case formulation is a dynamic psychological explanation of a patient's problem that has treatment utility. CBT formulations take into account a number of people, cultural and environmental variables (Nezu & Nezu, 1989).

However, research suggests that there is low inter-rater reliability between therapists when asked to formulate the same case and that there may be discrepancies in what is considered an essential part of a formulation. A study which explored the diversity of therapists' viewpoints regarding the purpose and essential features of cognitive-behavioural therapy (CBT) case formulation of depression revealed whilst there was some agreement between what was considered to be least important in a formulation, there was a lack of complete consensus amongst the therapists about the most important aspects (Flitcroft, James, Freeston, & Wood-Mitchell, 2007).

It is believed that case formulation improves the outcome of CBT. A study by Jacobson et al. (1989) showed that how detailed the formulation does not change the outcome of therapy at termination although detailed formulation led to somewhat improved maintenance of gains at six-month follow-up. The studies have questioned whether the formulation should be explicitly shared with the patient and underlined the importance of intuitive case formulation processes (Tarrier, 2006). Several writers have provided illustrations and strategies for developing case conceptualizations based on Beck's cognitive model (Beck, 1995; Freeman, 1992; Needleman, 1999; Padesky, 1996). The use of such illustrations will make formulation less time consuming and more user-friendly. We also believe the therapist can and should share this illustrated formulation with the patient initially. Such discussion should be collaborative yet educational to the patient considering the lack of familiarity of case formulation in Sri Lankan patients.

Phase 2 comments also suggest that socialising to CBT should be given more emphasis. At the beginning of CBT therapist will focus on three key tasks assessment, formulation and socialising the patient to CBT. It is customary for the therapist to spend a lot of time and energy socialising the patient to CBT in the initial sessions. Socialising to CBT includes keeping the structure of the session, dealing with any doubts the patients may have about CBT and educating them about CBT using specific examples for them. Socialising to CBT is an investment as it is essential for the

smooth and efficient running of subsequent therapy sessions. LeBon (2013) proposed that socialising to CBT can be done quickly and efficiently by using pre-arranged templates, metaphors, stories, example in the patient's presentation to explain the CBT model. Those strategies were already in place during the pilot study. LeBron also proposed summarisation and giving reading material as other strategies. Giving reading material was not effective as patients were not good at reading them. Perhaps abridged and user-friendly reading materials could be used in subsequent mCBT.

Phase 2 of the study suggests components of behavioural activation, relaxation techniques and addressing somatic symptoms are more helpful than other techniques therefore priority should be given. Similarly, Chowdhary et al (2016) found that strategies such as treatment engagement, psychoeducation, behaviour activation, problem-solving, the involvement of significant others, activation of social networks and relaxation were acceptable and beneficial for Indian patients with moderate to severe depression.

Behavioural activation is a non-cognitive strategy of CBT s aimed at increasing enjoyable and self-fulfilling activities. It works on the basis of individuals suffering from depression experience avoidance and decreased participation in adaptive activities leading to decreased opportunities for them to experience joy making this vicious cycle. Behavioural activation is a helpful technique in treating depression in non-Western patients (Hirayama, Ogawa, Yanai, Suzuki, & Shimizu, 2019). Hong Kong based study found that behavioural activation not only could treat depression but also could help to prevent major depression (Wong et al., 2018). Researchers suggest that this could help prevent major depression with the incidence rate reduced by half. Therefore, behavioural activation appears to have both short-term and long-term positive effects on depression.

It is not clear why behavioural activation is reactively more efficacious and feasible in non-Western settings. But being action oriented, focused on somatic functions, ability deliver by health professionals with less training (Ekers, Richards, McMillan, Bland, & Gilbody, 2011; Wong et al., 2018). The last factor will augur well with Sri Lankan psychotherapy delivery due to the scarcity of trained therapists.

In our mCBT manual behavioural activation is only discussed in session 2 afterwards, patients are expected to practice it which will be checked and discussed in session 3. Considering the importance of this, perhaps it could be followed by the therapist in a few other sessions as well.

Dealing with physical or somatic symptoms in depressed patients with psychotherapy appears to be important in the Sri Lankan context due to the prominence of somatic symptoms in these patients. However, a study conducted by Sumathipala et al (Sumathipala et al., 2008) suggested that CBT for structured psychotherapy for somatic symptoms is useful. Interestingly they did not exclude patients with depression. Therefore, it is not unreasonable to assume some of these somatic presentations were in the context of depression. They used monitoring somatic symptoms, reattribution technique, limit the unnecessary consultations with health care providers and discourage inappropriate discussions with ill-informed relatives and friends regarding somatic complaints (Sumathipala et al., 2008). In the modified CBT manual we have included somatic symptoms monitoring and reattribution. In addition, discouraging unnecessary consultations with health care providers and discourage inappropriate discussions with ill-informed relatives and friends regarding somatic complaints could be used if that is necessary.

It is interesting to note that phase 2 results suggested relaxation techniques are among the most useful strategies for depression among Sri Lankan patients. The most recent Cochrane metanalysis (Jorm, Morgan, & Hetrick, 2008) examined studies on the effectiveness of relaxation techniques in individuals with depressive disorder. It concluded that individuals who learned relaxation techniques were less depressed than those in the "no treatment" comparison groups. But the effect size was small. The studies that compared relaxation techniques with CBT also showed both groups improved but cognitive behavioral therapy had a greater beneficial effect (Jorm et al., 2008). We have included relaxation as an optional module in session 5. Perhaps many of our depressed patients were anxious ad tense. This may explain why relaxation techniques were found to be relatively more useful. It is not clear whether most Sri Lankan depressed patients are anxious. Therefore, unless patients are anxious and tense focusing more on relaxation techniques may not be warranted. We advocate to keep it as an optional module.

In phase 2 it was noted that while some patients felt empowered at the end of CBT, others were not confident what they could do if a similar problem occurred in the future. CBT is a skills-based therapy with a lot of emphasis on the educational approach. The focus is on patient learning skills needed for them to be their own therapists by addressing their own problems on their own. This means the CBT therapists' role is to help equip clients with skills and help them practice these, rather than be an expert that solves the issues. This may have a conflicted take in Sri Lanka. The patients in Sri Lanka view the doctors / therapists as experts not as equals. Telling them that they are experts after the completion of therapy is something difficult to digest. On the other hand, Buddhism, the major religion in Sri Lanka, encourages individuals to be self-sufficient through individual efforts.

In phase 2 of the study, it was reported that therapy being brief and short were at times stressful for the therapists. Delivering mCBT and being part of the research were new experiences for the therapists. Psychologists who delivered CBT were relatively new to their field and they are used to a longer version of CBT. These factors may have contributed to stress (Cushway & Tyler, 1994). But we believe when therapists become more familiar with therapy the stress will be reduced.

7.1.14 Treatment fidelity

We believe that as this is a manualised and relatively less complex therapy, training clinicians including nurses to deliver this may be possible. If such training and subsequent treatment delivery are possible, it may certainly increase access to patients to such treatments.

Yet the efficacy of treatment may be linked to experience and the expertise of the therapist (Goldberg et al., 2016). Treatment fidelity refers to the standard of implementation of psychological treatment (Borrelli, 2011). There are two aspects of treatment fidelity (Hildebrand et al., 2012). The first is treatment adherence, i.e. whether the right psychotherapeutic procedures were used. An example from surgery is selecting the optimal operative procedures. CBT has repeatedly shown to be effective for depression. The second component is that of competence. This refers to how well the chosen procedures were implemented. An example from surgery in this case is performing the operative procedures in a skilful manner. A third notion, that of treatment differentiation, i.e. whether the distinctiveness of the psychological treatment was maintained by not including extraneous and possibly proscribed elements. We believe that with the modified CBT for depression in Sri Lanka, we have safeguarded the fidelity of CBT by adhering to these notions.

In order to uphold treatment fidelity, therapist competence is important (Perepletchikova, Treat, & Kazdin, 2007). Therapist competence in this context may be defined as “the extent to which a therapist has the knowledge and skill required to deliver a treatment to the standard required for it to achieve its expected effects” (Fairburn & Cooper, 2011). Therefore, when assessing therapist competence, one is assessing the therapist’s capacity to provide treatment to an acceptable standard. While training nurses to deliver this treatment will certainly improve access to the treatment, we wonder whether there will be issues in the fidelity of treatment due to therapist competence. Just like with psychiatry trainees, we propose to use the two-stage approach to train nurses in it, although we have not attempted this so far in Sri Lanka.

7.1.15 Treatment Process Issues

In this study, we evaluated both the process of selecting core treatment elements and modifying the manner of delivery of CBT to Sri Lankan patients with depression.

Because we were trying to see the feasibility of a novel therapy that could be incorporated into the existing treatment model, we decided to conduct the sessions in the mental health clinic, where most of the outpatient care is provided in Sri Lanka. We believe adapting CBT to suit Sri Lankan cultural context will make to more effective and acceptable to Sri Lankan patients with depression. But it should be more accessible to the patients. In that, it should be readily available to the patients in Sri Lanka. Most of the patients with common mental health disorders such as depression receive treatment at the outpatient clinics of the government hospitals. They are assessed and reviewed at the outpatient clinics. They receive usual treatment including medication, psychoeducation, advice and other social interventions at the outpatient clinic. Therefore, we believed providing psychotherapy at the outpatient clinics may be appropriate. Consequently, modified CBT was provided at the outpatient clinic building of Colombo North Teaching Hospital. We tried to have at the same time as psychiatry outpatient clinics so, patients do not have come twice for psychotherapy and usual treatment. However, both patients and therapists faced certain challenges with these arrangements. We believed that if mCBT is to be provided as a part of routine treatment for depression in the state of the hospital of Sri Lanka, it will be provided in the mental health clinic. This treatment is most likely to be provided by the psychiatrists, doctors, or nurses, considering the available human resources in the health sector of Sri Lanka. However, we conducted the sessions with clinical psychologists who are not a part of the normal mental health team in Sri Lanka. Given our focus on the fidelity of treatment, we believed it is important to have highly trained clinicians such as clinical psychologists to deliver the treatment. In addition, we believe clinical psychologists should be and will be part of the mental health treatment team of Sri Lanka.

We encountered the following problems in conducting mCBT at the clinic with clinical psychologists. First finding a suitable place with adequate privacy in the mental health clinic was a challenge. The mental health clinic at CNTH Ragama has three large rooms and two smaller rooms Ten to twelve doctors in total see patients in the three big rooms, and two small rooms are used by the consultant psychiatrists to see patients. As CNTH, Ragama is the main teaching hospital for the Faculty of Medicine, University of Kelaniya, in addition to doctors, there are medical students in the clinic. This relative lack of space makes it rather unsuitable for conducting psychotherapy due to turbulence in the environment as well as lack of privacy. When other patients went home quickly after taking medication, psychotherapy patients became impatient and on two instances psychotherapy patients wanted to leave without waiting for their sessions. These patients did not like

waiting in the mental health clinic probably partly due to the stigma attached to attending the psychiatry clinic. This situation could have been avoided if the waiting time could be minimized or patients had a place to wait until the therapy. Both these were not possible due to disorganization and lack of space in the mental health clinic respectively.

There were issues with how clinical psychologists were accepted by the patients and other health care professionals. Most of the Sri Lankan patients are only familiar with doctors and nurses as the health care providers. Many of the patients mistook clinical psychologists for doctors initially. The ancillary staff of the clinic had the same confusion about the clinical psychologists at the beginning. However, their place was accepted by the patients and other staff with time. In Sri Lanka, clinical psychologists do not work in government hospitals. They only work in private hospitals, private schools and non-governmental organizations. They found working in government hospitals is more rewarding and fulfilling. However, they acknowledged that their professional identity needs to be established. They further stated, “few patients not only preferred to call as ‘doctor’, but they also identified as medics even when we have explained several times who we are”. Yet, they did not believe it impacted on the delivery of psychotherapy or efficacy of psychotherapy.

These findings led us to believe a separate and dedicated psychotherapy clinic out of the mental health clinic may be more suitable for this purpose. This kind of psychotherapy clinic will give more privacy, sense of purpose and less stigmatizing

7.1.16 Homework assignments

This treatment component had to be adapted to deliver in the brief format. One way to solve this problem is provided is mastering the technique using it as a homework assignment. However, because our patient cohort was not very keen on homework assignments, was not an option for our patient population.

Homework is an important component of CBT; in the context of CBT, homework can be defined as “specific, structured, therapeutic activities that are routinely discussed in session, to be completed between sessions” (Kazantzis, Lampropoulos, & Deane, 2005). Homework assignments, “specific, structured, therapeutic activities that are routinely discussed in session, to be completed between sessions”, are an essential part of CBT. These assignments are included in almost all CBT therapy manuals and frequently used in therapeutic practice. Completion of homework assignments was emphasized in the conception of CBT by its creator, Aaron Beck (Beck, 1980) and is positively associated with the outcome of therapy (Helbig-Lang & Fehm, 2004). Homework non-compliance is one of the main reasons for therapy failure in CBT (Helbig-Lang & Fehm, 2004). Studies have

suggested rates of non-compliance are up to 50% (Helbig-Lang & Fehm, 2004; Kazantzis et al., 2005). Reasons for homework non-compliance include aversion towards the concept of homework, disregard for the importance or relevance of the homework and the inconvenience of completing homework because of the amount of time consumed (Tang & Kreindler, 2017). Homework compliance could be improved by the provision of a written note or homework sheets on the task and explaining it and making it simple (Helbig-Lang & Fehm, 2004). Shen et al. (2006) pointed out that Easterners are less likely to complete homework tasks due to their cultural heightened fear of failure Therefore it has been suggested to present homework as an experiment for better understanding of the self rather than as a task to be completed (Guo & Hanley, 2015).

Sri Lankan students are forced to complete a lot of homework by school teachers. They are punished if they do not complete the homework. Homework has been one of the reasons for not liking the teacher and school. As a consequence, we had to ensure homework is not a central part of the treatment, fearing over-reliance on homework may have a negative impact on therapeutic alliance and treatment adherence. Our response to these issues was twofold. Although CBT required homework, we tried to pace interventions. It has been found that completion of homework can be improved by using certain strategies (Tang & Kreindler, 2017). Explaining clearly the importance and rationale of homework, allowing the patient to practice the homework tasks during the therapy sessions to increase confidence and making homework simple to make it more feasible are associated with better completion rates. In modified CBT we took care to explain why homework is necessary. Considering the negative meaning attached to homework in Sri Lanka, we did not use that term. We practiced homework assignments during the session. Understanding the difficulty of completing homework, we made homework assignments simple. While we encouraged them to complete homework by checking whether they have completed the assignments and praising them for completing it, we did not make the completion of homework a pre-requisite for them to come for the sessions. If they could not complete the homework, we explored the reasons for it, used problem solving techniques to address the issue and practiced homework given in the previous session at the beginning of the new session.

7.1.17 Striking a balance between directive and collaborative

As discussed before, CBT is a more directive psychotherapy when compared to many other therapies. However, it remains a collaborative therapy where the patient retains control of the therapy. The patient may decide on treatment goals as well as the agenda of each session along with

the therapist. While this may abode well with Western ideals, non-Western patients may expect the therapist to take a more instructive stance in conducting the therapy and adopt the position of a teacher or an expert. This is in line with traditional Sri Lankan thinking which places emphasis on the social hierarchy as well as Sri Lankan expectation of a health professional. If a doctor asks a Sri Lankan patient about what treatment option they would prefer, the usual answer will be "You are the doctor, you decide". At times as Guo & Hanley (2015) mentioned failure to adopt the role of an expert may cast doubt over Sri Lankan therapist's professionalism and knowledge. This preference for a directive therapy style has been well documented among non-Western patients (Li & Kim, 2004). Patients with Asian cultural background who had directive counselling reported greater therapeutic alliance, session depth and found therapists to be more empathic and cross-culturally competent when compared to the patients who had non-directive counselling.

In our modified CBT we gave the freedom for the patients to decide their treatment goals and tried actively to get the patient's involvement in setting the therapy agenda. Patients were rather reluctant to take part in these processes, particularly in setting treatment goals. The patients' typical response was 'I just want to get better'. Their participation in setting the agenda was less lukewarm. But in general, they preferred the therapist taking the lead and felt comfortable with that. We felt this may have made modified CBT more effective as far as the time is concerned. Yet, adopting an extreme instructive or directive approach may run the risk of CBT becoming a generic educational approach rather than individualised psychotherapy. Therefore, one should strike a balance between culturally adapting it to suit the context without damaging the fidelity.

We emphasised more on behavioural components of CBT in the modified CBT than the cognitive components. There were a few reasons behind the strategy. Sri Lankan individuals have difficulty discussing emotions and thoughts in therapy and have difficulty in describing them in words. Sri Lankans are traditionally not encouraged to express or discuss emotions. Further, discussing emotions will be difficult due to a lack of vocabulary to describe those. Due to the difficulty in finding correct terms to describe the emotions those are subjected to misinterpretation at times making this even more difficult. In contemporary Sri Lankan society, people, in general, seem to adopt a more materialistic attitude toward the lives. Thus, it is not surprising that Sri Lankan patients often expect to experience tangible improvements earlier on in their therapy. Behavioural components of CBT have tangible results early on when compared to cognitive components (Fenn & Byrne, 2013).

7.1.18 Lost in translation

Language plays a significant role in CBT as it is the primary delivery system of it (Guo & Hanley, 2015). Some of the terminology used in CBT such as negative automatic thoughts and cognitive errors are alien to Sri Lankan languages are difficult to translate straightaway. Many of these terms are easily understood by Western patients as meanings are quite consistent between the professional and colloquial terms. However, when these terms are used in therapy with Sri Lankan patients, even after translating those to Sinhalese, the meaning is often lost in translation. It should be noted that the Sri Lankan therapists whether psychiatrists or psychologists have learned these terms in English and may find it rather difficult to translate them into their mother tongue. Correct translation and comprehension by the patients are important as this is central to patient understanding the formulation of CBT and instruction given by the therapist. Although the differences in translation can sometimes be seen as subtle, they impact on the effectiveness of the therapy. Difficulty in finding correct Sinhala word for psychological terms may impact on the therapeutic alliance as the therapy may become artificial and foreign. Our therapists who conducted the session reported difficulties in translating psychological technical terms swiftly to Sinhalese. Even when it was translated, therapists felt the meaning was lost in translation as the patient did not get the correct meaning. Therefore, it will be important to include Sinhala translations or explanations as an appendix to the manual, which is written in English.

7.1.19 Cultural beliefs and CBT concepts

The basic premise of CBT is that there is a close connection between thoughts, feelings and behaviour and thereby changing one will lead to change of the rest. For, example as in the behavioral activation, alteration of activity levels will result in improvement of thought and mood. However, some Sri Lankans believe that thoughts are central to every action and it is the forerunner of mood and actions. They perceive this to be fundamental teaching of Buddhism and find it difficult to believe behaviour can be a forerunner. When delivering modified CBT, one relatively older patient found the concept of behavioural activation rather difficult to fathom as it was against what he believed in. He cited one well known verse from Buddhist teaching to explain his belief.

This verse was in Pali “Manopubbangama dhamma - manosettha manomaya- manasa ce padutthena” and English meaning was ‘all mental phenomena have mind as their forerunner; they have mind as their chief; they are mind-made”. He argued that therefore, behavioural activation is futile as behaviour is not going to change the thoughts. This was managed with gentle discussion and behavioural experiments which proved it to be useful.

Although we did not have any other such experience we believe some CBT concepts may not be in keeping with cultural beliefs. These cultural beliefs may be deep rooted in some Sri Lankan as it is the core of their cultural identity. Challenging such concepts without due consideration may result in an identity crisis and further anxiety leading to the poor outcome of therapy (Chen & Davenport, 2005). Guo and Hanley (2015) suggested that the therapist try to work with the client to find more flexible versions of these culturally rooted beliefs.

7.1.20 Local cultural knowledge of the therapist

Experienced traditional healers such as Buddhist monks use stories to convey their messages. Stories, when familiar and relevant, can be compelling when used in the correct context (Naeem et al., 2019). We used the folk stories and jataka stories (religious literature concerning the previous births of Buddha in both human and animal form) to drive the message home. In one of the sessions, a female patient half-jokingly said that she could not complete the behavioural experiment as it was a Saturday (generally considered to be an inauspicious day). This was not the first occasion where her superstitious beliefs had interfered with the therapy. The therapist used a Buddhist jataka story to explain the futility of the superstitions. She was a practicing Buddhist and she found this story very compelling and it changed her thinking patterns.

The story was from the Nakkhata Jataka it tells a story of how someone lost a marriage opportunity because they consulted an astrologer who told them the planets are not aligned correctly. “The fool may watch for 'lucky days,'- Yet luck shall always miss; - ’Tis luck itself is luck's own star -What can mere stars achieve?”

Sri Lankan People often use religion as an explanatory model for mental illness, depression in particular. Some of the patients with depression believe that actions in the past including in previous births can make a person depressed. As the depression is due to Karma which is perceived to be a predetermined sequence, there is nothing one can do about depression. Therefore, such beliefs about the causes of depression can influence help-seeking behaviour. The same patient who had the issue with superstition also had this view and reluctant to fully engage in therapy. When she mentioned this as the reason for lack of participation in therapy following Buddhist principles were discussed. It was discussed that Buddha taught there are five types of factors (Niyamas) at work that cause things to happen, called the Five Niyamas. Karma is only one of these factors. Present circumstances are

the result of countless factors that are always in flux. There is no single cause that makes everything to be the way it is. After explaining this to her she took an effort to seek help.

Both these cases highlight the need for the therapist to have a good knowledge of local culture, religion and folk stories. The therapist should be able to use this knowledge when necessary and appropriate. The challenge with this approach is that it cannot be included in the manual and the therapist cannot be trained in this aspect either. Therefore, whether this can be reliably reproduced in research is questionable.

7.2 Conclusions and limitations

We restricted our sample to Sinhalese speaking population, who, represent the majority ethnic group of Sri Lankan. Considering the similarity in presentations of depression, beliefs of depression between ethnic groups and similar challenges in delivering and accessing mental health service in Sri Lanka, we encountered no reason to believe our treatment efforts would not be appropriate for other ethnicities in Sri Lanka.

We still do not know the mechanism by which the modified CBT was effective. Our study design could not suggest which elements were essential and which were not. For example, we cannot separate the modified CBT per se from the therapeutic relationship patients had with their therapist. Testimonials from participants suggest that the activity scheduling, relaxation techniques and addressing of physical symptoms of CBT were more beneficial, but this is not conclusive. We plan to investigate this in future studies.

The essential component analysis of CBT for depression found the value of problem-solving and social skills training for adolescents and adults (Keller et al., 2000; Kennard et al., 2009).

Problem-solving skills known as the Friendship Bench intervention comprising 6 sessions of individual problem-solving therapy delivered by trained and supervised local health workers were effective in Zimbabwean patients with depression and anxiety (Chibanda et al., 2016). The problem-solving skills module was included as an optional module in the modified CBT (Session 5). This was thought to be an important component in Phase 1. However, this was not identified as one of the most effective strategies by the patients or clinicians in Phase 2.

In conclusion, the main finding of this study was that the modified CBT for depression was acceptable and effective. These encouraging results of the feasibility study will pave the way for a randomised clinical trial (RCT) to test the clinical effectiveness of the therapy. The findings of the feasibility study will be used to improve the CBT manual further, prior to RCT.

This study did not compare treatment as usual (TAU) or standard CBT with modified CBT. This would be done in the subsequent RCT. The authors acknowledge that intervention with CBT implies close follow-up and regular appointments than usually expected in TAU. A better therapeutic relationship may have influenced the outcome. In this study, the intervention was delivered by 'highly trained' clinicians which fact may question the wider applicability of these interventions. This too could be addressed by using nurses as clinicians along with psychiatrists and psychologists in the RCT to discover if there will be a difference in outcome depending on the professional background of the therapist. There is a growing body of evidence from non-western countries including Uganda, Chile and Zimbabwe to suggest that community members without formal mental health education can be trained to deliver basic psychotherapy services (Araya et al., 2003; Bass et al., 2013; Chibanda et al., 2016). Thus, we are optimistic that we will be able to train nurses to deliver the modified CBT in Sri Lanka.

7.3 Implications

7.3.1. Practical implications

The main aim of our study was to address the lack of culturally appropriate psychotherapy for Sri Lanka. We have done so by developing a culturally appropriate CBT manual that modified the existing CBT manual through incorporation of key stakeholders' views and then evaluating the acceptability and feasibility of the modified manual. The first practical implication of the research is that it has produced a psychotherapy treatment manual for depression which is acceptable to patients in Sri Lanka and feasible for Sri Lankan mental health clinicians. The availability of this culturally adapted manual can therefore contribute to improving psychotherapy services in Sri Lanka. In the next chapter, we discuss the establishment of a dedicated psychotherapy clinic in Sri Lanka and how the treatment manual was used in that setting. The second practical implication concerns training in psychotherapy for psychiatry and psychotherapy trainees in culturally modified therapies. Usually, they are trained in unmodified Western forms of psychotherapy without formal reference to culturally modified psychotherapies. If the modified psychotherapies are better suited to the Sri Lankan setting trainees should be exposed to modified psychotherapies. Many Sri Lankan psychiatry and psychotherapy trainees have been exposed to this manual over the last two years. This is

discussed in detail in the next chapter. A third practical implication stems from the possibility of making this or similar therapies widely accessible to the Sri Lankan public by training other clinicians, such as mental health nurses, using this or similar culturally modified treatment manuals. Considering the narrow and specific focus of such manuals, training people with a clinical background, such as nurses is possible with the involvement of the Ministry of Health and Sri Lanka College of Psychiatrists. However, such programmes would need to be carefully supervised as the need for regular supervision has been highlighted in psychotherapies provided by nurses (Peters, Wearden, Morriss, Dowrick, Lovell, Brooks, Cahill, Chew-Graham, & FINE Trial Group 2011).

7.3.2 Research implications

Our study was a manual development, feasibility and pilot study. The findings concerning acceptability and efficacy are therefore provisional. It will be necessary to do larger scale studies, including RCTs, before confident conclusions can be drawn.

In Phase 1 of the study, we consulted key stakeholders in modifying the CBT manual. Hindu and Muslim religious healers were not included in the study. The findings of the study are applicable only to the Buddhist/Sinhalese communities. Our study needs to be extended to the other religious and cultural traditions which are important in a substantial minority of the Sri Lankan population. Similarly, our study population in Phase 2 also mostly consisted of Sinhalese people living in the suburban area. Subsequent studies could be expanded to include people from ethnic minorities and rural areas.

Subsequent studies should also include therapists of different professional backgrounds to examine the efficacy of psychotherapy using the manual when therapy is provided by other professionals. This study contributes to the growing evidence pointing to the need for adaptation of evidence based interventions and the efficacy and acceptability of culturally adapted CBT as a treatment option for depression. If successful completion of the RCT demonstrates an improvement in outcomes, it could change the landscape of mental health treatment in Sri Lanka.

Chapter 8

Establishing a dedicated psychotherapy clinic

Chapter 8

Establishing a dedicated psychotherapy clinic

8.1. Introduction - Bridging the gap between research and practice

We found with Phase 1 and 2 of the study that shorter and briefer psychotherapy is effective and feasible in the Sri Lankan context. The modified manual was based on input from all stakeholders including patients, carers, clinicians and traditional healers. Therapy based on the modified manual was found to be acceptable by the patients, feasible by the clinicians and appeared to be effective. Yet the question of how these findings can be applied to Sri Lankan clinical practice has not been addressed adequately. While these findings may inform Sri Lankan mental health clinicians to move away from using evidence not suitable in the Sri Lankan setting to inform clinical practice, it will not be integrated into the clinical practice unless firm steps are taken to that effect.

The gulf between research findings and clinical practice has always been an issue. The overarching goal of establishing a dedicated psychotherapy clinic was to build a bridge between research findings and clinical practice with an emphasis on how the modified CBT manual can be integrated into Sri Lankan clinical practice (Bero et al., 1998). Rarely researchers themselves can translate the research findings to clinical practice (Baker, McFall, & Shoham, 2008). This unique combination will serve a bidirectional process – how research informs clinical practice as well as how day-to-day clinical practice informs and modifies research.

Results of Phase 1 of the study revealed that the general public's perception of mental health treatment in Sri Lanka is changing and that the Sri Lankan public desires more than just medication. Improvement in Sri Lankan mental health, including the increase in the number of psychiatrists and the introduction of psychologists, allowed more professionals to focus more on psychotherapies. Furthermore, changing social attitudes and improvement of economic conditions in post war Sri Lanka, including a greater emphasis on the choice will increase the demand for psychotherapies. With the increase in the number of psychiatrists, the professional role of psychiatrists in Sri Lanka has changed from treating only severe mental illnesses such as schizophrenia, bipolar affective disorder and severe depression to treating other mental illnesses as well. However, this change is not reflected in the training of psychiatrists in Sri Lanka.

The development of a comprehensive bio-psycho-social treatment model that goes beyond the biomedical approach has been a long-felt need. Despite a widespread consensus that the introduction of psychotherapy will improve patient care, there has been a limited success so far in bringing about sustainable change in Sri Lanka. While internationally developed models are useful, the choice of any particular model should be driven by local need, local structure, and ability and availability of local healthcare providers (Minas, 2015). Any new model should have clear objectives and be properly evaluated.

The student researcher (AR) has established the first dedicated psychotherapy clinic in the state health sector in Sri Lanka and used these research findings in the practice in this clinic. Such practice will not only test the validity and applicability of these findings in the wider clinical practice but also increase the confidence in such psychotherapy among the practitioners. As the clinic serves as one of the main training centres of psychotherapy in Sri Lanka, future psychotherapists in Sri Lanka will have a better understanding and greater confidence in culturally modified psychotherapy.

8.2 Rationale for a dedicated psychotherapy clinic

As discussed earlier, we discovered in this study that very few Sri Lankan patients receive psychotherapy even though almost all the participating psychiatrists believed psychotherapy would be beneficial in the Sri Lankan context. In addition to insufficient time, lack of structure and inadequate training were identified as the possible reasons for the non-provision of psychotherapy in Sri Lanka. Another difficulty was that even when psychiatrists used psychotherapeutic principles they did not name them as psychotherapy and patients failed to recognise them as such. Studies suggest that when patients are unaware that they are being provided psychotherapy, it is less effective. In order to address at least some of these issues, we set forth with the task of establishing a clinic dedicated to psychotherapy. This is the first such clinic in the Sri Lankan state health sector. Although psychotherapy has been provided in the state sector, it is mostly proffered in an ad hoc manner without a clear structure (Hanwella, 2011). Without a clear structure, it can be difficult to establish treatment credibility which is closely linked with treatment outcome (Lambert, 2013). The structure may also improve attendance and compliance with homework, which has been recognised as one of the main treatment obstacles (Kazantzis et al., 2016). Having a dedicated psychotherapy clinic will certainly improve the training of psychotherapy in Sri Lanka.

Therefore, we established a dedicated psychotherapy clinic in Ragama, Sri Lanka with the aim of improving psychotherapy provision and changing the attitude towards psychotherapy among patients and clinicians.

8.3 The dedicated psychotherapy clinic in Ragama

We decided to locate the clinic away from the hospital, in a purpose-built building in the Faculty of Medicine, University of Kelaniya in Ragama to make it more acceptable for the patients and create a distinction between the hospital mental health clinic where patients receive pharmacological treatment. Locating the psychotherapy clinic away from the hospital had both advantages and drawbacks. It certainly increased the acceptability of treatment even among people who would generally show a negative attitude towards mental health. Yet not having support staff such as nurses and ancillary staff made administrative tasks including record keeping difficult.

The clinic is held once a week, on Friday mornings, serviced by a psychiatrist (student researcher AR), postgraduate trainees in psychiatry, both registrars (basic trainees) and senior registrars (advanced trainees), medical officers in mental health and clinical psychology trainees. Psychotherapies provided in the clinic are mostly individual therapy followed by couples' therapy and family therapy. The predominant theoretical underpinning of psychotherapies provided is CBT. Patients are mostly referred to this clinic by psychiatrists and less so by physicians, paediatricians, oncologists, teachers and civil society leaders such as religious leaders. The psychotherapy clinic was begun in January 2017 and has been in operation continuously since then except for public holidays.

8.4 Method

We conducted a survey or clinical audit to evaluate the functioning of the clinic. We perused the case records and patient enrolment registry at the clinic to extract the data on the number of patients who attended the clinic and their diagnoses. We also studied available outcome measure data - pre- and post-therapy Clinical Global Impression (CGI) scale scores of the patients who attended the clinic. The patients and therapists were also questioned about their satisfaction with the therapy at the clinic and training opportunities at the clinic, respectively. However, except for the patient registration information, other information was incomplete. Clinical governance implies a need to engage in a demonstrable form of clinical audit.

8.5 Outcome of the psychotherapy clinic

Treatment provision

From January 2017 to March 2018, for a period of 15 months, 307 patients have been treated at the clinic. Patients with varied diagnoses have attended the clinic and the primary diagnoses of these patients are shown in Table 10.

Table 10

Primary diagnoses of patients treated at the dedicated psychotherapy clinic in Ragama

Diagnosis	**Number (%)**
Depression	81 (26%)
Anxiety disorders including GAD, Social Phobia, Agoraphobia, Panic Disorder and Specific Phobia	86 (28%)
OCD	31 (10%)
Dysmorphophobia	7 (2%)
PTSD	7 (2%)
Eating disorders	3 (1%)
Sexual Disorders	11 (4%)
Personality disorders	14 (5%)
Schizophrenia	9 (3%)
Bipolar Affective Disorder	10 (3%)
Grief	12 (4%)
Relationship issues	12 (4%)
Stress	6 (2%)
Diagnoses not documented	18 (6%)

Most of the patients, (93%), have received individual therapy and the rest were treated with couples' therapy or family therapy. Data is only available for 97 patients regarding the number of sessions attended. On average, 4.7 sessions were attended by those patients. A minority of patients, 9 of the 97 (9.1%), attended only the first session and failed to return for subsequent sessions. Outcome data is available only for 29 patients. The Clinical Global Impression scale for these patients showed a clear improvement, from a pre-intervention value of 4.5 to a post-intervention value of 2.8.

The clinic as a training centre

This clinic has served as a training centre for trainees in psychiatry and clinical psychology to learn and further enhance psychotherapy skills. They have been able to learn various psychotherapy skills ranging from building therapeutic rapport with the patient, coming up with a psychotherapeutic formulation, jointly agreeing on goals and strategies (collaborative empiricism,), to specific psychotherapeutic skills of CBT, supportive psychotherapy, grief therapy and DBT. Trainees initially provide psychotherapy jointly with AR (student researcher), in which they learn processes and techniques through observations. At the end of the clinic, all the clinicians discuss presentations, formulations and specific psychotherapeutic processes utilised.

The feedback we have received from patients and trainees has been overwhelmingly good. Low attrition rates and high retention of patients show that this clinic has been acceptable to patients.

"This is really good, I feel empowered with therapy. This clinic is a refreshing experience."

"This is life changing. I consider myself to be fortunate for being able to attend therapy in this way."

"My child benefitted a lot from this clinic. I wish we had more of these."

Psychiatry trainee:

"This hands-on experience and ability to learn in a formal and structured way is an invaluable training opportunity."

Psychology trainee:

"Having a clinic like this allows us to have easy access to good, committed patients."

Research

Two research projects evaluating the efficacy of psychotherapy in the Sri Lankan context are being carried out in this clinic.

1. Experience and management of grief in Sri Lanka
2. Single session of CBT for somatoform disorder

8.6 Discussion

Our patient group presents with a wide range of diagnoses, from general stress to schizophrenia. This goes against the generally held view that psychotherapy is only for minor ailments. Some of these patients were referred for psychotherapy due to their resistance to pharmacological treatment options. We have mostly provided individual therapy and for a minority, couples therapy or family therapy. We have not provided group therapy except for a group for parents with children with conduct disorder. That group was not a success and was complicated with poor active participation and lack of attendance later on. We have not included data of this group in the analysis as it was abandoned after 3 sessions. People in this region are rather reluctant to discuss their problems in a group setting (Ng & James, 2013) and this may have contributed to the poor success of group therapy.

The outcome data of this clinic suggests that the objectives of the clinic have been achieved. Service utility has exceeded the expectation. Treatment retention has been satisfactory. The clinical outcomes of the patients who were treated at the clinic were remarkable. These findings suggest the psychotherapy provided is effective and acceptable to the patients. It is important to note that the average length of psychotherapy was only 4.7 sessions. Irrespective of the length of the therapy, the clinical improvements of the patients are significant. This may confirm that shorter psychotherapy is not only acceptable to Sri Lankan patients but also effective. However, we cannot draw firm conclusions from this due to the heterogeneity of the presentation and type of therapy used. High service utility and high rates of retention question the cynical view about Sri Lankan patients not wanting anything else other than medication; such views are ill founded. Therefore, our patients are not only open to new interventions but stick to them as well.

Concerns have been expressed regarding the “scientist-practitioner gap” in mental health and psychotherapy in particular (Drabick & Goldfried, 2000; Kazdin, 2008). The widely cited Boulder model proposes to better integrate research findings in clinician training and graduate programmes for clinical psychology in particular (Teachman et al., 2012). This dedicated psychotherapy clinic serves as one of the primary psychotherapy training centres for psychiatry trainees and clinical psychology trainees. Final year medical students of the University of Kelaniya, one of the seven medical schools in Sri Lanka, receive brief but meaningful exposure to this clinic. So, using the modified CBT manual or its principles in clinical practice, we translated our evidence from efficacy to effectiveness. Further, by using the modified CBT manual or its principles at the clinic, we also incorporate study findings in training. Thus, those findings will be inculcated into Sri Lankan mental health practice and will be used for a long time.

One of the main obstacles in psychotherapy training is a lack of clinical training opportunities for trainees. Having a psychotherapy clinic where patients come prepared for psychotherapy provides trainees a great opportunity to train. Except for their comments however, we have not been able to assess the effectiveness of training provided through this clinic.

This clinic has received a considerable number of referrals from psychiatrists as well as non-mental health clinicians such as physicians and paediatricians. The continued flow of referrals to the clinic may indicate that this clinic may have been able to create a positive attitude about psychotherapy and medical psychotherapy (psychotherapy provided by trained medical practitioners) in particular.

Altering therapeutic systems creates unforeseen dynamics and changes elsewhere. The introduction of the dedicated psychotherapy clinic led to the identification of an unmet need which did not usually present in mental health, such as for academic counselling. Societal and professional perceptions of accessibility and needs have also created an environment of increased expectations and new demand. Therefore, we believe replicating such clinics in the other major centres a worthy cause.

Finally, a very important lesson about the sustainability of service. This may depend on the financial viability of the service, continued professional input to the service, and service utilisation by the patients (Minas, 2015). In our dedicated psychotherapy clinic, the building was a university building and support staff were provided by the university without a cost. Professional staff including psychiatrists, psychiatry trainees and psychology trainees provided their services during their regular working hours without incurring additional cost to the service or patients. There has been a gradual increase in the number of patients attending the clinic suggesting continued service utilisation. This model can be replicated in some other centres in Sri Lanka in the same manner, without additional financial liability. However, the initiation or establishment and more importantly sustainability of service of this kind in Sri Lanka are mostly dependent on committed and able leadership, rather than finances. Therefore, it is very important to have a psychiatrist who is passionate and committed to the provision of psychotherapy. Clinical leadership of mental health treatment initiatives is typically vested in consultant psychiatrists, but psychologists take part in treatment. This team approach produced growing confidence among patients and other referring professionals who are used to clinical leadership being provided by medical specialists.

Further improvements

While we have effectively built a strong, three-way bridge between research, clinical practice and training, this bridge can be strengthened further. This clinic has been an overall success, but it can be further improved in a number of ways. For example, by having a clinic administrator such as a dedicated nurse or administrative assistant who could coordinate appointments, allocate patients to available clinicians, allocate clinic rooms for clinicians and maintain clinical records. At present, the clinical records of the patients are in the form of a clinic book which the patient carries. Therefore, we don't hold any records in the clinic, which fact could prove problematic. Outcome measures are not routinely used to measure the improvement of the patient or quality of training, which in turn could be used to further improve the quality. Regular group supervision at the end of the clinic will strengthen the training.

We have learnt that the service utility of the psychotherapy clinic by Sri Lankan patients is high. Therefore, cynical views such as Sri Lankan patients not wanting anything other than medication as treatment are ill founded. It should be noted that patient retention at the clinic has also been good. We felt that if patients believe they are being offered something worthwhile, they attend regularly. Therefore, Sri Lankan patients are not only open to new interventions but remain faithful to those interventions as well.

It was heartening to note that clinicians and the authorities were also open to innovations (and not only the patients) as the psychotherapy clinic received the fullest support from the Department of Psychiatry of the Faculty of Medicine, University of Kelaniya and University administration. The notion of support and recognition among colleagues was further demonstrated by the fact that the clinic receiving referrals from far and wide.

We believe this clinic was a success because its establishment was informed by research findings. The success of this clinic suggests that research recommendations are not only worthy of implementation but also feasible. The success of this dedicated clinic bestows a lot of confidence in those of us planning to begin new initiatives.

REFERENCES

References

Abeyasinghe, R., & Gunnell, D. (2008). Psychological autopsy study of suicide in three rural and semi-rural districts of Sri Lanka. *Soc Psychiatry Psychiatr Epidemiol, 43*(4), 280-285. doi:10.1007/s00127-008-0307-3

Abeyasinghe, R. R., Galappaththy, G. N., Smith Gueye, C., Kahn, J. G., & Feachem, R. G. (2012). Malaria control and elimination in Sri Lanka: documenting progress and success factors in a conflict setting. *PLoS One, 7*(8), e43162. doi:10.1371/journal.pone.0043162

Albert, P. R. (2015). Why is depression more prevalent in women?. *J Psychiatry Neurosci,* 40(4), 219-221. doi:10.1503/jpn.150205

Alvidrez, J., Azocar, F., & Miranda, J. (1996). Demystifying the concept of ethnicity for psychotherapy researchers. *J Consult Clin Psychol, 64*(5), 903-908. doi:10.1037//0022-006x.64.5.903

American Psychiatric Association. (2010). Practice Guideline for the treatment of patients with major depressive disorder (3rd ed.). In. Arlington: American Psychiatric Association.

American Psychiatric Association, A. (2013). *Diagnostic and statistical manual of mental disorders : DSM-5* (Fifth edition. ed.).

Anandakumar, D., Ratnatunga, S. S., Dayabandara, M., Hanwella, R., & de Silva, V. A. (2016). Depressive disorder in patients attending the outpatient department of a tertiary care hospital in Colombo. *Ceylon Med J, 61*(3), 118-122. doi:10.4038/cmj.v61i3.8347

Araya, R., Rojas, G., Fritsch, R., Gaete, J., Rojas, M., Simon, G., & Peters, T. J. (2003). Treating depression in primary care in low-income women in Santiago, Chile: a randomised controlled trial. *Lancet, 361*(9362), 995-1000. doi:10.1016/S0140-6736(03)12825-5

Ariyasinghe, D., Abeysinghe, R., Siriwardhana, P., & Dassanayake, T. (2015). Prevalence of major depressive disorder among spouses of men who use alcohol in a rural community in Central Sri Lanka. *Alcohol Alcohol, 50*(3), 328-332. doi:10.1093/alcalc/agu105

Arnberg, F. K., Alaie, I., Parling, T., & Jonsson, U. (2013). Recent randomized controlled trials of psychological interventions in healthcare: a review of their quantity, scope, and characteristics. *J Psychosom Res, 75*(5), 401-408. doi:10.1016/j.jpsychores.2013.08.019

Arora, N. K. (2003). Interacting with cancer patients: the significance of physicians' communication behavior. *Soc Sci Med, 57*(5), 791-806. doi:10.1016/s0277-9536(02)00449-5

Arseculeratne, S. N. (2002). Interactions between Traditional Medicine and 'Western' Medicine in Sri Lanka. Social Scientist, 30, 5, 4-17.

Attride-Stirling, J. (2001). Thematic networks: an analytic tool for qualitative research. *Qualitative Research, 1*(3), 385-405.

Baker, T. B., McFall, R. M., & Shoham, V. (2008). Current Status and Future Prospects of Clinical Psychology: Toward a Scientifically Principled Approach to Mental and Behavioral Health Care. *Psychol Sci Public Interest, 9*(2), 67-103. doi:10.1111/j.1539-6053.2009.01036.x

Ball, H. A., Siribaddana, S. H., Kovas, Y., Glozier, N., McGuffin, P., Sumathipala, A., & Hotopf, M. (2010). Epidemiology and symptomatology of depression in Sri Lanka: a cross-sectional population-based survey in Colombo District. *J Affect Disord, 123*(1-3), 188-196. doi:10.1016/j.jad.2009.08.014

Bass, J. K., Annan, J., McIvor Murray, S., Kaysen, D., Griffiths, S., Cetinoglu, T., . . . Bolton, P. A. (2013). Controlled trial of psychotherapy for Congolese survivors of sexual violence. *N Engl J Med, 368*(23), 2182-2191. doi:10.1056/NEJMoa1211853

Beck, A. T. (1980). *Cognitive therapy of depression*. Chichester: Wiley.

Beck, A. T., Steer, R. A., & Garbin, M. G. (1988). Psychometric properties of hte Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychology Review, 8*(1), 77-100.

Beck A. T. (2010). Buddhism and cognitive behavioural therapy. *Cognitive Therapy Today*, 10, 1.

Beck, J. S. (1995). *Cognitive therapy: Basics and beyond.* New York: Guildford Press.

Beidas, R. S., & Kendall, P. C. (2010). Training Therapists in Evidence-Based Practice: A Critical Review of Studies From a Systems-Contextual Perspective. *Clin Psychol (New York), 17*(1), 1-30. doi:10.1111/j.1468-2850.2009.01187.x

Bengtsson, M. (2016). How to plan and perform a qualitative study using content analysis. *NursingPlus Open, 2*, 8-14.

Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth: a direct-comparison meta-analysis. *J Couns Psychol, 58*(3), 279-289. doi:10.1037/a0023626

Benuto, L. T., & O'Donohue, W. (2015). Is culturally sensitive cognitive behavioural therapy an empirically supported treatment?: the case for Hispaniacs. *International Journal of Psychology and Psychological Therapy, 15*(3), 405-421.

Bernal, G., Bonilla, J., & Bellido, C. (1995). Ecological validity and cultural sensitivity for outcome research: issues for the cultural adaptation and development of psychosocial treatments with Hispanics. *J Abnorm Child Psychol, 23*(1), 67-82. doi:10.1007/bf01447045

Bernal, G., & Scharron-del-Rio, M. R. (2001). Are empirically supported treatments valid for ethnic minorities? Toward an alternative approach for treatment research. *Cultur Divers Ethnic Minor Psychol, 7*(4), 328-342. doi:10.1037/1099-9809.7.4.328

Bero, L. A., Grilli, R., Grimshaw, J. M., Harvey, E., Oxman, A. D., & Thomson, M. A. (1998). Closing the gap between research and practice: an overview of systematic reviews of interventions to promote the implementation of research findings. The Cochrane Effective Practice and Organization of Care Review Group. *BMJ, 317*(7156), 465-468. doi:10.1136/bmj.317.7156.465

Beyers, J. (2017). Religion and culture. *HTS Theological studies, 73*(1), 1-9.

Bhui, K., & Morgan, N. (2007). Effective psychotherapy in a racially and culturally diverse society. *Advances in Psychiatric Treatment, 13*, 187-193. doi:10.1192/apt.bp.106.002295

Biesheuvel-Leliefeld, K. E., Kok, G. D., Bockting, C. L., Cuijpers, P., Hollon, S. D., van Marwijk, H. W., & Smit, F. (2015). Effectiveness of psychological interventions in preventing recurrence of depressive disorder: meta-analysis and meta-regression. *J Affect Disord, 174*, 400-410. doi:10.1016/j.jad.2014.12.016

Billingham, S. A., Whitehead, A. L., & Julious, S. A. (2013). An audit of sample sizes for pilot and feasibility trials being undertaken in the United Kingdom registered in the United Kingdom Clinical Research Network database. *BMC Med Res Methodol, 13*, 104. doi:10.1186/1471-2288-13-104

Blier, P., Keller, M. B., Pollack, M. H., Thase, M. E., Zajecka, J. M., & Dunner, D. L. (2007). Preventing recurrent depression: long-term treatment for major depressive disorder. *J Clin Psychiatry, 68*(3), e06.

Bolton, P., Lee, C., Haroz, E. E., Murray, L., Dorsey, S., Robinson, C., . . . Bass, J. (2014). A transdiagnostic community-based mental health treatment for comorbid disorders: development and outcomes of a randomized controlled trial among Burmese refugees in Thailand. *PLoS Med, 11*(11), e1001757. doi:10.1371/journal.pmed.1001757

Borkovec, T. D., & Nau, S. T. (1972). Credibility of Analogue Therapy Rationales. *J Behav Ther Exp Psychiatry, 3*, 257-260.

Borrelli, B. (2011). The Assessment, Monitoring, and Enhancement of Treatment Fidelity In Public Health Clinical Trials. *J Public Health Dent, 71*(s1), S52-S63. doi:10.1111/j.1752-7325.2011.00233.x

Bowen, D. J., Kreuter, M., Spring, B., Cofta-Woerpel, L., Linnan, L., Weiner, D., . . . Fernandez, M. (2009). How we design feasibility studies. *Am J Prev Med, 36*(5), 452-457. doi:10.1016/j.amepre.2009.02.002

Bryant, C. (2010). Anxiety and depression in old age: challenges in recognition and diagnosis. *Int Psychogeriatr, 22*(4), 511-513. doi:10.1017/S1041610209991785

Burcusa, S. L., & Iacono, W. G. (2007). Risk for recurrence in depression. *Clin Psychol Rev, 27*(8), 959-985. doi:10.1016/j.cpr.2007.02.005

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: a review of meta-analyses. *Clin Psychol Rev, 26*(1), 17-31. doi:10.1016/j.cpr.2005.07.003

Casas, J. M. (1998). Cognitive behavioural approaches: A minority perspective. *The Counselling Psychologist, 16*, 106-110.

Chadda, R. K. (2014). Caring for the family caregivers of persons with mental illness. *Indian J Psychiatry, 56*(3), 221-227. doi:10.4103/0019-5545.140616

Chen, C. & Shan, W. (2019). Pharmacological and non-pharmacological treatments for major depressive disorder in adults: A systematic review and network meta-analysis. *Psychiatry Res,* 281, 112595. doi:10.1016/j.psychres.2019.112595

Chen, J. G., Zou, B., & Shuster, J. (2017). Relationship Between Patient Satisfaction And Physician Characteristics. *J Patient Exp, 4*(4), 177-184. doi:10.1177/2374373517714453

Chen, S. W. H., & Davenport, D. S. (2005). Cognitive behavioural therapy with ChInese American vlients: Cautions and modifications. *Psychotherapy: Theory, research, practice, training, 42*(1), 101-110.

Chentsova-Dutton, Y. E., Tsai, J. L., & Gotlib, I. H. (2010). Further evidence for the cultural norm hypothesis: positive emotion in depressed and control European American and Asian American women. *Cultur Divers Ethnic Minor Psychol, 16*(2), 284-295. doi:10.1037/a0017562

Chibanda, D., Weiss, H. A., Verhey, R., Simms, V., Munjoma, R., Rusakaniko, S., . . . Araya, R. (2016). Effect of a Primary Care-Based Psychological Intervention on Symptoms of Common Mental Disorders in Zimbabwe: A Randomized Clinical Trial. *JAMA, 316*(24), 2618-2626. doi:10.1001/jama.2016.19102

Choudhry, F. R., Mani, V., Ming, L. C., & Khan, T. M. (2016). Beliefs and perception about mental health issues: a meta-synthesis. *Neuropsychiatr Dis Treat, 12*, 2807-2818. doi:10.2147/NDT.S111543

Chowdhary, N., Anand, A., Dimidjian, S., Shinde, S., Weobong, B., Balaji, M., . . . Patel, V. (2016). The Healthy Activity Program lay counsellor delivered treatment for severe depression in India: systematic development and randomised evaluation. *Br J Psychiatry, 208*(4), 381-388. doi:10.1192/bjp.bp.114.161075

Chowdhary, N., Jotheeswaran, A. T., Nadkarni, A., Hollon, S. D., King, M., Jordans, M. J., . . . Patel, V. (2014). The methods and outcomes of cultural adaptations of psychological treatments for depressive disorders: a systematic review. *Psychol Med, 44*(6), 1131-1146. doi:10.1017/S0033291713001785

Cipriani, A., Furukawa, T. A., Salanti, G., et al. (2018). Comparative efficacy and acceptability of 21 antidepressant drugs for the acute treatment of adults with major depressive disorder: a systematic review and network meta-analysis. *Lancet*, 391(10128), 1357-1366.

Comas-Diaz, L. (2006). Latino healing: The integration of ethnic psychology into psychotherapy. *Psychotherapy (Chic), 43*(4), 436-453. doi:10.1037/0033-3204.43.4.436

Constantine, M. G., Miville, M. L., & Kindaichi, M. M. (2008). Multicultural competence in counselling psychology: Practice and training. In S. T. Brown & R. W. Lent (Eds.), *Handbook of Counselling Psychology* (pp. 141-158). New York: Willy.

Cooper, L. A., Gonzales, J. J., Gallo, J. J., Rost, K. M., Meredith, L. S., Rubenstein, L. V., . . . Ford, D. E. (2003). The acceptability of treatment for depression among African-American, Hispanic, and white primary care patients. *Med Care, 41*(4), 479-489. doi:10.1097/01.MLR.0000053228.58042.E4

Crespo, M. M. (2006). *Effects of culturally specific dynamically oriented group art therapy with immigrant Latinas.* (PhD), California Institute of Integral Studies, San Francisco, CA.

Cuijpers, P., Berking, M., Andersson, G., Quigley, L., Kleiboer, A., & Dobson, K. S. (2013). A meta-analysis of cognitive-behavioural therapy for adult depression, alone and in comparison with other treatments. *Can J Psychiatry, 58*(7), 376-385. doi:10.1177/070674371305800702

Cuijpers, P., Cristea, I.A., Karyotaki, E., Reijnders, M. & Huibers, M. J. (2016). How effective are cognitive behavior therapies for major depression and anxiety disorders? A meta-analytic update of the evidence. *World Psychiatry*, 15(3), 245-258. doi:10.1002/wps.20346

Cuijpers, P., Karyotaki, E., Reijnders, M., Purgato, M., & Barbui, C. (2018). Psychotherapies for depression in low- and middle-income countries: a meta-analysis. *World Psychiatry, 17*(1), 90-101. doi:10.1002/wps.20493

Cushway, D., & Tyler, P. A. (1994). Stress and coping in clinical psychologists. *Health and Science, 10*(1), 35-42.

David, D., Cristea, I., Hofmann, S. G. (2018). Why cognitive behavioral therapy is the current gold standard of psychotherapy. *Front Psychiatry,* 9:4. doi:10.3389/fpsyt.2018.00004

De Silva, M. J., Cooper, S., Li, H. L., Lund, C. & Patel, V. (2013). Effect of psychosocial interventions on social functioning in depression and schizophrenia: meta-analysis. *Br J Psychiatry*, 202 (4), 253-260.

de Silva, P., & Samarasinghe, D. (1985). Behavior therapy in Sri Lanka. *J Behav Ther Exp Psychiatry, 16*(2), 95-100. doi:10.1016/0005-7916(85)90043-6

De Vaus, J., Hornsey, M. J., Kuppens, P., & Bastian, B. (2018). Exploring the East-West Divide in Prevalence of Affective Disorder: A Case for Cultural Differences in Coping With Negative Emotion. *Pers Soc Psychol Rev, 22*(3), 285-304. doi:10.1177/1088868317736222

de Zoysa, P. (2010). The practice of mindfulness based benaviour therapy in Sri Lanka. *Sri Lanka Journal of Psychiatry, 1*(2), 67-69.

de Zoysa, P. (2011). The use of Buddhist mindfulness meditation in psychotherapy: a case report from Sri Lanka. *Transcult Psychiatry, 48*(5), 675-683. doi:10.1177/1363461511418394

de Zoysa, P. (2013). The use of mindfulness practice in the treatment of a case of obsessive compulsive disorder in Sri Lanka. *J Relig Health, 52*(1), 299-306. doi:10.1007/s10943-011-9461-0

Deegalla, M. (2006). *Buddhism, Conflict and Violence in Modern Sri Lanka*. Oxford: Routledge.

Degnan, A., Baker, S., Edge, D., Nottidge, W., Noke, M., Press, C. J., . . . Drake, R. J. (2018). The nature and efficacy of culturally-adapted psychosocial interventions for schizophrenia: a systematic review and meta-analysis. *Psychol Med, 48*(5), 714-727. doi:10.1017/S0033291717002264

Department of Census and Statistics, S. L. (2015). *Census of population and housing 2012*. Colombo: Department of Census nad Statistics.

DeRubeis, R. J., Siegle, G. J., & Hollon, S. D. (2008). Cognitive therapy versus medication for depression: treatment outcomes and neural mechanisms. *Nat Rev Neurosci, 9*(10), 788-796. doi:10.1038/nrn2345

Doherty, M., Buchy, P., Standaert, B., Giaquinto, C., & Prado-Cohrs, D. (2016). Vaccine impact: Benefits for human health. *Vaccine, 34*(52), 6707-6714. doi:10.1016/j.vaccine.2016.10.025

Drabick, D. A. G., & Goldfried, M. R. (2000). Training the scientist–practitioner for the 21st century: Putting the bloom back on the rose. *Journal of Clinical Psychology, 56*(3), 327-340. doi:10.1002/(SICI)1097-4679(200003)56:3<327::AID-JCLP9>3.0.CO;2-Y

Dugdale, D. C., Epstein, R., & Pantilat, S. Z. (1999). Time and the patient-physician relationship. *J Gen Intern Med, 14 Suppl 1*, S34-40. doi:10.1046/j.1525-1497.1999.00263.x

Ediriweera H. W., Fernando S. M. & Pai N. B. (2012). Mental health literacy survey among Sri Lankan carers of patients with schizophrenia and depression. *Asian J Psychiatr,* 5(3), 246-250. doi:10.1016/j.ajp.2012.02.016

Egede, L. E., & Ellis, C. (2010). Diabetes and depression: global perspectives. *Diabetes Res Clin Pract, 87*(3), 302-312. doi:10.1016/j.diabres.2010.01.024

Ekers, D., Richards, D., McMillan, D., Bland, J. M., & Gilbody, S. (2011). Behavioural activation delivered by the non-specialist: phase II randomised controlled trial. *Br J Psychiatry, 198*(1), 66-72. doi:10.1192/bjp.bp.110.079111

Engelgau, M., Okamato, M., Navaratne, K. M., & Gopalan, S. (2009). *Prevention and Control of Selected chronic NCDs in Sri Lanka: Policy Options and Action*. Washington DC: The World Bank.

Fairburn, C. G., & Cooper, Z. (2011). Therapist competence, therapy quality, and therapist training. *Behav Res Ther, 49*(6-7), 373-378. doi:10.1016/j.brat.2011.03.005

Fenn, K., & Byrne, M. (2013). The key principles of cognitive behavioural therapy. *InnovAiT: Education and inspiration for general practice, 6*(9), 579-585.

Fernando, D. (2000). Health care systems in transition III. Sri Lanka, Part I. An overview of Sri Lanka's health care system. *J Public Health Med, 22*(1), 14-20. doi:10.1093/pubmed/22.1.14

Fernando, S. (2010). *Mental Health, Race and Culture* (3rd ed.). London: Palgrave Macmillan.

Fernando, S., & Weerakody, C. (2009). Challenges in developing community mental health services in Sri Lanka. *Journal of Health Management, 11*(1), 195-208.

Fernando, S. M., Deane, F. P., & McLeod, H. J. (2010). Sri Lankan doctors' and medical undergraduates' attitudes towards mental illness. *Soc Psychiatry Psychiatr Epidemiol, 45*(7), 733-739. doi:10.1007/s00127-009-0113-6

Fernando, S. M., Deane, F. P., McLeod, H. J., & Davis, E. L. (2017). A carer burden and stigma in schizophrenia and affective disorders: Experiences from Sri Lanka. *Asian J Psychiatr, 26*, 77-81. doi:10.1016/j.ajp.2017.01.023

Flaskerud, J. H., & Liu, P. Y. (1991). Effects of an Asian client-therapist language, ethnicity and gender match on utilization and outcome of therapy. *Community Ment Health J, 27*(1), 31-42. doi:10.1007/bf00752713

Flitcroft, A., James, A. I., Freeston, M., & Wood-Mitchell, A. (2007). Determining what is important in a good formulation. *Behavioural and Cognitive Psychotherapy, 35*(3), 325-333.

Freeman, A. (1992). Developing treatment conceptualizations in cognitive therapy. In A. Freeman & F. Dattilio (Eds.), *Casebook of cognitive-behavior therapy*. New York: Plenum Press.

Gadit, A., & Khalid, N. (2002). *State of Mental Health in Pakistan: Service, Education and Research*. Karachchi: Hamdard Foundation.

Gater, R., de Almeida e Sousa, B., Barrientos, G., Caraveo, J., Chandrashekar, C. R., Dhadphale, M., . . . et al. (1991). The pathways to psychiatric care: a cross-cultural study. *Psychol Med, 21*(3), 761-774. doi:10.1017/s003329170002239x

Gelso, C. J., Williams, E. N., & Fretz, B. R. (2014). *Counselling psychology*. California: Wadsworth / Thomson Learning.

Goldberg, D., & Huxley, P. (1980). *Mental illness in the community: the pathways to psychiatric care*. London: Tavistock Publications.

Goldberg, S. B., Rousmaniere, T., Miller, S. D., Whipple, J., Nielsen, S. L., Hoyt, W. T., & Wampold, B. E. (2016). Do psychotherapists improve with time and experience? A longitudinal analysis of outcomes in a clinical setting. *J Couns Psychol, 63*(1), 1-11. doi:10.1037/cou0000131

Gomez, D. M., Gunarathna, C., Gunarathna, S., Gnanapragasam, K., & Hanwella, R. (2017). Help-seeking behaviour and its impact on patients attending a psychiatry clinic at National Hospital of Sri Lanka. *Ceylon Med J, 62*(4), 222-227. doi:10.4038/cmj.v62i4.8571

Greenberg, R. P., Constantino, M. J., & Bruce, N. (2006). Are patient expectations still relevant for psychotherapy process and outcome? *Clin Psychol Rev, 26*(6), 657-678. doi:10.1016/j.cpr.2005.03.002

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy (Chic), 43*(4), 531-548. doi:10.1037/0033-3204.43.4.531

Grootenboer, E. M., Giltay, E. J., van der Lem, R., van Veen, T., van der Wee, N. J., & Zitman, F. G. (2012). Reliability and validity of the Global Assessment of Functioning Scale in clinical outpatients with depressive disorders. *J Eval Clin Pract, 18*(2), 502-507. doi:10.1111/j.1365-2753.2010.01614.x

Gunawardena, C. A. (2005). *Encyclopedia of Sri Lanka* (2nd ed.). Slough: New Dawn Press, Inc.

Guo, F., & Hanley, T. (2015). Adapting cognitive behavioral therapy to meet the needs of Chinese clients: Opportunities and challenges. *Psych J, 4*(2), 55-65. doi:10.1002/pchj.75
Guven, E., & Gokce, G. (2018). How Effective are Efficiency Studies?: An Evaluation in the Context of Cognitive Behavioral Therapies. *Turk Psikiyatri Derg, 29*(1), 54-66.
Haine-Schlagel, R., Brookman-Frazee, L., Fettes, D. L., Baker-Ericzen, M., & Garland, A. F. (2012). Therapist Focus on Parent Involvement in Community-Based Youth Psychotherapy. *J Child Fam Stud, 21*(4), 646-656. doi:10.1007/s10826-011-9517-5
Hall, G. C. (2001). Psychotherapy research with ethnic minorities: empirical, ethical, and conceptual issues. *J Consult Clin Psychol, 69*(3), 502-510. doi:10.1037//0022-006x.69.3.502
Hall, G. C., Ibaraki, A. Y., Huang, E. R., Marti, C. N., & Stice, E. (2016). A Meta-Analysis of Cultural Adaptations of Psychological Interventions. *Behav Ther, 47*(6), 993-1014. doi:10.1016/j.beth.2016.09.005
Hammer-Helmich, L., Haro, J. M., Jonsson, B., Tanguy Melac, A., Di Nicola, S., Chollet, J., . . . Saragoussi, D. (2018). Functional impairment in patients with major depressive disorder: the 2-year PERFORM study. *Neuropsychiatr Dis Treat, 14*, 239-249. doi:10.2147/NDT.S146098
Hansen, R., Gaynes, B., Thieda, P., Gartlehner, G., Deveaugh-Geiss, A., Krebs, E., & Lohr, K. (2008). Meta-analysis of major depressive disorder relapse and recurrence with second-generation antidepressants. *Psychiatr Serv, 59*(10), 1121-1130. doi:10.1176/appi.ps.59.10.1121
Hanwella, R. (2011). Postgraduate training in psychotherapy in Sri Lanka: the need for a systematic approach. *Sri Lanka Journal of Psychiatry, 2*(2), 49-50.
Hardeveld, F., Spijker, J., De Graaf, R., Nolen, W. A., & Beekman, A. T. (2010). Prevalence and predictors of recurrence of major depressive disorder in the adult population. *Acta Psychiatr Scand, 122*(3), 184-191. doi:10.1111/j.1600-0447.2009.01519.x
Hardy, G. E., Barkham, M., Shapiro, D. A., Reynolds, S., & Rees, A. (1995). Credibility and outcome of cognitive behavioural and psychodynamic - interpersonal psychotherapy. *British Journal of Clinical Psychology, 34*, 555-569.
Health Economics Cell, Ministry of Health, Nutrition & Indigenous Medicine. (2016). *Sri Lanka National Health Accounts 2013*. Colombo: The Ministry of Health, Sri Lanka Retrieved from http://www.health.gov.lk/enWeb/publication/NHA/Sri%20Lanka%20National%20Health%20Accounts%202013.pdf.
Helbig-Lang, S., & Fehm, L. (2004). Problems with homework in CBT: Rare exception or rather frequent? *Behavioural and Cognitive Psychotherapy, 32*, 291-301. doi:10.1017/S1352465804001365
Hildebrand, M. W., Host, H. H., Binder, E. F., Carpenter, B., Freedland, K. E., Morrow-Howell, N., . . . Lenze, E. J. (2012). Measuring treatment fidelity in a rehabilitation intervention study. *Am J Phys Med Rehabil, 91*(8), 715-724. doi:10.1097/PHM.0b013e31824ad462
Hirayama, T., Ogawa, Y., Yanai, Y., Suzuki, S. I., & Shimizu, K. (2019). Behavioral activation therapy for depression and anxiety in cancer patients: a case series study. *Biopsychosoc Med, 13*, 9. doi:10.1186/s13030-019-0151-6
Hodge, D. R., Jackson, K. F., & Vaughn, M. G. (2010). Culturally sensitive interventions and health and behavioral health youth outcomes: a meta-analytic review. *Soc Work Health Care, 49*(5), 401-423. doi:10.1080/00981381003648398
Hofmann, S. G., Asnaani, A., Vonk, I. J., Sawyer, A. T., & Fang, A. (2012). The Efficacy of Cognitive Behavioral Therapy: A Review of Meta-analyses. *Cognit Ther Res, 36*(5), 427-440. doi:10.1007/s10608-012-9476-1
Holikatti, P. C., Kar, N., Mishra, A., Shukla, R., Swain, S. P., & Kar, S. (2012). A study on patient satisfaction with psychiatric services. *Indian J Psychiatry, 54*(4), 327-332. doi:10.4103/0019-5545.104817
Hollon, S. D., DeRubeis, R. J., Shelton, R. C., Amsterdam, J. D., Salomon, R. M., O'Reardon, J. P., . . . Gallop, R. (2005). Prevention of relapse following cognitive therapy vs medications in

moderate to severe depression. *Arch Gen Psychiatry, 62*(4), 417-422. doi:10.1001/archpsyc.62.4.417
Holmes, K. K. e., Bertozzi, S. e., Bloom, B. R. e., & Jha, P. e. (2017). *Major infectious diseases* (3rd ed.).
Huey, S. J., Jr., & Polo, A. J. (2008). Evidence-based psychosocial treatments for ethnic minority youth. *J Clin Child Adolesc Psychol, 37*(1), 262-301. doi:10.1080/15374410701820174
Husain, F., Anderson, M., Lopes Cardozo, B., Becknell, K., Blanton, C., Araki, D., & Vithana, E. K. (2011). Prevalence of war-related mental health conditions and association with displacement status in postwar Jaffna District, Sri Lanka. *JAMA, 306*(5), 522-531. doi:10.1001/jama.2011.1052
Hwang, W. C. (2009). The Formative Method for Adapting Psychotherapy (FMAP): A community-based developmental approach to culturally adapting therapy. *Prof Psychol Res Pr, 40*(4), 369-377. doi:10.1037/a0016240
Ijaz, S., Davies, P., Williams, C. J., Kessler, D., Lewis, G., & Wiles, N. (2018). Psychological therapies for treatment-resistant depression in adults. *Cochrane Database Syst Rev, 5*, CD010558. doi:10.1002/14651858.CD010558.pub2
Index Mundi. (2016). Current Health Expenditure. Retrieved from https://www.indexmundi.com/facts/sri-lanka/current-health-expenditure#SH.XPD.CHEX.GD.ZS
Institute of Research and Development (IRD). National survey on metal health in Sri Lanka 2007. Colombo: IRD; 2008.
Interian, A., & Diaz-Martinez, A. M. (2007). Considerations for culturally competent cognitive behavioral therapy for depression with Hispanic patients. *Cognitive and Behavioral Practice, 14*(1), 84-97.
Iwata, N., & Buka, S. (2002). Race/ethnicity and depressive symptoms: a cross-cultural/ethnic comparison among university students in East Asia, North and South America. *Soc Sci Med, 55*(12), 2243-2252. doi:10.1016/s0277-9536(02)00003-5
Iwata, N., & Higuchi, H. R. (2000). Responses of Japanese and American university students to the STAI items that assess the presence or absence of anxiety. *J Pers Assess, 74*(1), 48-62. doi:10.1207/S15327752JPA740104
Jacobson, N. S., Schmaling, K. B., Holtzworth-Munroe, A., Katt, J. L., Wood, L. F., & Follette, V. M. (1989). Research-structured vs clinically flexible versions of social learning-based marital therapy. *Behaviour Research and Therapy, 27*(2), 173-180. doi:https://doi.org/10.1016/0005-7967(89)90076-4
Jarrett, R. B., Minhajuddin, A., Gershenfeld, H., Friedman, E. S., & Thase, M. E. (2013). Preventing depressive relapse and recurrence in higher-risk cognitive therapy responders: a randomized trial of continuation phase cognitive therapy, fluoxetine, or matched pill placebo. *JAMA Psychiatry, 70*(11), 1152-1160. doi:10.1001/jamapsychiatry.2013.1969
Jenkins, R., Mendis, J., Cooray, S., & Cooray, M. (2012). Integration of mental health into primary care in Sri Lanka. *Ment Health Fam Med, 9*(1), 15-24.
Jimenez, D. E., Bartels, S. J., Cardenas, V., Dhaliwal, S. S., & Alegria, M. (2012). Cultural beliefs and mental health treatment preferences of ethnically diverse older adult consumers in primary care. *Am J Geriatr Psychiatry, 20*(6), 533-542. doi:10.1097/JGP.0b013e318227f876
Jones, M. (2015). The Sri Lankan path to health for all from the colonial period to Alma-Ata. In A. Medcalf, S. Bhattacharya, H. Momen, M. Saavedra, & M. Jones (Eds.), *Health for all: The Journey of Universal Health Coverage*. Hyderabad (IN): Orient Blackswan.
Jones, M., & Liyanage, C. (2018). Traditional medicine and primary health care in Sri Lanka: Policy, perceptions, and practice. *6*(1), 157. doi:https://doi.org/10.1163/22879811-12340029
Jorm, A. F., Morgan, A. J., & Hetrick, S. E. (2008). Relaxation for depression. *Cochrane Database Syst Rev*(4), CD007142. doi:10.1002/14651858.CD007142.pub2

Judd, L. L., Akiskal, H. S., Zeller, P. J., Paulus, M., Leon, A. C., Maser, J. D., . . . Keller, M. B. (2000). Psychosocial disability during the long-term course of unipolar major depressive disorder. *Arch Gen Psychiatry, 57*(4), 375-380. doi:10.1001/archpsyc.57.4.375

Julious, S. A. (2005). Sample size of 12 per group rule of thumb for a pilot study. *Pharmaceutical Statistics, 4*, 287-291.

Jung, W. Y., Jang, S. H., Kim, S. G., Jae, Y. M., Kong, B. G., Kim, H. C., . . . Kim, C. R. (2016). Times to Discontinue Antidepressants Over 6 Months in Patients with Major Depressive Disorder. *Psychiatry Investig, 13*(4), 440-446. doi:10.4306/pi.2016.13.4.440

Kakuma, R., Minas, H., van Ginneken, N., Dal Poz, M. R., Desiraju, K., Morris, J. E., . . . Scheffler, R. M. (2011). Human resources for mental health care: current situation and strategies for action. *Lancet, 378*(9803), 1654-1663. doi:10.1016/S0140-6736(11)61093-3

Kalibatseva, Z., & Leong, F. T. (2014). A critical review of culturally sensitive treatments for depression: recommendations for intervention and research. *Psychol Serv, 11*(4), 433-450. doi:10.1037/a0036047

Kaluthanthri, K. D. M. S. (2014). *Ageing and the changing role of family in Sri Lanka.* University of Adelaide,

Karandawala, I. (2004). *Traditional treatment methods used by the psychiatric patients seeking treatment from the Univeresity Psychaitric Unit, National Hospital of Sri Lanka.* University of Colombo,

Karunathilake, I. M. (2012). Health changes in Sri Lanka: benefits of primary health care public health. *Asia Pacific Journal of Public Health, 24*(4), 663-671.

Kathriarachchi, S. T., Seneviratne, V. L. & Amarakoon, L. (2019). Development of mental health care in Sri Lanka: Lessons learned. *Taiwan J Psychiatry*,33, 55-65

Kazantzis, N., Lampropoulos, G. K., & Deane, F. P. (2005). A national survey of practicing psychologists' use and attitudes toward homework in psychotherapy. *J Consult Clin Psychol, 73*(4), 742-748. doi:10.1037/0022-006X.73.4.742

Kazantzis, N., Whittington, C., Zelencich, L., Kyrios, M., Norton, P. J., & Hofmann, S. G. (2016). Quantity and Quality of Homework Compliance: A Meta-Analysis of Relations With Outcome in Cognitive Behavior Therapy. *Behav Ther, 47*(5), 755-772. doi:10.1016/j.beth.2016.05.002

Kazdin, A. E. (2008). Evidence-based treatment and practice: New opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. *American Psychologist, 63*(3), 146-159. doi:10.1037/0003-066X.63.3.146

Keller, M. B., McCullough, J. P., Klein, D. N., Arnow, B., Dunner, D. L., Gelenberg, A. J., . . . Zajecka, J. (2000). A comparison of nefazodone, the cognitive behavioral-analysis system of psychotherapy, and their combination for the treatment of chronic depression. *N Engl J Med, 342*(20), 1462-1470. doi:10.1056/NEJM200005183422001

Kennard, B. D., Clarke, G. N., Weersing, V. R., Asarnow, J. R., Shamseddeen, W., Porta, G., . . . Brent, D. A. (2009). Effective components of TORDIA cognitive-behavioral therapy for adolescent depression: preliminary findings. *J Consult Clin Psychol, 77*(6), 1033-1041. doi:10.1037/a0017411

Kessler, R. C., Akiskal, H. S., Ames, M., Birnbaum, H., Greenberg, P., Hirschfeld, R. M., . . . Wang, P. S. (2006). Prevalence and effects of mood disorders on work performance in a nationally representative sample of U.S. workers. *Am J Psychiatry, 163*(9), 1561-1568. doi:10.1176/ajp.2006.163.9.1561

Kessler, R. C., & Bromet, E. J. (2013). The epidemiology of depression across cultures. *Annu Rev Public Health, 34*, 119-138. doi:10.1146/annurev-publhealth-031912-114409

Kessler, R. C., & Price, R. H. (1993). Primary prevention of secondary disorders: a proposal and agenda. *Am J Community Psychol, 21*(5), 607-633. doi:10.1007/bf00942174

Kessler, R. C., & Ustun, T. B. (2004). The World Mental Health (WMH) Survey Initiative Version of the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI). *Int J Methods Psychiatr Res, 13*(2), 93-121. doi:10.1002/mpr.168

Kessler, R. C., & Ustun, T. B. (2008). *The WHO World Mental Health Surveys: Global Perspectives on the Epidemiology of Mental Disorders*. New York: Cambridge University Press.
Kessler, R. C., Walters, E. E., & Forthofer, M. S. (1998). The social consequences of psychiatric disorders, III: probability of marital stability. *Am J Psychiatry, 155*(8), 1092-1096. doi:10.1176/ajp.155.8.1092
Khaltar, A., Priyadarshani, N. G., Delpitiya, N. Y., Jayasinghe, C., Jayasinghe, A., Arai, A., & Tamashiro, H. (2017). Depression among older people in Sri Lanka: With special reference to ethnicity. *Geriatr Gerontol Int, 17*(12), 2414-2420. doi:10.1111/ggi.13090
Khan, A., Faucett, J., Lichtenberg, P., Kirsch, I. & Brown W. A. (2010). A systematic review of comparative efficacy of treatments and controls for depression. *PLoS One*, 7(7), e41778. doi:10.1371/journal.pone.0041778
Kirmayer, L. J. (2015). Mindfulness in cultural context. *Transcult Psychiatry, 52*(4), 447-469. doi:10.1177/1363461515598949
Kisa, R., Baingana, F., Kajungu, R., Mangen, P. O., Angdembe, M., Gwaikolo, W., & Cooper, J. (2016). Pathways and access to mental health care services by persons living with severe mental disorders and epilepsy in Uganda, Liberia and Nepal: a qualitative study. *BMC Psychiatry, 16*, 305. doi:10.1186/s12888-016-1008-1
Kleinman, A. M. (1977). Depression, somatization and the "new cross-cultural psychiatry". *Soc Sci Med, 11*(1), 3-10. doi:10.1016/0037-7856(77)90138-x
Klitzman, R. (2007). "Patient-time", "doctor-time", and "institution-time": perceptions and definitions of time among doctors who become patients. *Patient Educ Couns, 66*(2), 147-155. doi:10.1016/j.pec.2006.10.005
Kohn, L. P., Oden, T., Munoz, R. F., Robinson, A., & Leavitt, D. (2002). Adapted cognitive behavioral group therapy for depressed low-income African American women. *Community Ment Health J, 38*(6), 497-504. doi:10.1023/a:1020884202677
Kohn, R., Saxena, S., Levav, I., & Saraceno, B. (2004). The treatment gap in mental health care. *Bull World Health Organ, 82*(11), 858-866. doi:/S0042-96862004001100011
Koschorke, M., Ramachandran, P., Kumar, S., Cohen, A., Weiss, H. A., Chatterjee, S., . . . Patel, V. (2014). Experiences of stigma and discrimination of people with schizophrenia in India. *Social Science & Medicine, 123*. doi:10.1016/j.socscimed.2014.10.035
Krah, E., de Kruijf, J., & Ragno, L. (2018). Integrating Traditional Healers into the Health Care System: Challenges and Opportunities in Rural Northern Ghana. *J Community Health, 43*(1), 157-163. doi:10.1007/s10900-017-0398-4
Kroeber, A. L., & Kluckhohn, C. (1952). *Culture: A critical review of concepts and definitions*. Cambridge, MA: Peabody Museum.
Krueger, R. A., & Casey, M. A. (2014). *Focus Groups; a practical guide for applied research* (5th ed.). California: Sage Publications.
Lambert, M. J. (2013). Outcome in psychotherapy: the past and important advances. *Psychotherapy (Chic), 50*(1), 42-51. doi:10.1037/a0030682
Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, research, practice, training, 38*(4), 357-361. doi:10.1037/0033-3204.38.4.357
Lasalvia, A., Zoppei, S., Van Bortel, T., Bonetto, C., Cristofalo, D., Wahlbeck, K., Bacle, S. V., Van Audenhove, C., van Weeghel, J., Reneses, B., Germanavicius, A., Economou, M., Lanfredi, M., Ando, S., Sartorius, N., Lopez-Ibor, J. J., Thornicroft, G., & ASPEN/INDIGO Study Group (2013). Global pattern of experienced and anticipated discrimination reported by people with major depressive disorder: a cross-sectional survey. *Lancet,* 381(9860), 55–62.
Eldridge, S. M., Lancaster, G. A., Campbell, M. J., Thabane, L., Hopewell, S., Coleman, C. L., & Bond, C. M. (2016). Defining Feasibility and Pilot Studies in Preparation for Randomised Controlled Trials: Development of a Conceptual Framework. PloS one, 11(3), e0150205.
Laungani, P. (2004). *Asian perspectives in counselling and psychotherapy*. New York: Brunner-Routledge.

LeBon, T. (2013). How to engage and socialise clients into CBT more quickly. Retrieved from http://cbtfortherapists.blogspot.com/2013/06/how-to-engage-and-socialise-clients.html
Lee, E. E., & Farran, C. J. (2004). Depression among Korean, Korean American, and Caucasian American family caregivers. *J Transcult Nurs, 15*(1), 18-25. doi:10.1177/1043659603260010
Leon, A. C., Davis, L. L., & Kraemer, H. C. (2011). The role and interpretation of pilot studies in clinical research. *J Psychiatr Res, 45*(5), 626-629. doi:10.1016/j.jpsychires.2010.10.008
Leong, F. T., & Lee, S. H. (2006). A cultural accommodation model for cross-cultural psychotherapy: Illustrated with the case of Asian Americans. *Psychotherapy (Chic), 43*(4), 410-423. doi:10.1037/0033-3204.43.4.410
Leong, F. T. L., & Kalibatseva, Z. (2011). Cross-Cultural Barriers to Mental Health Services in the United States. *Cerebrum : the Dana forum on brain science, 2011*, 5.
Leong, F. T. L., & Serafica, F. C. (2001). Cross-cultural perspective on Super's career development theory: Career maturity and cultural accommodation. In *Contemporary models in vocational psychology: A volume in honor of Samuel H. Osipow.* (pp. 167-205). Mahwah, NJ, US: Lawrence Erlbaum Associates Publishers.
Lepine, J. P., & Briley, M. (2011). The increasing burden of depression. *Neuropsychiatr Dis Treat, 7*(Suppl 1), 3-7. doi:10.2147/NDT.S19617
Lewis-Fernández, R., & Kleinman, A. (1994). Culture, personality, and psychopathology. *Journal of Abnormal Psychology, 103*(1), 67-71. doi:10.1037/0021-843X.103.1.67
Li, L. C., & Kim, B. S. K. (2004). Effects of Counseling Style and Client Adherence to Asian Cultural Values on Counseling Process With Asian American College Students. *Journal of Counseling Psychology, 51*(2), 158-167. doi:10.1037/0022-0167.51.2.158
Lin, C. T., Albertson, G. A., Schilling, L. M., Cyran, E. M., Anderson, S. N., Ware, L., & Anderson, R. J. (2001). Is patients' perception of time spent with the physician a determinant of ambulatory patient satisfaction? *Arch Intern Med, 161*(11), 1437-1442. doi:10.1001/archinte.161.11.1437
Linardon, J., Fairburn, C. G., Fitzsimmons-Craft, E. E., Wilfley, D. E., & Brennan, L. (2017). The empirical status of the third-wave behaviour therapies for the treatment of eating disorders: A systematic review. *Clin Psychol Rev, 58*, 125-140. doi:10.1016/j.cpr.2017.10.005
Liston, Y. (1999). The Transformation of Buddhism during British Colonialism. *Journal of Law and Religion, 14*(1), 189-210. doi:10.2307/1051784
Liyanage, U. L. N. S., Rowel, W. W. J. S. M., Hewawitharana, U. H., de Silva, V. & Dissanayake, D. M. T. (2018). Stigma due to their work in mental health, among mental health professionals in Sri Lanka. *Sri Lanka Journal of Psychiatry*, 9(1), 4–8.
Lo, H. T., & Fung, K. P. (2003). Culturally competent psychotherapy. *Can J Psychiatry, 48*(3), 161-170. doi:10.1177/070674370304800304
Lowes, R. L. (1995). Are you expected to see too many patients? *Med Econ, 72*(6), 52-53, 57-59.
Lund, C., Breen, A., Flisher, A. J., Kakuma, R., Corrigall, J., Joska, J. A., . . . Patel, V. (2010). Poverty and common mental disorders in low and middle income countries: A systematic review. *Soc Sci Med, 71*(3), 517-528. doi:10.1016/j.socscimed.2010.04.027
Malhi, G. S., Bassett, D., Boyce, P., Bryant, R., Fitzgerald, P. B., Fritz, K., Hopwood, M., Lyndon, B., Mulder, R., Murray, G., Porter, R., & Singh, A. B. (2015). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders. *Aust N Z J Psychiatry,* 49(12), 1087–1206. https://doi.org/10.1177/0004867415617657
Malla, A., Joober, R., & Garcia, A. (2015). "Mental illness is like any other medical illness": a critical examination of the statement and its impact on patient care and society. *J Psychiatry Neurosci, 40*(3), 147-150. doi:10.1503/jpn.150099
Manassis, K. (2005). Family Involvement in Psychotherapy: What's the Evidence? . In J. L. Hudson & R. M. Rapee (Eds.), *Psychopathology and the Family*. Sydney: Elsevier.
Manickam, L. S. (2010). Psychotherapy in India. *Indian J Psychiatry, 52*(Suppl 1), S366-370. doi:10.4103/0019-5545.69270

Markus, H. R., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review, 98*(2), 224-253. doi:10.1037/0033-295X.98.2.224
Maselko, J., Bates, L., Bhalotra, S., Gallis, J. A., O'Donnell, K., Sikander, S., & Turner, E. L. (2018). Socioeconomic status indicators and common mental disorders: Evidence from a study of prenatal depression in Pakistan. *SSM Popul Health, 4*, 1-9. doi:10.1016/j.ssmph.2017.10.004
Mathibela, M. K., Egan, B. A., Du Plessis, H. J., & Potgieter, M. J. (2015). Socio-cultural profile of Bapedi traditional healers as indigenous knowledge custodians and conservation partners in the Blouberg area, Limpopo Province, South Africa. *J Ethnobiol Ethnomed, 11*, 49. doi:10.1186/s13002-015-0025-3
McCarter, T. (2008). Depression overview. *Am Health Drug Benefits*, 1(3), 44-51.
Mehta, F. R. (2016). Addressing the Challenge of Noncommunicable Diseases: Some Key Issues and a Country Case Study. *Asia Pacific Journal of Public Health, 28*(1_suppl), 111S-114S. doi:10.1177/1010539515612969
Mendenhall, E., Narayanan, G., & Prabhakaran, D. (2012). Depression and diabetes in India: perspectives and recommendations. *Diabet Med, 29*(9), e308-311. doi:10.1111/j.1464-5491.2012.03708.x
Merriam, S. B. a., & Tisdell, E. J. a. (2015). *Qualitative research : a guide to design and implementation* (Fourth edition. ed.).
Minas, H. (2015). A mental health human resources strategy for Sri Lanka. *Sri Lanka Journal of Psychiatry, 6*(1), 1-3.
Minas, H., Mendis, J., & Hall, T. (2017). Mental Health System Development in Sri Lanka. In H. Minas & M. Lewis (Eds.), *Mental Health in Asia and the Pacific: Historical and Cultural Perspectives* (pp. 59-77). New York: Springer.
Ministry of Finance and Planning. (2012). *Household income and expenditure survey 2012/13*. Colombo: Ministry of Finance and Planning, Sri Lanka.
Ministry of Health. (2016). *National Health Strategic Masterplan 2016-2025*. Colombo: Ministry of Health, Sri Lanka.
Ministry of Health. (2017). *Annual Health Bulletin 2015*. Colombo: Ministry of Health, Sri Lanka.
Ministry of Health of the People's Republic of China. (2012). *The China Health Statistical Yearbook 2012*. Beijing: China Statistics Press.
Miranda, J., Azocar, F., Organista, K. C., Dwyer, E., & Areane, P. (2003). Treatment of depression among impoverished primary care patients from ethnic minority groups. *Psychiatr Serv, 54*(2), 219-225. doi:10.1176/appi.ps.54.2.219
Mokgobi, M. G. (2014). Health care practitioners' opinions about traditional healing. *Afr J Phys Health Educ Recreat Dance, 20*(Suppl 2), 14-23.
Moodley, R., & Ocampo, M. (2014). *Critical psychiatry and mental health: Exploring work of Suman Fernando in clinical practice*. New York: Routledge.
Mooney, T. K., Gibbons, M. B., Gallop, R., Mack, R. A., & Crits-Christoph, P. (2014). Psychotherapy credibility ratings: patient predictors of credibility and the relation of credibility to therapy outcome. *Psychother Res, 24*(5), 565-577. doi:10.1080/10503307.2013.847988
Morse, J., & Field, P. (1996). *Nursing research: the application of qualitative approaches*. London: Chapman & Hall.
Muñoz, R. F, & Miranda, J. (1996). I*ndividual therapy manual for cognitive- behavioral treatment of depression.* Santa Monica, CA: RAND.
Murray, C. J., & Lopez, A. D. (1996). *The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries, and Risk Factors in 1990 and Projected to 2020*. Cambridge, MA: Harvard University Press.
Murray, L. K., Dorsey, S., Haroz, E., Lee, C., Alsiary, M. M., Haydary, A., . . . Bolton, P. (2014). A Common Elements Treatment Approach for Adult Mental Health Problems in Low- and Middle-Income Countries. *Cogn Behav Pract, 21*(2), 111-123. doi:10.1016/j.cbpra.2013.06.005

Naeem, F., Ayub, M., Gobbi, M., & Kingdon, D. (2009). Development of Southampton Adaptation Framework for CBT (SAF-CBT): a framework for adaptation of CBT in non-western culture. *Journal of Pakistan Psychiatric Society, 6*(2), 79-84.

Naeem, F., Phiri, P., Rathod, S., & Ayub, M. (2019). Cultural adaptation of cognitive–behavioural therapy. *BJPsych Advances, 25*(6), 387-395.

Naeem, F., Waheed, W., Gobbi, M., Ayub, M., & Kingdon, D. (2011). Preliminary evaluation of culturally sensitive CBT for depression in Pakistan: findings from Developing Culturally-sensitive CBT Project (DCCP). *Behav Cogn Psychother, 39*(2), 165-173. doi:10.1017/S1352465810000822

Nakimuli-Mpungu, E., Wamala, K., Okello, J., Alderman, S., Odokonyero, R., Musisi, S., . . . Mills, E. J. (2014). Outcomes, feasibility and acceptability of a group support psychotherapeutic intervention for depressed HIV-affected Ugandan adults: a pilot study. *J Affect Disord, 166*, 144-150. doi:10.1016/j.jad.2014.05.005

Nasser, A. (2004). *Factors affecting attitudes towards seeking and using formal mental health and psychological services among Arab-Muslim population.* (PhD), Ohio State University, Ohio.

National Institute for Health and Care Excellence (NICE). (2009, April 2018). Depression in adults: recognition and management. Retrieved from https://www.nice.org.uk/guidance/cg90/resources/depression-in-adults-recognition-and-management-pdf-975742638037

Needleman, L. D. (1999). *Cognitive case conceptualization: A guidebook for practitioners*. Mahwah, NJ: Lawrence Erbaum Associates.

Neki, J. S. (1992). Confidentiality, secrecy, and privacy in psychotherapy : sociodynamic considerations. *Indian J Psychiatry, 34*(3), 171-173.

Netto, G., Bhopal, R., Lederle, N., Khatoon, J., & Jackson, A. (2010). How can health promotion interventions be adapted for minority ethnic communities? Five principles for guiding the development of behavioural interventions. *Health Promot Int, 25*(2), 248-257. doi:10.1093/heapro/daq012

Newman, M. G., & Fisher, A. J. (2010). Expectancy/Credibility Change as a Mediator of Cognitive Behavioral Therapy for Generalized Anxiety Disorder: Mechanism of Action or Proxy for Symptom Change? *Int J Cogn Ther, 3*, 245-261. doi:10.1521/ijct.2010.3.3.245

Nezu, A. M., & Nezu, C. M. (1989). *Clinical Decision Making in Behaviour Therapy: A Problem Solving Perspective*. Champaign, IL: Research Press.

Ng, C. T., & James, S. (2013). "Directive approach" for chinese clients receiving psychotherapy: is that really a priority? *Front Psychol, 4*, 49. doi:10.3389/fpsyg.2013.00049

Ng, C. W., How, C. H., & Ng, Y. P. (2017). Managing depression in primary care. *Singapore Med J, 58*(8), 459-466. doi:10.11622/smedj.2017080

Obeysekere, G. (1985). Depression and Buddhism and the work of culture in Sri Lanka. In A. Kleinman & B. Good (Eds.), *Culture and depression: studies in the anthropology and cross-cultural psychiatry of affect and disorder*. Berkeley: University of California Press.

Padesky, C. A. (1996). *Collaborative case conceptualization: A client session*. Oakland, CA: New Harbinger Press.

Pagnin, D., de Queiroz, V., Pini, S. & Cassano, G. B. (2004). Efficacy of ECT in depression: a meta-analytic review. *J ECT*, 20 (1), 13-20. doi:10.1097/00124509-200403000-00004

Pampallona, S., Bollini, P., Tibaldi, G., Kupelnick, B., & Munizza, C. (2004). Combined pharmacotherapy and psychological treatment for depression: a systematic review. *Arch Gen Psychiatry, 61*(7), 714-719. doi:10.1001/archpsyc.61.7.714

Patel, V. (2001). Cultural factors and international epidemiology. *Br Med Bull, 57*, 33-45. doi:10.1093/bmb/57.1.33

Patel, V. (2011). Traditional healers for mental health care in Africa. *Glob Health Action, 4*. doi:10.3402/gha.v4i0.7956

Patel, V., Simon, G., Chowdhary, N., Kaaya, S., & Araya, R. (2009). Packages of care for depression in low- and middle-income countries. *PLoS Med, 6*(10), e1000159. doi:10.1371/journal.pmed.1000159

Patel, V., Simunyu, E., & Gwanzura, F. (1997). The pathways to primary mental health care in high-density suburbs in Harare, Zimbabwe. *Soc Psychiatry Psychiatr Epidemiol, 32*(2), 97-103. doi:10.1007/bf00788927

Perepletchikova, F., Treat, T. A., & Kazdin, A. E. (2007). Treatment integrity in psychotherapy research: analysis of the studies and examination of the associated factors. *J Consult Clin Psychol, 75*(6), 829-841. doi:10.1037/0022-006X.75.6.829

Perera, B., Torabi, M. R., Jayawardana, G., & Pallethanna, N. (2006). Depressive symptoms among adolescents in Sri Lanka: prevalence and behavioral correlates. *J Adolesc Health, 39*(1), 144-146. doi:10.1016/j.jadohealth.2005.10.013

Peters, S., Wearden, A., Morriss, R., Dowrick, C. F., Lovell, K., Brooks, J., Cahill, G., Chew-Graham, C., & FINE Trial Group (2011). Challenges of nurse delivery of psychological interventions for long-term conditions in primary care: a qualitative exploration of the case of chronic fatigue syndrome/myalgic encephalitis. *Implement Sci*., 6, 132. https://doi.org/10.1186/1748-5908-6-132

Pomey, M. P., Ghadiri, D. P., Karazivan, P., Fernandez, N., & Clavel, N. (2015). Patients as partners: a qualitative study of patients' engagement in their health care. *PLoS One, 10*(4), e0122499. doi:10.1371/journal.pone.0122499

Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M. R., & Rahman, A. (2007). No health without mental health. *Lancet, 370*(9590), 859-877. doi:10.1016/S0140-6736(07)61238-0

Purgato, M., Gastaldon, C., Papola, D., van Ommeren, M., Barbui, C., & Tol, W. A. (2018). Psychological therapies for the treatment of mental disorders in low- and middle-income countries affected by humanitarian crises. *Cochrane Database Syst Rev, 7*, CD011849. doi:10.1002/14651858.CD011849.pub2

Rajapakse, T., & Sivapalasingham, A. (2011). Patients presenting with depression to a psychiatry clinic: a descriptive survey. *Sri Lanka Journal of Psychiatry, 2*(1), 36-38.

Rannan-Eliya, R. P. (2006). *Sri Lanka's Health System – Achievements and Challenges*. Colombo: Institute for Health Policy.

Rathod, S., Gega, L., Degnan, A., Pikard, J., Khan, T., Husain, N., . . . Naeem, F. (2018). The current status of culturally adapted mental health interventions: a practice-focused review of meta-analyses. *Neuropsychiatr Dis Treat, 14*, 165-178. doi:10.2147/NDT.S138430

Rathod, S., Kingdon, D., Phiri, P., & Gobbi, M. (2010). Developing culturally sensitive cognitive behaviour therapy for psychosis for ethnic minority patients by exploration and incorporation of service users' and health professionals' views and opinions. *Behav Cogn Psychother, 38*(5), 511-533. doi:10.1017/S1352465810000378

Rathod, S., Phiri, P., Harris, S., Underwood, C., Thagadur, M., Padmanabi, U., & Kingdon, D. (2013). Cognitive behaviour therapy for psychosis can be adapted for minority ethnic groups: a randomised controlled trial. *Schizophr Res, 143*(2-3), 319-326. doi:10.1016/j.schres.2012.11.007

Rathod, S., Pinninti, N., Irfan, M., Gorczynski, P., Rathod, P., Gega, L., & Naeem, F. (2017). Mental Health Service Provision in Low- and Middle-Income Countries. *Health Serv Insights, 10*, 1178632917694350. doi:10.1177/1178632917694350

Reber, A. S., Allen, R., & Reber, E. S. (2009). *The Penguin dictionary of psychology* (4th ed. ed.). London: Penguin.

Reddy, M. S. (2010). Depression: the disorder and the burden. *Indian J Psychol Med, 32*(1), 1-2. doi:10.4103/0253-7176.70510

Resnicow, K., Baranowski, T., Ahluwalia, J. S., & Braithwaite, R. L. (1999). Cultural sensitivity in public health: defined and demystified. *Ethn Dis, 9*(1), 10-21.

Rihmer, Z. (2001). Can better recognition and treatment of depression reduce suicide rates? A brief review. *Eur Psychiatry, 16*(7), 406-409. doi:10.1016/s0924-9338(01)00598-3
Rodrigo, A., Kuruppuarachchi, K. A. L. A., & Pathmeswaran, A. (2015). Validation of the Beck Depression Inventory II among the Sinhalese speaking population in Sri Lanka. *Sri Lanka Journal of Psychiatry, 6*(2), 20-24.
Rohner, R. P. (1984). Toward a conception of culture for cross-cultural psychology. *Journal of Cross-Cultural Psychology, 15*(2), 111-138. doi:10.1177/0022002184015002002
Rojas-Garcia, A., Ruiz-Perez, I., Rodriguez-Barranco, M., Goncalves Bradley, D. C., Pastor-Moreno, G., & Ricci-Cabello, I. (2015). Healthcare interventions for depression in low socioeconomic status populations: A systematic review and meta-analysis. *Clin Psychol Rev, 38*, 65-78. doi:10.1016/j.cpr.2015.03.001
Rossello, J., & Bernal, G. (1999). The efficacy of cognitive-behavioral and interpersonal treatments for depression in Puerto Rican adolescents. *J Consult Clin Psychol, 67*(5), 734-745. doi:10.1037//0022-006x.67.5.734
Samarasekara, N., Davies, M. L. N., & Siribaddana, S. (2012). *The stigma of mental illness in Sri Lanka: the perspectives of community mental health workers* (Vol. 2).
Samaraweera, S., Sumathipala, A., Siribaddana, S., Sivayogan, S., & Bhugra, D. (2008). Completed suicide among Sinhalese in Sri Lanka: a psychological autopsy study. *Suicide Life Threat Behav, 38*(2), 221-228. doi:10.1521/suli.2008.38.2.221
Sampson, R., O'Rourke, J., Hendry, R., Heaney, D., Holden, S., Thain, A., & MacVicar, R. (2013). Sharing control of appointment length with patients in general practice: a qualitative study. *Br J Gen Pract, 63*(608), e185-191. doi:10.3399/bjgp13X664234
Samuels, J., Schudrich, W., & Altschul, D. (2009). Toolkit for Modifying Evidence Based Practices to Increase Cultural Competence. Retrieved from https://www.montclair.edu/profilepages/media/8019/user/toolkit.pdf
Sandell, R., Clinton, D., Frövenholt, J., & Bragesjö, M. (2011). Credibility clusters, preferences, and helpfulness beliefs for specific forms of psychotherapy. *Psychology and psychotherapy, 84*, 425-441. doi:10.1111/j.2044-8341.2010.02010.x
Saveanu, R. V. & Nemeroff, C. B. (2012). Etiology of depression: genetic and environmental factors. *Psychiatr Clin North Am*, 2012, 35(1), 51-71.
Schwartz-Lifshitz, M., Zalsman, G., Giner, L., & Oquendo, M. A. (2012). Can we really prevent suicide? *Curr Psychiatry Rep, 14*(6), 624-633. doi:10.1007/s11920-012-0318-3
Scorzelli, J., & Reinke-Scorzelli, M. (1994). Cultural Sensitivity and Cognitive Therapy in India. *Counseling Psychologist - COUNS PSYCHOL, 22*, 603-610. doi:10.1177/0011000094224006
Shen, E. K., Alden, L. E., Sochting, I., & Tsang, P. (2006). Clinical observations of a Cantonese cognitive-behavioral treatment program for Chinese immigrants. *Psychotherapy (Chic), 43*(4), 518-530. doi:10.1037/0033-3204.43.4.518
Sholomskas, D. E., Syracuse-Siewert, G., Rounsaville, B. J., Ball, S. A., Nuro, K. F., & Carroll, K. M. (2005). We don't train in vain: a dissemination trial of three strategies of training clinicians in cognitive-behavioral therapy. *J Consult Clin Psychol, 73*(1), 106-115. doi:10.1037/0022-006X.73.1.106
Shweder, R. A., & Sullivan, M. A. (1993). Cultural Psychology: Who Needs It? *Annual Review of Psychology, 44*(1), 497-523. doi:10.1146/annurev.ps.44.020193.002433
Simons, L., Lathlean, J., & Squire, C. (2008). Shifting the focus: sequential methods of analysis with qualitative data. *Qual Health Res, 18*(1), 120-132. doi:10.1177/1049732307310264
Singla, D. R., Kohrt, B. A., Murray, L. K., Anand, A., Chorpita, B. F., & Patel, V. (2017). Psychological Treatments for the World: Lessons from Low- and Middle-Income Countries. *Annu Rev Clin Psychol, 13*, 149-181. doi:10.1146/annurev-clinpsy-032816-045217
Siriwardhana, C., Abas, M., Siribaddana, S., Sumathipala, A., & Stewart, R. (2015). Dynamics of resilience in forced migration: a 1-year follow-up study of longitudinal associations with mental health in a conflict-affected, ethnic Muslim population. *BMJ open*, 5(2), e006000. https://doi.org/10.1136/bmjopen-2014-006000

Siriwardhana, C., Wickramage, K., Siribaddana, S., Vidanapathirana, P., Jayasekara, B., Weerawarna, S., Pannala, G., Adikari, A., Jayaweera, K., Pieris, S., & Sumathipala, A. (2015). Common mental disorders among adult members of 'left-behind' international migrant worker families in Sri Lanka. *BMC public health*, 15, 299. https://doi.org/10.1186/s12889-015-1632-6

Smith, T. B., Rodriguez, M. D., & Bernal, G. (2011). Culture. *J Clin Psychol, 67*(2), 166-175. doi:10.1002/jclp.20757

Spencer, J. (1995). The Past in the Present in Sri Lanka. A Review Article. *Comparative Studies in Society and History, 37*(2), 358-367. doi:10.1017/S0010417500019691

Spencer, J., Handler, R., Kapferer, B., Khare, R. S., McGilvray, D. B., Obeyesekere, G., . . . Southwold, M. (1990). Writing Within: Anthropology, Nationalism, and Culture in Sri Lanka. *Current Anthropology, 31*(3), 283-300.

Spijker, J., Graaf, R., Bijl, R. V., Beekman, A. T., Ormel, J., & Nolen, W. A. (2004). Functional disability and depression in the general population. Results from the Netherlands Mental Health Survey and Incidence Study (NEMESIS). *Acta Psychiatr Scand, 110*(3), 208-214. doi:10.1111/j.1600-0447.2004.00335.x

Strong, S. R. (1968). Counseling: An interpersonal influence process. *Journal of Counseling Psychology, 15*(3), 215-224. doi:10.1037/h0020229

Sue, D. W., & Sue, D. (2000). *Counselling the culturally different: theory and practice*. New York: Wiley.

Sue, S., Zane, N., Nagayama Hall, G. C., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annu Rev Psychol, 60*, 525-548. doi:10.1146/annurev.psych.60.110707.163651

Sumathipala, A., Hewege, S., Hanwella, R., & Mann, A. H. (2000). Randomized controlled trial of cognitive behaviour therapy for repeated consultations for medically unexplained complaints: a feasibility study in Sri Lanka. *Psychol Med, 30*(4), 747-757. doi:10.1017/s0033291799002160

Sumathipala, A., Siribaddana, S., Abeysingha, M. R., De Silva, P., Dewey, M., Prince, M., & Mann, A. H. (2008). Cognitive-behavioural therapy v. structured care for medically unexplained symptoms: randomised controlled trial. *Br J Psychiatry, 193*(1), 51-59. doi:10.1192/bjp.bp.107.043190

Suraweera, C. (2013). Rating scales validated for Sri Lankan populations. *Sri Lanka Journal of Psychiatry, 4*(2), 16-24.

Sutton, C. A. (2015). *Culturally adapted interventions for Latinos: A meta-analysis.* (PsyD), Pacific University, Retrieved from https://commons.pacificu.edu/spp/1134

Tang, W., & Kreindler, D. (2017). Supporting Homework Compliance in Cognitive Behavioural Therapy: Essential Features of Mobile Apps. *JMIR Ment Health, 4*(2), e20. doi:10.2196/mental.5283

Tarrier, N. (2006). *Case formulation in cognitive behaviour therapy: The treatment of challenging and complex cases*. New York, NY, US: Routledge/Taylor & Francis Group.

Teachman, B. A., Drabick, D. A., Hershenberg, R., Vivian, D., Wolfe, B. E., & Goldfried, M. R. (2012). Bridging the gap between clinical research and clinical practice: introduction to the special section. *Psychotherapy (Chic), 49*(2), 97-100. doi:10.1037/a0027346

Ten Have, M., Penninx, B., Tuithof, M., van Dorsselaer, S., Kleinjan, M., Spijker, J., & de Graaf, R. (2017). Duration of major and minor depressive episodes and associated risk indicators in a psychiatric epidemiological cohort study of the general population. *Acta Psychiatr Scand, 136*(3), 300-312. doi:10.1111/acps.12753

Thapar, A., Collishaw, S., Pine, D. S., & Thapar, A. K. (2012). Depression in adolescence. *Lancet, 379*(9820), 1056-1067. doi:10.1016/S0140-6736(11)60871-4

Thara, R., Henrietta, M., Joseph, A., Rajkumar, S., & Eaton, W. W. (1994). Ten-year course of schizophrenia--the Madras longitudinal study. *Acta Psychiatr Scand, 90*(5), 329-336. doi:10.1111/j.1600-0447.1994.tb01602.x

Tolin, D. F. (2010). Is cognitive-behavioral therapy more effective than other therapies? A meta-analytic review. *Clin Psychol Rev, 30*(6), 710-720. doi:10.1016/j.cpr.2010.05.003
Triandis, H. C., & Lambert, W. W. (1980). *Handbook of cross-cultural psychology*. Boston, Mass. ; London: Allyn and Bacon.
Tseng, W.-S. (2001). *Handbook of cultural psychiatry*. San Diego ; London: Academic Press.
Uragoda, C. G. (1987). *A history of medicine in Sri Lanka*. Colombo: Sri Lanka Medical Association.
Ustun, T. B., Ayuso-Mateos, J. L., Chatterji, S., Mathers, C., & Murray, C. J. (2004). Global burden of depressive disorders in the year 2000. *Br J Psychiatry, 184*, 386-392. doi:10.1192/bjp.184.5.386
van Loon, A., van Schaik, A., Dekker, J., & Beekman, A. (2013). Bridging the gap for ethnic minority adult outpatients with depression and anxiety disorders by culturally adapted treatments. *J Affect Disord, 147*(1-3), 9-16. doi:10.1016/j.jad.2012.12.014
Vogt, B. (1999). *Skill and Trust: The Tovil Healing Ritual of Sri Lanka as Culture-Specific Psychotherapy*. Amsterdam: Amsterdam University Press.
Vos, T., Flaxman, A. D., Naghavi, M., Lozano, R., Michaud, C., Ezzati, M., . . . Memish, Z. A. (2012). Years lived with disability (YLDs) for 1160 sequelae of 289 diseases and injuries 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet, 380*(9859), 2163-2196. doi:10.1016/S0140-6736(12)61729-2
Wang, P. S., Angermeyer, M., Borges, G., Bruffaerts, R., Tat Chiu, W., G, D. E. G., . . . Ustun, T. B. (2007). Delay and failure in treatment seeking after first onset of mental disorders in the World Health Organization's World Mental Health Survey Initiative. *World Psychiatry, 6*(3), 177-185.
Wang, P. S., Berglund, P. A., Olfson, M., & Kessler, R. C. (2004). Delays in initial treatment contact after first onset of a mental disorder. *Health Serv Res, 39*(2), 393-415. doi:10.1111/j.1475-6773.2004.00234.x
Weersing, V. R., & Weisz, J. R. (2002). Community clinic treatment of depressed youth: Benchmarking usual care against CBT clinical trials. *Journal of Consulting and Clinical Psychology, 70*(2), 299-310. doi:10.1037/0022-006X.70.2.299
Weiss, W. M., Murray, L. K., Zangana, G. A., Mahmooth, Z., Kaysen, D., Dorsey, S., . . . Bolton, P. (2015). Community-based mental health treatments for survivors of torture and militant attacks in Southern Iraq: a randomized control trial. *BMC Psychiatry, 15*, 249. doi:10.1186/s12888-015-0622-7
Weissman, M. M., Verdeli, H., Gameroff, M. J., Bledsoe, S. E., Betts, K., Mufson, L., . . . Wickramaratne, P. (2006). National survey of psychotherapy training in psychiatry, psychology, and social work. *Arch Gen Psychiatry, 63*(8), 925-934. doi:10.1001/archpsyc.63.8.925
Whaley, A. L., & Davis, K. E. (2007). Cultural competence and evidence-based practice in mental health services: a complementary perspective. *Am Psychol, 62*(6), 563-574. doi:10.1037/0003-066X.62.6.563
White, S. W., Albano, A. M., Johnson, C. R., Kasari, C., Ollendick, T., Klin, A., . . . Scahill, L. (2010). Development of a cognitive-behavioral intervention program to treat anxiety and social deficits in teens with high-functioning autism. *Clin Child Fam Psychol Rev, 13*(1), 77-90. doi:10.1007/s10567-009-0062-3
Wiles, N. J., Thomas, L., Turner, N., Garfield, K., Kounali, D., Campbell, J., Kessler, D., Kuyken, W., Lewis, G., Morrison, J., Williams, C., Peters, T. J., & Hollinghurst, S. (2016). Long-term effectiveness and cost-effectiveness of cognitive behavioural therapy as an adjunct to pharmacotherapy for treatment-resistant depression in primary care: follow-up of the CoBalT randomised controlled trial. *Lancet. Psychiatry*, 3(2), 137–144.
Williams, J. B. (1988). A structured interview guide for the Hamilton Depression Rating Scale. *Arch Gen Psychiatry, 45*(8), 742-747. doi:10.1001/archpsyc.1988.01800320058007
Williams, S. Z., Chung, G. S., & Muennig, P. A. (2017). Undiagnosed depression: A community diagnosis. *SSM Popul Health, 3*, 633-638. doi:10.1016/j.ssmph.2017.07.012

Wong, S. Y. S., Sun, Y. Y., Chan, A. T. Y., Leung, M. K. W., Chao, D. V. K., Li, C. C. K., . . . Yip, B. H. K. (2018). Treating Subthreshold Depression in Primary Care: A Randomized Controlled Trial of Behavioral Activation With Mindfulness. *Ann Fam Med, 16*(2), 111-119. doi:10.1370/afm.2206

World Health Organization. (2005). Mental health atlas : 2005. In (Rev. ed ed.). Geneva: World Health Organization.

World Health Organization. (2007). Atlas: nurses in mental health 2007. Retrieved from https://www.who.int/mental_health/evidence/nursing_atlas_2007.pdf

World Health Organization. (2011). Mental health atlas : 2011. In. Geneva: World Health Organization.

World Health Organization. (2013). *Investing in mental health: evidence for action*. Geneva: World Health Organization.

World Health Organization. (2018). *WHO Sri-Lanka annual report, 2017*. Colombo: World Health Organization, Country Office for Sri-Lanka.

World Health Organization. (2019). Global health expenditure database. Retrieved from http://apps.who.int/nha/database/country_profile/Index/en

Zhu, L. (2018). Depression Symptom Patterns and Social Correlates among Chinese Americans. *Brain Sci, 8*(1). doi:10.3390/brainsci8010016

APPENDICES

Appendix 01 Ethical approval for phase 01

UNIVERSITY OF KELANIYA, SRI LANKA
FACULTY OF MEDICINE
ETHICS REVIEW COMMITTEE
FWA00013225

10.10.2013

Ref. No. P177/10/2013

Dr.Asiri Rodrigo
Lecturer in Psychiatry
Faculty of Medicine
University of Kelaniya
Ragama.

Subject: Culturally relevant psychotherapies for depression in Sri Lanka (Phase I)

Authors : Dr.Asiri Rodrigo, Prof.Harry Minas, Dr. Ritsuko Kakuma, Prof.Richard Newton, Dr.Piyanjali De Zoysa

Thank you for resubmitting the above research proposal. Ethics Review Committee which met on 11.12.2013 granted l approval to the above study..

With best wishes,

Secretary
ERC

PO Box 6, Thalagolla Road, Ragama, Sri Lanka
Telephone: (00 94 11) 2958166, 2958219, 2958037
Fax: (00 94 11) 2958251 & 295833

Appendix 02 Ethical approval for phase 02

Ethics Review Committee

A SIDCER(Strategic Initiative for Developing Capacity in Ethical Review)recognized ERC

Faculty of Medicine,University of Kelaniya, Sri Lanka
FWA00013225

Chairperson
Prof A. Pathmeswaran

Secretary
Dr Nirmala Perera

Committee members
Dr Madawa Chandrathilake
Mr Lavanhelo de Silva
Dr Ananda de Silva
Prof Kithsiri Gunawardena
Dr Aruni Hapangama
Dr Indira Kitulwatte
Dr Chamila Mettananda
Dr Durga Mohatuwagama
Dr Thilina Pathmawadana
Dr Chamila Ranasinha
Dr Lanka Ranaweera
Dr Ranmali Rodrigo
Dr Wasanthi Subasinghe
Prof Shirley Wijesinghe
Dr Shehan Williams
Rev (Dr.) Nihal Abeyasingha

18.11.2015

Ref. No. P/188/11/2015

Dr. Asiri Rodrigo
Lecturer in Psychiatry
Dept. of Psychiatry
Faculty of Medicine
University of Kelaniya.

Subject: Pilot study on Culturally relevant psychotherapies for depression in Sri Lanka

Authors: Dr. Asiri Rodrigo, Prof. Harry Minas, Dr. Ritsuko Kakuma, Prof. Richard Newton, Dr. Piyanjali de Zoysa

Thank you for submitting the above research proposal. Ethics Review Committee which met on 17.11.2015 granted conditional approval to the above study and made following suggestions.

Correct the ERC name.
Remove University logo from the study.

With best wishes,

Yours sincerely,

Dr. W.N.S. Perera
Secretary/ERC

Address all correspondence to: Secretary, Ethics Review Committee
Faculty of Medicine, University of Kelaniya, PO Box 06, Thalagolla Road, Ragama, Sri Lanka.
Telephone: +94-112961000, Fax: +94-112958337 /+94-112955280

Appendix 3 participant consent form- English

Global and Cultural Mental Health Unit
Centre for Mental Health

CONSENT FORM

Study Title: Culturally relevant psychotherapies for depression in Sri Lanka (Phase 2)

Principal Researcher: Dr Asiri Rodrigo
Associate Researchers: A/Prof Harry Minas, Dr Ritsuko Kakuma, A/Prof Richard Newton, Dr Piyanjali de Zoysa

Please tick '√' the relevant boxes.

- ☐ I have read or have had this document read to me in a language that I understand the purposes, procedures and risks / inconveniences of this research project as described within it.
- ☐ I understand that my participation is voluntary and that I am free to withdraw consent at any time
- ☐ I understand I will not be identified in any publication arising from the research
- ☐ I understand therapy sessions would be audio recorded for review process
- ☐ I understand that there are arrangements to protect the confidentiality of data;'
- ☐ I have had an opportunity to ask questions and I am satisfied with the answers I have received.
- ☐ I freely agree to participate in this research project, as described.
- ☐ I understand that I will be given a patient information form signed copy of this document to keep.
- ☐ I would like to receive a flyer with final results of the study, mailed to my postal address

If yes, please put the postal address here:

…….

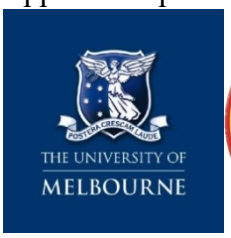
……

…...

Participant's name (printed) ……

Signature …… Date……./……../……

Appendix 4 participant consent form- Sinhala



<u>සමීක්ෂණයට සහභාගි වීමට කැමැත්ත ප්‍රකාශ කිරීමේ පත්‍රිකාව</u>

<u>අධ්‍යයන මාතෘකාව</u>: විශාදය සුවකිරීම සඳහා ශ්‍රී ලංකාවේ සංස්කෘතියට ගැලපෙන මනෝ චිකිත්සක ක්‍රම හඳුන්වා දීම පිළිබඳ නියමු අධ්‍යයනය

<u>ප්‍රධාන සමීක්ෂක</u>: වෛද්‍ය ආසිරි රොඩ්‍රිගු
<u>සහකාර සමීක්ෂකවරු</u>: මහාචාර්‍ය හැරී මිනාස් , වෛද්‍ය රිට්සුකෝ කකුමා, මහාචාර්‍ය රිචඩ් නිව්ටන්, වෛද්‍ය පියන්ජලී ද සොයිසා

- ✓ ලකුණ අදාළ කොටුව තුළ යොදන්න.

☐ මා විසින් මට අවබෝධ කර ගතහැකි භාෂාවකින් මෙම සමීක්ෂණ ව්‍යාපෘතියේ අරමුණු , ක්‍රියාපටිපාටියන් ,අවදානම් මොනවාද යන්න කියවා දැන ගතිමි.

☐ මට ප්‍රශ්න ඇසීමේ අවස්ථාවක් ලැබුණු අතර එම ප්‍රශ්න වලට ලැබුණු පිළිතුරු පිළිබඳ මම සෑහීමකට පත්වෙමි.

☐ මේ සමීක්ෂණය සඳහා කැමැත්තෙන් සහභාගි වෙමි.

☐ මම ලියවිල්ලේ සහතික කරන ලද පිටපතක් මා හට ලබා දෙන බව මම දනිමි.

☐ මමසමීක්ෂණයේ අවසාන ප්‍රතිඵල තැපෑලෙන් මා වෙත දන්වන්නේ නම් කෘතඥ වෙමි.

මා විසින් ඕස්ට්‍රේලියාවේ මෙල්බනර්ඊ විශ්ව විද්‍යාලයේ සමීක්ෂණ ආචාර ධර්ම් හා සම්පූණර්ත්වය පිළිබඳ කායර්ාලයට හා ශ්‍රී ලංකාවේ කැළණිය විශ්ව විදයාලයට අනුබද්ධ උතුරු කොළඹ ශික්ෂණ රෝහලේ ආචාර ධර්ම් කමිටුව වෙත මෙම සමීක්ෂණය සඳහා අවශ්‍ය තොරතුරු ලබා ගැනීම සඳහා වූ අවසරය ලබා දෙමි.

සහභාගි වන්නාගේ නම:

අත්සන : දිනය :

සාක්ෂිකරුගේ නම:

අත්සන : දිනය :

සමීක්ෂකගේ ප්‍රකාශය: මා විසින් මෙම සමීක්ෂණ ව්‍යාපෘතිය පිළිබඳව හා එහි අරමුණු , ක්‍රියාපටිපාටියන් ,අවදානම් පිළිබඳව වාචික විග්‍රහයක් සහභාගි වන්නන් වෙත ලබා දී ඇත.ඔවුන් විසින් එය පැහැදිලිව අවබෝධ කර ගෙන ඇත යන්න මාගේ විශ්වාසයි.

Appendix 5 participant information sheet- Sinhala

රෝගීන් සහ ඔවුන් රැකබලා ගන්නන් සඳහා වන විස්තර පත්‍රිකාව සහ සමීක්ෂණයට කැමැත්ත ප්‍රකාශ කිරීමේ පත්‍රිකාව.

<u>ව්‍යාපෘතියේ නම:</u>
විශාදය සුවකිරීම සඳහා ශ්‍රී ලංකාවේ සංස්කෘතියට ගැලපෙන මනෝ චිකිත්සක ක්‍රම හඳුන්වා දීමේ සමීක්ෂණය (අදියර 1)

<u>ප්‍රධාන සමීක්ෂණ නිලධාරි:</u>
වෛද්‍ය ආසිරි රුදිගු
මනෝ වෛද්‍ය දෙපාතර්මේන්තුව, වෛද්‍ය පීඨය, කැලණිය විශ්වවිද්‍යාලය, ශ්‍රී ලංකාව
මානසික සෞඛ්‍ය පිළිබඳ ජාත්‍යන්තර මධ්‍යස්ථානය(CIMH), මෙල්බනර්ඊ විශ්වවිද්‍යාලය, මෙල්බනර්ඊ, ඔස්ට්‍රේලියාව

<u>අධීක්ෂණය/ සහකාර සමීක්ෂකවරු:</u>
මහාචාර්ය හැරී මිනාස්, මානසික සෞඛ්‍ය පිළිබඳ ජාත්‍යන්තර මධ්‍යස්ථානය(CIMH), මෙල්බනර්ඊ විශ්වවිද්‍යාලය, මෙල්බනර්ඊ, ඔස්ට්‍රේලියාව
අචාර්ය රිට්සුකෝ කකුමා, මානසික සෞඛ්‍ය පිළිබඳ ජාත්‍යන්තර මධ්‍යස්ථානය(CIMH), මෙල්බනර්ඊ විශ්වවිද්‍යාලය, මෙල්බනර්ඊ, ඔස්ට්‍රේලියාව
මහාචාර්ය රිචඩ් නිව්ටන්, මෙල්බනර්ඊ, ඔස්ට්‍රේලියාව
වෛද්‍ය ප්‍රියන්ජලි ද සොයිසා, මනෝ වෛද්‍ය දෙපාතර්මේන්තුව, වෛද්‍ය පීඨය, කොළඹ විශ්වවිද්‍යාලය, ශ්‍රී ලංකාව

1. හැදින්වීම

"විශාදය සුවකිරීම සඳහා ශ්‍රී ලංකාවේ සංස්කෘතියට ගැලපෙන මනෝ චිකිත්සක ක්‍රම හඳුන්වා දීම" ලෙස හැදින්වෙන මෙම සමීක්ෂණය සඳහා ඔබගේ සහභාගිත්වය අපි බලාපොරොත්තු වෙමු. මක්නිසාද යත් ඔබ දැනට විෂාදය සඳහා ප්‍රතිකාර ලබා ගන්නා අයෙක් හෝ එවැනි රෝගියෙක් රැකබලා ගන්නා අයෙක් බැවිනි.

මෙම සමීක්ෂණයේ අරමුණ වන්නේ ශ්‍රී ලංකාව තුල විෂාදය සඳහා ප්‍රතිකාර වශයෙන් භාවිතා වන මනෝ චිකිත්සක ක්‍රම හෙවත් "ඖෂධ වලින් තොර ප්‍රතිකාර" සම්බන්ධයෙන්, විෂාදයෙන් පෙලෙන, එවැනි රෝගීන් රැකබලා ගන්නා සහ ඔවුන්ට ප්‍රතිකාර කරන ඔබ වැනි අයගේ අදහස්, සහ අත්දැකීම් පිළිබඳව තොරතුරු එක්රැස් කිරීමයි. මෙහිදී එම මනෝ චිකිත්සක ක්‍රම ශ්‍රී ලංකාවේ සංස්කෘතියට කෙසේ අනුකූල වන්නේ දැයි පිළිබඳව ඔබගේ ආකල්ප, අදහස් සහ සම්ප්‍රදායික විශ්වාසයන් පිළිබඳව සවිස්තරාත්මකව කරුණු විමසනු ඇත.

ශ්‍රී ලංකාව තුල තරමක සුලභ රෝගයක් ලෙස විෂාදය හැදින්විය හැකි අතර මනෝ චිකිත්සාව ඒ සඳහා ඉතා වටිනා ප්‍රතිකාර ක්‍රමයකි. නමුත් බොහෝ මනෝ චිකිත්සක ක්‍රම ගොඩනගා ඇත්තේ බටහිර රට වල වන අතර ඒවා වෙනත් රටවලදී භාවිත කිරීමට පෙර ඒ ඒ රටවල සංස්කෘතික ප්‍රවණතා අනුව ඒවාට යම් යම් වෙනස්කම් කිරීම වඩා ඵලදායි බව පෙනී ගොස් ඇත.
මෙම විස්තර පත්‍රිකාව සහ සමීක්ෂණයට කැමැත්ත ප්‍රකාශ කිරීමේ පත්‍රිකාව ඔබට සමීක්ෂණය පිළිබඳව වැඩිදුර තොරතුරු සපයනවා ඇත.
මෙම විස්තර ඉතා අවධානයෙන් කියවන්න. ඔබට තේරුම් ගැනීමට අපහසු හෝ තවදුරටත් විස්තර අවශ්‍ය නැනක් වෙතොත් ඔබ වෙත එන සමීක්ෂණ නිලධාරියාගෙන් ප්‍රශ්න කරන්න. ඔබ මෙම සමීක්ෂණයට සහභාගි වන බවට කැමැත්ත ප්‍රකාශ කිරීමට පෙර මේ පිළිබඳව ඔබගේ ඥාතියෙක්ගෙන්, හිතවතෙක්ගෙන් හෝ ඔබට ප්‍රතිකාර කරන වෛද්‍යවරයාගෙන් විමසීමට අවශ්‍ය නම් ඒ සඳහා ඔබට පූර්ණ නිදහස ඇත.

ඔබ මෙම සමීක්ෂණයට සහභාගී වන්නේ ස්ව කැමැත්තෙන් පමණක් වන අතර මෙයට සහභාගි නොවී සිටීමට ඔබට පූර්ණ නිදහස ඇත. මෙයට සහභාගී වීම හෝ නොවීම මත ඔබට රෝහලෙන් සහ සායන වලින් සැපයෙන සේවාවන්ගේ හා ප්‍රතිකාර වල කිසිදු වෙනසක් සිදු නොවන බව කරුණාවෙන් සලකන්න.
ඔබ මෙයට සහභාගි වීමට කැමැති නම් පහත ඇති කැමැත්ත ප්‍රකාශ කිරීමේ පත්‍රිකාව අත්සන් කළ යුතුය. එසේ අත්සන් කිරීමෙන් ඔබ

-මෙම පත්‍රිකාව හොඳින් කියවූ බවත්

-සමීක්ෂණයට ස්ව කැමැත්තෙන් සහභාගී වන බවත්

-සමීක්ෂණයේ රැඳී සිටීමට කැමති බවත්

-ඔබෙන් ලබාගන්නා ඔබෙගේ සෞඛ්‍ය තොරතුරු සමීක්ෂණ කණ්ඩායමට භාවිත කිරීමට ඉඩ දෙන බවත්

හැඟවේ.

2. මෙම සමීක්ෂණයේ අරමුණ කුමක්ද?

මෙහි පළමු අදියරේ අරමුණ වන්නේ විෂාදයෙන් පෙලෙන අය සහ ඔවුන් රැකබලා ගන්නන් අතර විෂාදය රෝගය පිළිබඳව, එම රෝගයේ මූලාරම්භය පිළිබඳව සහ මනෝ චිකිත්සක ක්‍රම වලින් එයට ප්‍රතිකාර කිරීම ගැන ඔවුන් දරන මතවාද, අදහස් සහ ආකල්ප පිළිබඳව අථර්වත් අවබෝධයක් ලබා ගැනීමයි. ශ්‍රී ලංකාව තුලදී විෂාදය සඳහා ප්‍රතිකාර ලෙස මනෝ චිකිත්සක ක්‍රම වලට යොමු වීමේදී සහ ඒවාට ප්‍රතිචාර දැක්වීමේදී ඒ සඳහා සංස්කෘතිකමය සාරධර්ම, විශ්වාසයන් සහ ආකල්ප වල ඇති බලපෑම ගැනද මෙම සමීක්ෂණයෙන් අවධානය යොමු කෙරේ.
විෂාදයට ප්‍රතිකාර ලෙස ඔබට ලැබුණු විවිධ ප්‍රතිකාර ක්‍රම ගැන අපි ඔබගෙන් ප්‍රශ්න කීපයක් අසන්නෙමු. ඒ අතර මනෝ චිකිත්සක ක්‍රම වලට ඔබගේ ඇති යොමු වීම සහ ඒවා කෙසේ ක්‍රියාත්මක කිරීම උචිතද යන්න පිළිබඳවද අපි ඔබගේ අදහස් බලාපොරොත්තු වන්නෙමු. ඔබ ලබා දෙන විස්තර දැනට විෂාදය සඳහා ලබා දෙන ප්‍රතිකාර ක්‍රම සහ අනාගතයේ ගොඩනැංවීමට බලපොරොත්තු වන ප්‍රතිකාර ක්‍රම වඩා සාථර්ක කර ගැනීමට උදව් වේ.
මෙම සමීක්ෂණයට රෝගීන් සහ ඔවුන් රැකබලා ගන්නන් විසි දෙනෙකු සහභාගී කර ගැනීමට බලාපොරොත්තුවේ. සමීක්ෂණය රාගම, උතුරු කොළඹ ශික්ෂණ රෝහලේදී සහ එහි සායන වලදී සිදු කරනු ලැබේ.
මෙම සමීක්ෂණය ප්‍රධාන සමීක්ෂක (වෛද්‍ය ආසිරි රුද්‍රිගු) ගේ ආචාර්ය උපාධිය (ඔස්ට්‍රේලියාවේ මෙල්බර්න් විශ්වවිද්‍යාලය මගින් පිරිනමනු ලබන) සඳහා වන උපාධි පරීක්ෂණයේද කොටසක් වනු ඇත. එම උපාධි පරීක්ෂන්යේද අරමුණ ශ්‍රී ලංකාවේ සංස්කෘතිකාංග වලට ගැලපෙන වඩා හොඳ මනෝ චිකිත්සා ක්‍රමයක් ගොඩනැංවීමයි.

බටහිර රටවල බහුලව භාවිත කරන ප්‍රජානන චර්යාත්මක චිකිත්සාව (cognitive behavior therapy) හෙවත් චර්යාත්මක ක්‍රම වලින් මානසික රෝග සුව කිරීමේ ක්‍රම ශ්‍රී ලංකාවට හඳුන්වා දීමේදී ඒවාට මොනයම් ආකාරයේ වෙනස්කම් සිදු කල යුතුද යන්න පිළිබඳවද ඉතා වැදගත් තොරතුරු මෙම සමීක්ෂණයෙන් සොයාගැනීමට බලාපොරොත්තුවේ.

සමීක්ෂණයේ මෙම පළමු අදියර සහ උපාධි පරීක්ෂණය සඳහා කිසිදු රාජ්‍ය හෝ රාජ්‍ය නොවන සංවිධානයකින් මුල්‍යමය ආධාර ලබා දෙනු නොලැබේ. මෙම සමීක්ෂණය සඳහා ඔබ ලබා දෙන සහභාගිත්වය නිසා සමීක්ෂණ කණ්ඩායමේ කිසිවකුට මුල්‍යමය හෝ වෙනත් ප්‍රතිපාදන මඟින් ලාබ ප්‍රයෝජන අත්නොවේ. නමුත් මෙම සමීක්ෂණයේ දෙවන කොටස වන අහඹු සායනික පරීක්ෂණය (Randomized clinical trial) සඳහා වන වියදම් සඳහා වෛද්‍ය රොද්‍රිගු විසින් යම් මුල්‍ය ප්‍රතිපාදන ලබා ගැනීමට ඉඩ ඇත.

3. මෙම සමීක්ෂණ ව්‍යාපෘතියට සහභාගී වනවා යනු කුමක්ද?

ඔබ මෙම සමීක්ෂණයට සහභාගී වීමට කැමති නම් පළමුව ඒ සඳහා වන කැමැත්ත ප්‍රකාශ කිරීමේ පත්‍රිකාව අත්සන් කලයුතු වේ. පසුව ඔබගෙන් තනිව හෝ කණ්ඩායම් වශයෙන් කෙරෙන සාකච්ඡා මාගර්යෙන් ප්‍රශ්න කීපයක් අසනු ඇත. එම සාකච්ඡා රාගම ශික්ෂණ රෝහලේ හෝ අනුබද්ධ සායන වලදී සිදු කරනු ලැබේ.සාකච්ඡාව සඳහා මිනිත්තු 15-20ක කාලයක් ගතවනු ඇත. ප්‍රධාන සමීක්ෂක හෝ වෙනත් සුදුසුකම් ලත් වෛද්‍යවරයෙක් විසින් සාකච්ඡාව මෙහෙයවනු ලබයි. මෙහිදී ඔබට ප්‍රශ්න පත්‍රයකට පිළිතුරු ලිවීමට සිදු නොවේ. සමීක්ෂක විසින් අසනු ලබන ප්‍රශ්න වලට ඔබ ලබා දෙන පිළිතුරු හඬ පටයක් මඟින් පටිගත කරනු ඇත. ඔබගේ පෞද්ගලික වෛද්‍ය ලිපිගොනු වලට පිවිසීමට අප බලපොරොත්තු නොවේ. මෙම සහභාගිත්වය වෙනුවෙන් ඔබට මුල්‍යමය හෝ වෙනත් දීමනාවක් ලබා දෙනු නොලැබේ.

4. සමීක්ෂණයට සහභාගී වීමෙන් ලැබෙන ප්‍රතිලාභ මොනවාද?

මෙමගින් ඔබට සෘජු ප්‍රතිලාභයක් ලැබෙන බවට සහතික විය නොහැක. නමුත් මෙම සමීක්ෂණය මඟින් විෂාදය සඳහා අනාගතයේ යෙදවීමට බලාපොරොත්තු වන ප්‍රතිකාර, විශේෂයෙන් මනෝ චිකිත්සක ප්‍රතිකාර වල වැඩිදියුණුව සඳහා තොරතුරු ලැබෙන බැවින් වක්‍ර ලෙස ඔබට ප්‍රතිලාභ අත් විය හැක. සමීක්ෂණයට අදාළ සාකච්ඡාවෙන් පසු විෂාදය පිළිබඳව හෝ එහි ප්‍රතිකාර ගැන වැඩිදුර තොරතුරු දැන ගැනීමට ඔබට අවශ්‍ය නම් ඒවා ලබා දීමට අපි ඉතා සතුටින් ඉදිරිපත් වන්නෙමු.

<u>5. මෙහිදී මුහුණ දීමට සිදුවිය හැකි අවදානම් තත්ත්ව මොනවාද?</u>

මෙම සමීක්ෂණයට සහභාගී වීම මඟින් ඔබට කිසිදු අවදානම් තත්වයකට මුහුණ දීමට සිදු වනු ඇතැයි අපි අපේක්ෂා නොකරමු. යම් කිසි ප්‍රශ්නයකට පිළිතුරු දීමට අපහසු නම් හෝ පිළිතුරු දීමට ඔබ අකමැතිනම් එම ප්‍රශ්නය මඟ හැර ඊලඟ ප්‍රශ්නයට යන ලෙස ඔබට ඉල්ලා සිටිය හැකිය. එසේම ඔබ කැමති ඕනෑම අවස්ථාවක සාකච්ඡාව නවත්වන ලෙස සමීක්ෂකගෙන් ඉල්ලා සිටීමට ඔබට පූර්ණ අයිතිය ඇත.

<u>6. මම අනිවාර්යෙන්ම මෙම සමීක්ෂණයට සහභාගී විය යුතුද?</u>

මෙයට සහභාගී වීම ස්ව කැමැත්තෙන් පමණක් සිදුවන්නකි. ඔබ සහභාගී වීමට අකමැති නම් සහභාගී නොවී සිටිය හැක. මුලින් ඔබ සහභාගී වීමට කැමැත්ත ප්‍රකාශ කර පසුව එම අදහස වෙනස් වුයේ නම් ඔබ කැමති ඕනෑම අවස්ථාවක සමීක්ෂණයෙන් ඉවත් වීමට ඔබට නිදහස ඇත. එසේ ඔබ පසුව ඉවත් වීමට තීරණය කලේ නම් ඒ දක්වා ඔබ ලබා දුන් තොරතුරු සමීක්ෂක කණ්ඩායම සතුව තබා ගැනීම පසුව සිදු කරන ප්‍රතිපල ඇගයීම් වලට පහසුවක් වෙයි. නමුත් එසේ තබා ගැනීමට ඔබ විරුද්ධ නම් සමීක්ෂණයෙන් ඉවත් වීමට ප්‍රථම ඒ බව සමීක්ෂකවරයාට දන්වන්න.

ඔබ ස්ව කැමැත්තෙන් සහභාගී වූ බවට ඔබ අත්සන් කල කැමැත්ත ප්‍රකාශ කිරීමේ පත්‍රිකාවේ පිටපතක් ඔබට අවශ්‍ය නම් ලබා දිය හැකිය.

සමීක්ෂණය සම්පූර්ණ කල පසු ඔබ ලබා දුන් පිළිතුරු හා තොරතුරු ඉවත් කිරීමේ හැකියාවක් නොමැත. මන්ද යත් එක් එක් අය සඳහා හඳුනාගැනීමේ තොරතුරු අප ලබා නොගන්නා බැවිනි. සමීක්ෂණයට සහභාගී වීම, නොවීම, හෝ අතරමඟ හැරයාම නිසා රෝහලෙන් හෝ වෛද්‍යවරුන්ගෙන් ඔබට ලැබෙන ප්‍රතිකාර වල හෝ ඔබව රැකබලා ගන්නා අයගෙන් ලැබෙන උදව් වල කිසිදු වෙනසක් සිදු නොවන බව කරුණාවෙන් සලකන්න.

<u>7. මෙම සමීක්ෂණ ව්‍යාපෘතියේ අවසන් ප්‍රතිපල මා දැනගන්නේ කෙසේද?</u>

මෙම සමීක්ෂණයේ අවසන් ප්‍රතිපල ඔබට තැපැල් මඟින් ලබාදීමේ හැකියාවක් ඇත. නමුත් එය සිදුවන්නේ ඔබගේ කැමැත්ත මත හා ඔබගේ පෞද්ගලික ලිපිනය අපට ලබා දීමට කැමති නම් පමණි. අවසන් ප්‍රතිපල දැනගැනීමේ හෝ නොදැනගැනීමේ අයිතිය ඔබ සතු වේ.

<u>8. මා පිළිබඳව ලබා ගත් තොරතුරු වලට කුමක් වේද?</u>

ඔබගේ නම සහ ලිපිනය ලබා ගැනීම ඔබගේ කැමැත්ත මත පමණක් සිදුවේ. ලිපිනය ලබා ගනුයේ මෙහි අවසන් ප්‍රතිපල ඔබට දැනගැනීමට අවශ්‍ය නම් පමණි. එසේ දැනගැනීමට අනවශ්‍ය නම් ඔබගේ නම, ලිපිනය ලබා දීම අවශ්‍ය නැත.

ඔබ එසේ නම, ලිපිනය ලබා දුන්නත් එම තොරතුරු ඔබ සමඟ කල සාකච්ඡාවේ තොරතුරු සමඟ සම්බන්ධ කර සුරක්ෂිත කරන්නේ නැත. එනිසා සාකච්ඡාවේදී ලබාගත් තොරතුරු සම්පූර්ණයෙන්ම නිනර්ාමිකව පවතී. ඔබගේ නම, ලිපිනය වෙනයම් කටයුත්තක් සඳහා භාවිත කරනු නොලැබේ.

සාකච්ඡාවේදී පටිගත කල ඔබගේ හඬ පටයේ අඩංගු තොරතුරු පරිගණක ගත දත්ත ගොනුවකට ඇතුලත් කල වහාම අදාල හඬ පටය මකා දමනු ලැබේ. සාමාන්‍යයෙන් සතියකට වරක් පමණ මෙම මකා දැමීම් සිදු කරන අතර ඊට පෙර ඒවා ඉතා ආරක්ෂිතව ගබඩා කර තබනු ලැබේ. මෙම සමීක්ෂණයට අදාළ අනික් සියලුම තොරතුරු, සමීක්ෂණ කණ්ඩායමට පමණක් පිවිසිය හැකි ලෙස සැකසූ ආරක්ෂිත පරිගණක තුල සාමාන්‍යයෙන් වසර හතක පමණ කාලයක් තබාගනු ඇත. පසුව ඒවා ඉතා ආරක්ෂාකාරී ක්‍රමවේදයකට අනුව මකා දමනු ලැබේ.

යම් දිනක මෙම සමීක්ෂණයේ සමස්ත ප්‍රතිපලය ශ්‍රී ලංකාවේ හෝ ලෝකයේ පිළිගත් වෛද්‍ය සඟරාවක පළකිරීම හෝ ප්‍රසිද්ධ වෛද්‍යමය සැසිවාරයකදී ඉදිරිපත් කිරීම සිදුවිය හැකි අතර එහිදී ඔබගේ පෞද්ගලික තොරතුරු අනාවරනය කරනු නොලැබේ.

<u>9. මා විසින් සමීක්ෂණය සඳහා ලබා දෙන ලද තොරතුරු නැවත මා හට පරිශීලනය කළ හැකිද?</u>

ඔබට එම තොරතුරු කිසිවක් නැවත ලබා ගත නොහැක.මන්දයත් අප විසින් ඔබගෙන් තොරතුරු ලබා ගැනීමේදී ඔබේ පුද්ගලික අනන්‍යතාවය සටහන් කර නොගන්නා බැවිනි.

10. මෙම සමීක්ෂණව්‍යාපෘතිය සඳහා අනුමැතිය ලැබී තිබේද?

මෙම ව්‍යාපෘතියේ ආචාර ධර්ම පිළිබඳ අනුමැතිය ඕස්ට්‍රේලියාවේ මෙල්බර්ඊ විශ්ව විද්‍යාලයේ සමීක්ෂණආචාර ධර්ම හා සම්පූර්ණත්වය පිළිබඳ ආයතනයෙන් හා ශ්‍රී ලංකාවේ කැළණිය විශ්ව විද්‍යාලයේ උතුරු කොළඹ ශික්ෂණ රෝහලේ ආචාර ධර්ම කමිටුව විසින් ලබා දී ඇත.මෙම සමීක්ෂණයසිදුකරගෙන යනු ලබන්නේ ඕස්ට්‍රේලියාවේ ජාතික සෞඛ්‍ය හා වෛද්‍ය පර්යේෂණආයතනයේ (National Statement on Ethical Conduct in Human Research 2007) ප්‍රඥප්තියට අනුකූලවය. මෙම ප්‍රඥප්තිය ගොඩනඟා ඇත්තේ මානව අධ්‍යයනයන් සඳහා සහභාගී වන පුද්ගලයන්ගේ ආරක්ෂාව සඳහා ය.ජාතික සෞඛ්‍යවෛද්‍ය හා පර්යේෂණකවුන්සිලයේ ප්‍රතිපත්ති වලට අනුකූලව පර්යේෂණ ආචාර ධර්ම කමිටුව විසින් කලින් කලට ව්‍යාපෘතිය වලට අදාළ විගණනයන් සිදු කරනු ලබයි.එනිසා ඔබවිසින් අත්සන් කරන ලද සහභාගී වීමේ කැමැත්ත ප්‍රකාශ කරනු ලබන ලිපියේ පිටපතක් මානව සමීක්ෂණආචාර ධර්ම කමිටුව මඟින් ඉල්ලා සිටීමටද පුලුවන.

11.මා හට ඇති ප්‍රශ්ණ පිළිබඳ විමසිය යුත්තේ කාගෙන්ද?

එය ඔබට ඇති ප්‍රශ්ණයේ ස්වභාවය මත වෙනස් වේ.ඒ සඳහා පහත විස්තර අනුව ක්‍රියා කරන්න.

වැඩි විස්තර සඳහා

ඔබට මෙම ව්‍යාපෘතියසම්බන්ධයෙන් වැඩිදුර තොරතුරු දැන ගැනීමට අවශ්‍ය නම් හෝ මෙයට අදාළ වෙනත් ගැටළු තිබෙනම් ප්‍රධාන සමීක්ෂක වෛද්‍යආසිරි රොඩ්‍රිගු හෝ පහත ඕනෑම සමීක්ෂණනිලධාරියෙක් සමඟ සම්බන්ධ විය හැකිය.

නම	තනතුර	සම්බන්ධ කර ගැනීමේ විස්තර
වෛද්‍යආසිරි රොඩ්‍රිගු	ප්‍රධාන සමීක්ෂක	asirir2000@yahoo.com +94-11-2958039
මහාචාර්ය හැරී මිනාස්	අධීක්ෂක/ සහකාර සමීක්ෂක	h.minas@unimelb.edu.au +61383440908
වෛද්‍යරිට්සුකෝ කකුමා	අධීක්ෂක/ සහකාර සමීක්ෂක	rkakuma@unimelb.edu.au +61383440908
මහාචාර්රිචඩ් නිව්ටන්	අධීක්ෂක/ සහකාර සමීක්ෂක	Richard.Newton@austin.org.au +61394966496
වෛද්‍යපියන්ජලී ද සොයිසා	අධීක්ෂක/ සහකාර සමීක්ෂක	ptdz@sltnet.lk +94112691688

පැමිණිලි සඳහා

ඔබට මෙම ව්‍යාපෘතිය සම්බන්ධයෙන්යම්කිසි පැමිණිල්ලක් ඇතොත් පහත සඳහන් පුද්ගලයන් වෙත ඒ බව දැනුම් දිය හැකිය.

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Secretary
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Appendix 6 Participant Information (Plain Language Statement) and Consent Form for health professionals

Participant Information (Plain Language Statement) and Consent Form – psychiatrist, psychiatry advanced trainees, psychiatry medical officers and psychologist, final year psychology students

Full Project Title:
Culturally relevant psychotherapies for depression in Sri Lanka (Phase 1)

Short Title:

Culturally relevant psychotherapies for depression in Sri Lanka

Principal Researcher:
Dr Asiri Rodrigo
Department of Psychiatry, Faculty of Medicine, University of Kelaniya, Ragama, Sri Lanka
Centre for International Mental Health (CIMH) University of Melbourne, Melbourne Australia

Supervisors / Associate Researchers:

A/Prof Harry Minas, CIMH, University of Melbourne, Melbourne, Australia

Dr Ritsuko Kakuma, CIMH, University of Melbourne, Melbourne, Australia

A/Prof Richard Newton, Austin Health, Melbourne, Australia

Dr Piyanjali de Zoysa, Department of Psychological Medicine, University of Colombo, Sri Lanka

1. Introduction

You are invited to take part in this research project, which is called 'Culturally Relevant Psychotherapy for Depression in Sri Lanka- Phase 1'. You have been invited to participate because you are providing treatment for people with depression.

This research project aims to gather information on the views and experiences of those having depression, caring for someone with depression or treating them for it, regarding the use of psychotherapy for depression in Sri Lanka. The cultural values, beliefs and attitudes towards use of psychotherapy will be explored in detail. Depression is a common mental illness in Sri Lanka and psychotherapy or counselling is known to be a valuable treatment for depression. Psychotherapy (colloquially known as talking therapy) is a form of treatment for mental and emotional disorders that uses psychological techniques designed to achieve relief of symptoms and changes in behaviour and hence improved social and vocational functioning and personal growth by encouraging communication of conflicts and insight into problems. A psychotherapist is trained to assist the patient in understanding and tackling his/her mental health and emotional problems. Counselling is

psychosocial support provided by an individual who does not have a mental health background or formal degree in counselling. Psychotherapies were developed in Western countries and these may need modification to be suitable for different cultures.

This Participant Information and Consent Form tell you about the research project. It explains what is involved to help you decide if you wish to take part.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with your supervisor (if any).

Participation in this research is voluntary. If you don't wish to take part, you don't have to. Your decision will not be appraised negatively.

If you decide you want to take part in the research project, you will be asked to sign a consent form. By signing it you are telling us that you:

- Understand what you have read
- Consent to take part in the research project
- Consent to be involved in the research described

2. What is the purpose of this research project?

There are different varieties of psychotherapy used in depression and Cognitive Behavioural Therapy (CBT) is the most widely used psychotherapy. At the heart of CBT is an assumption that a person's mood is directly related to his or her patterns of thought. Negative, dysfunctional thinking affects a person's mood, sense of self, behaviour, and even physical state. The goal of cognitive behavioural therapy is to help a person learn to recognize negative patterns of thought, evaluate their validity, and replace them with healthier ways of thinking.

The aim of this particular Phase (1) of the research project is to gain meaningful understanding about your experiences and attitudes towards providing therapy, especially CBT, to depressed patients. In particular, issues around necessary cultural modification, barriers to therapy, helpful and unhelpful techniques, and factors that influence outcome of therapy will be explored.

We will be asking about the treatment you have offered for depression and your opinion and preference regarding how psychotherapeutic treatment could be conducted. The details you provide will be extremely helpful to us in developing a culturally sensitive cognitive behavioural therapy.

Twelve to twenty mental health clinicians who are offering treatment for depression will be participating in this study along with twelve of patients/ carers and five to eight traditional healers / lay counsellors. Acknowledging the work commitment of participants, interviews would be conducted at a time and place convenient for you.

This study will form part of the principal researcher's (Dr Asiri Rodrigo) research degree – PhD from University of Melbourne, Australia. The objective of the research degree is to design a culturally relevant psychotherapy for depression in Sri Lanka. This Phase of the study would provide valuable information on what mental health clinicians in Sri Lanka think would be suitable cultural adaptations to cognitive behavioural therapy.

This phase of the study and the research degree are not being funded by any grant at present and Dr. Rodrigo is not receiving any commercial sponsorship. No member of the research team will receive a personal financial benefit from your involvement in this research project.

3. What does participation in this research project involve?

If you are happy to participate in this study you will first need to sign the consent form.

Participation involves individual discussion at a convenient time and place for you. It will take 15-45 minutes to complete. The principal researcher or another clinician will facilitate the discussion. The answers you provide to the questions posed by the researcher will be recorded on a tape-recorder.

Once the CBT manual is modified those of you who are providing CBT would be invited again to comment on the modified CBT manual. You may however opt to take part in the first interview only.

No payments or incentive will be given for participation.

4. What are the possible benefits?

We cannot guarantee or promise that you personally will receive any benefits from this research; however, possible benefits may include this study leading to a more culturally appropriate and sensitive psychotherapeutic treatment for depression in Sri Lanka.

5. What are the possible risks?

We do not anticipate you to face any risks by participating in this survey.
You can decline to answer and request the person conducting the discussion to move onto the next topic or even end the discussion at that point.

6. Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any point. You may decide to take part in the first discussion but can refuse to be re-interviewed when the modified CBT manual is complete.

If you decide to leave the project, the researchers would like to keep the information you have provided up to that point. This is to help them make sure that the results of the research can be measured properly. If you do not want them to do this, you must tell them before you withdraw from the research project.

It will not be possible to withdraw the answers you have provided during the discussion once it is completed as no identifying data is collected along with the answers you have provided during the discussion.

Your decision whether to take part or not, or to take part and then withdraw will not affect relationship with the researchers and other health professionals.

7. How will I be informed of the final results of this research project?

Once the proposed changes to the existing CBT manual are drafted, your input would be sought for further refinement. You will be informed of the overall final results of the study by way of a flyer posted to your address.

8. What will happen to information about me?

Providing your name and contact details is entirely optional. Even if you do provide these details they would not be recorded anywhere along with the answers you provided to the questions during the discussion. So, any information you provide us with during the discussion would remain completely anonymous. Although the small sample size may have some implication on the confidentiality of data, steps would be taken to protect the confidentiality as much as possible.

Your contact details will not be used for any other purpose.

The tape recordings of your answers to the questions will be erased / deleted immediately after they have been typed on to an electronic data file. This will be done on a weekly basis and the tape recordings will be stored securely until transcription. All data related to this study will be stored in locked cabinets and password protected electronic documents accessible only to the researchers for a period of 7 years after which they will be confidentially shredded and deleted respectively. The data we collect for this research project does not involve the establishment of a databank.

Publication of the findings of this study in a medical journal and/or conference presentation, will involve the information being presented as overall information provided by all participants. No individual identifying data will be publicised.

9. Can I access research information kept about me?

You would not be able to access any information you have provided as answers to the questions during the interview as we would not be collecting any identifying data during the discussion.

10. Is this research project approved?

This research project has been approved by the Human Research Ethics Committee, University of Melbourne, Australia and the Ethics Committee, Colombo North Teaching Hospital, University of Kelaniya, Ragama, Sri Lanka. This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)* produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.

11. Who can I contact?

The person you may need to contact will depend on the nature of your query. Therefore, please note the following:

For further information:

If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact the principal researcher, Dr Asiri Rodrigo or any of the following researchers.

Name	Dr Asiri Rodrigo	A/Prof Harry Minas	Dr Ritsuko Kakuma
Role	Principal Researcher	Supervisor / Associate Researcher	Supervisor / Associate Researcher
Contact information	asirir2000@yahoo.com +94-11-2958039	h.minas@unimelb.edu.au +61 3 8344 0908	rkakuma@unimelb.edu.au +61 3 8344 0908

Name	A/Prof Richard Newton	Dr Piyanjali de Zoysa
Role	Supervisor / Associate Researcher	Supervisor / Associate Researcher
Contact information	Richard.Newton@austin.org.au +61 3 9496 6496	ptdz@sltnet.lk +94 11 2691688

For complaints:

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

Manager, Human Research Ethics, Research Ethics and Integrity Level 1, 780 Elizabeth Street The University of Melbourne Vic. 3010 Phone: +61 3 8344 2073; Fax +61 3 9347 6739 Email: research-integrity@unimelb.edu.au	AND / OR	Secretary Scientific and Ethical Review Committee, Faculty of Medicine, University of Kelaniya, 6, Thalagolla Road, Ragama, Sri Lanka Telephone :+94 112961142 Email : ercmedfac@kln.ac.lk

CONSENT FORM

Study Title: Culturally relevant psychotherapies for depression in Sri Lanka (Phase 1)

Principal Researcher: Dr Asiri Rodrigo
Associate Researchers: A/Prof Harry Minas, Dr Ritsuko Kakuma, A/Prof Richard Newton, Dr Piyanjali de Zoysa

Please tick '√' the relevant boxes.

- ☐ I have read or have had this document read to me in a language that I understand, and I understand the purposes, procedures and risks of this research project as described within it.
- ☐ I understand that my participation is voluntary and that I am free to withdraw consent at any time
- ☐ I understand taking part in this involves participation in an interview which will be audio recorded
- ☐ I understand that there are arrangements to protect the confidentiality of data although small sample size may have some implication on this
- ☐ I have had an opportunity to ask questions and I am satisfied with the answers I have received.
- ☐ I freely agree to participate in this research project, as described.
- ☐ I understand that I will be given a signed copy of this document to keep.
- ☐ I would like to receive a flyer with final results of the study, mailed to my postal address

- ☐ **I am happy to be contacted again for a follow-up interview later on**

Participant's name (printed) ……

Signature …… Date……./……../…….

Appendix 7 English participant information patients and cares- phase 1

Participant Information (Plain Language Statement) – Patients and Carers

Full Project Title:
Culturally relevant psychotherapies for depression in Sri Lanka (Phase 1)

Short Title:

Culturally relevant psychotherapies for depression in Sri Lanka

Principal Researcher:

Dr Asiri Rodrigo
Department of Psychiatry, Faculty of Medicine, University of Kelaniya, Ragama, Sri Lanka
Centre for International Mental Health (CIMH) University of Melbourne, Melbourne Australia

Supervisors / Associate Researchers:

A/Prof Harry Minas, CIMH, University of Melbourne, Melbourne, Australia

Dr Ritsuko Kakuma, CIMH, University of Melbourne, Melbourne, Australia

A/Prof Richard Newton, Austin Health, Melbourne, Australia

Dr Piyanjali de Zoysa, Department of Psychological Medicine, University of Colombo, Sri Lanka

1. Introduction

You are invited to take part in this research project, which is called 'Culturally Relevant Psychotherapy for Depression in Sri Lanka- Phase 1'. You have been invited to participate because you are getting treatment for depression or caring for a person with depression.

Please read this information sheet carefully. It tells you about the research project and explains what participation in it would involve. This information will help you decide if you wish to take part. Ask questions about anything that you don't understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or your family doctor.

2. What is the purpose of this research project?

Depression is a common mental illness in Sri Lanka and psychotherapy or counselling is a widely used treatment option for management of depression that has been developed in other (western) countries. Psychotherapy (colloquially known as talking therapy) is a form of treatment for mental and emotional disorders that uses psychological techniques designed to achieve relief of symptoms and changes in behaviour

and hence improved social and vocational functioning and personal growth by encouraging communication of conflicts and insight into problems. A psychotherapist is trained to assist the patient in understanding and tackling his/her mental health and emotional problems. Counselling is psychosocial support provided by an individual who does not have a mental health background or formal degree in counselling.

There are different varieties of psychotherapy used in depression and Cognitive Behavioural Therapy (CBT) is the most widely used psychotherapy. At the heart of CBT is an assumption that a person's mood is directly related to his or her patterns of thought. Negative, dysfunctional thinking affects a person's mood, sense of self, behaviour, and even physical state. The goal of cognitive behavioural therapy is to help a person learn to recognize negative patterns of thought, evaluate their validity, and replace them with healthier ways of thinking.

The aim of this study is to gain understanding of the views and experiences regarding management of depression, particularly psychotherapy, from patients with depression and from carers of patients with depression in Sri Lanka. The cultural values, beliefs and attitudes towards use of psychotherapy will be explored in detail.

The information we collect will be extremely helpful in improving the treatment for depression in Sri Lanka.

This study will form part of the principal researcher's (Dr Asiri Rodrigo) research degree – PhD from University of Melbourne, Australia – which aims to address the role of psychotherapy for the treatment of depression in Sri Lanka.

This phase of the study and the research degree are not being funded by any grant at present and Dr. Rodrigo is not receiving any commercial sponsorship. No member of the research team will receive a personal financial benefit from your involvement in this research project.

3. What does participation in this research project involve?

If you are happy to participate in this study you would first need to sign the consent form.

Participation involves an individual interview at Colombo North Teaching Hospital (CNTH), Ragama. The interview will take 15-45 minutes to complete. The principal researcher will conduct the interview. The answers you provide to the questions posed by the researcher will be recorded on a tape-recorder.

We will not require access to your personal records and no payments or incentive will be given for participation.

4. What are the possible benefits?

We cannot guarantee or promise that you will receive any benefits from this research; however, possible benefits may include this study serving as an educational session regarding all treatment options that are available for depression – especially psychotherapy. After you have had the discussion we would be happy to answer any queries you may have or clarify doubts about depression and its treatment.

5. What are the possible risks?

We do not anticipate you to face any risks by participating in this survey.

If responding to any of the questions is distressing or difficult you can decline to answer and request the interviewer to move onto the next topic or even end the discussion at that point. If you become distressed, the researcher will refer you to an appropriate person of your treating team to provide support.

6. Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any point.

If you decide to leave the project, the researchers would like to keep the information you have provided up to that point. This is to help them make sure that the results of the research can be measured properly. If you do not want them to do this, you must tell them before you withdraw from the research project.

It will not be possible to withdraw the answers you have provided during the interview once it is completed as no identifying data is collected along with the answers you have provided during the interview.

Your decision whether to take part or not will not affect your care, the support we provide to you and your family, your relationship with the researchers and other health professionals in any way.

7. How will I be informed of the final results of this research project?

You will be informed of the overall final results of the study by way of a flyer posted to your address if you choose to provide us with your name and address specifically for this purpose only. You have the option of choosing to know or not know the results of this study in this manner at the time you provide consent.

8. What will happen to information about me?

Providing your name and address is entirely optional. You can choose to provide them if you wish to know about the final outcome of the research project which we will inform you about, by way of flyer posted to you at the end of the project. If you do not wish to receive this information you do not have to provide your name and address.

Even if you do provide these details they would not be recorded anywhere along with the answers you provided to the questions during the interview; it will only be on the consent form. So, any information you provide us with during the interview would remain completely anonymous. Although the small sample size may have some implication on the confidentiality of data, steps would be taken to protect the confidentiality as much as possible.

All data related to this study will be stored in locked cabinets and password protected electronic documents accessible only to the researchers for a period of 7 years after which they will be confidentially shredded and deleted respectively. The data we collect for this research project does not involve the establishment of a databank.

Publication of the findings of this study in a medical journal and/or conference presentation, will involve the information being presented as aggregated information provided by all participants. No individual identifying data will be published.

9. Can I access research information kept about me?

You will not be able to access any information you have provided as answers to the questions during the interview as we would not be collecting any identifying data during the discussion. We would therefore not be able to determine which set of responses is yours once the data is collected.

10. Is this research project approved?

This research project has been approved by the Human Research Ethics Committee, University of Melbourne, Australia and the Ethics Committee, Colombo North Teaching Hospital, University of Kelaniya, Ragama, Sri Lanka. This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)* produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.

11. Who can I contact?

The person you may need to contact will depend on the nature of your query. Therefore, please note the following:

For further information:

If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project (for example, feelings of distress), you can contact the principal researcher, Dr Asiri Rodrigo or any of the following researchers.

Name	Dr Asiri Rodrigo	A/Prof Harry Minas	Dr Ritsuko Kakuma
Role	Principal Researcher	Supervisor / ...iate Researcher	Supervisor / Associate Researcher
Contact information	asirir2000@yahoo.com +94-11-2958039	.....as@unimelb.edu.au +61 3 8344 0908	rkakuma@unimelb.edu.au +61 3 8344 0564

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Name	A/Prof Richard Newton	Dr Piyanjali de Zoysa
Role	Supervisor / Associate Researcher	Supervisor / Associate Researcher
Contact information	Richard.Newton@austin.org.au +61 3 9496 6496	ptdz@sltnet.lk +94 11 2691688

For complaints:

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

Manager, Human Research Ethics,
Research Ethics and Integrity
Level 1, 780 Elizabeth Street
The University of Melbourne Vic. 3010
Phone: +61 3 8344 2073;
Fax +61 3 9347 6739
Email: research-integrity@unimelb.edu.au

AND / OR

Secretary
Scientific and Ethical Review Committee,
Faculty of Medicine,
University of Kelaniya,
6, Thalagolla Road,
Ragama, Sri Lanka

Telephone :+94 112961142

Email : ercmedfac@kln.ac.lk

CONSENT FORM

Study Title: Culturally relevant psychotherapies for depression in Sri Lanka (Phase 1)

Principal Researcher: Dr Asiri Rodrigo
Associate Researchers: A/Prof Harry Minas, Dr Ritsuko Kakuma, A/Prof Richard Newton, Dr Piyanjali de Zoysa

Please tick '√' the relevant boxes.

- ☐ I have read or have had this document read to me in a language that I understand, and I understand the purposes, procedures and risks of this research project as described within it.
- ☐ I understand that my participation is voluntary and that I am free to withdraw consent at any time
- ☐ I understand taking part in this involves participation in an interview which will be audio recorded
- ☐ I understand that there are arrangements to protect the confidentiality of data although small sample size may have some implication on this
- ☐ I have had an opportunity to ask questions and I am satisfied with the answers I have received.
- ☐ I freely agree to participate in this research project, as described.
- ☐ I understand that I will be given a signed copy of this document to keep.
- ☐ I would like to receive a flyer with final results of the study, mailed to my postal address

Participant's name (printed) ……

Signature …… Date……./……../…….

Appendix 8 participant information traditional healers phase 1

Participant Information (Plain Language Statement) and Consent Form – traditional healers and lay counsellors

Full Project Title:

Culturally relevant psychotherapies for depression in Sri Lanka (Phase 1)

Short Title:

Culturally relevant psychotherapies for depression in Sri Lanka

Principal Researcher:

Dr Asiri Rodrigo
Department of Psychiatry, Faculty of Medicine, University of Kelaniya, Ragama, Sri Lanka
Centre for International Mental Health (CIMH) University of Melbourne, Melbourne Australia

Supervisors / Associate Researchers:

A/Prof Harry Minas, CIMH, University of Melbourne, Melbourne, Australia

Dr Ritsuko Kakuma, CIMH, University of Melbourne, Melbourne, Australia

A/Prof Richard Newton, Austin Health, Melbourne, Australia

Dr Piyanjali de Zoysa, Department of Psychological Medicine, University of Colombo, Sri Lanka

1. Introduction

You are invited to take part in this research project, which is called 'Culturally Relevant Psychotherapy for Depression in Sri Lanka- Phase 1'. You have been invited to participate because you are providing care for people with mental health issues.

Depression is a common mental illness in Sri Lanka and psychotherapy or counselling is known to be a valuable treatment for depression. Psychotherapy (colloquially known as talking therapy) is a form of treatment for mental and emotional disorders that uses psychological techniques designed to achieve relief of symptoms and changes in behaviour and hence improved social and vocational functioning and personal growth by encouraging communication of conflicts and insight into problems. A psychotherapist is trained to assist the patient in understanding and tackling his/her mental health and emotional problems. Counselling is psychosocial support provided by an individual who does not have a mental health background or formal degree in counselling. Psychotherapies were developed in Western countries and these may need modification to be suitable for different cultures. This research project aims to gather information on the views and experiences of those having depression, caring for someone with depression or treating them for it, regarding the use of psychotherapy or counseling. .

The cultural values, beliefs and attitudes towards use of psychotherapy will be explored in detail. Depression is a common mental illness in Sri Lanka and psychotherapy is known to be a valuable treatment for depression.

This Participant Information and Consent Form tell you about the research project. It explains what is involved to help you decide if you wish to take part.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with your supervisor (if any).

Participation in this research is voluntary. If you don't wish to take part, you don't have to. Your decision will not be appraised negatively.

If you decide you want to take part in the research project, you will be asked to sign a consent form. By signing it you are telling us that you:

- Understand what you have read
- Consent to take part in the research project
- Consent to be involved in the research described

2. What is the purpose of this research project?

The aim of this particular Phase (1) of the research project is to gain meaningful understanding about your experiences in providing treatment to patients with psychiatric symptoms, depressive symptoms in particular, helpful and unhelpful techniques, and factors that influence outcome of therapy.

We would be asking about your attitudes towards western psychotherapeutic treatment. The details you provide would be extremely helpful to us in developing a culturally sensitive talking treatment therapy.

Five to eight traditional healers / lay counsellors will be participating in this study along with twelve mental health clinicians who are offering treatment for depression and twelve of patients/ carers. Acknowledging your other commitments, interviews would be conducted at a time and place convenient for you.

This study will form part of the principal researcher's (Dr. Asiri Rodrigo) research degree – PhD from University of Melbourne, Australia. The objective of the research degree is to design a culturally relevant psychotherapy for depression in Sri Lanka. This Phase of the study would provide valuable information on what mental health clinicians in Sri Lanka think would be suitable cultural adaptations to cognitive behavioural therapy.

This phase of study and the research degree are not being funded by any grant at present and Dr. Rodrigo is not receiving any commercial sponsorship. No member of the research team will receive a personal financial benefit from your involvement in this research project. Dr. Rodrigo will be applying for a research grant in the future to cover the costs of the second phase of the study which would involve a randomized controlled trial.

3. What does participation in this research project involve?

If you are happy to participate in this study you would first need to sign the consent form before any study involvement.

Participation involves individual discussion at a convenient time and place for you. It will take 15-45 minutes to complete. The principal researcher or another clinician will facilitate the discussion. The answers you provide to the questions posed by the researcher will be recorded on a tape-recorder.

No payments or incentive will be given for participation.

5. What are the possible benefits?

We cannot guarantee or promise that you personally will receive any benefits from this research; however, possible benefits may include this study leading to a more culturally appropriate and sensitive psychotherapeutic treatment for depression in Sri Lanka.

5. What are the possible risks?

We do not anticipate you to face any risks by participating in this survey.
You can decline to answer and request the person conducting the discussion to move onto the next topic or even end the discussion at that point.

6. Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any point.

If you decide to leave the project, the researchers would like to keep the information you have provided up to that point. This is to help them make sure that the results of the research can be measured properly. If you do not want them to do this, you must tell them before you withdraw from the research project.

It will not be possible to withdraw the answers you have provided during the discussion once it is completed as no identifying data is collected along with the answers you have provided during the discussion.

Your decision whether to take part or not, or to take part and then withdraw will not affect relationship with the researchers and other health professionals. .

7. How will I be informed of the final results of this research project?

Once the proposed changes to the existing CBT manual are drafted, your input would be sought for further refinement. You will be informed of the overall final results of the study by way of a flyer posted to your address.

8. What will happen to information about me?

Providing your name and contact details is entirely optional. Even if you do provide these details they would not be recorded anywhere along with the answers you provided to the questions during the discussion. So, any information you provide us with during the discussion would remain completely anonymous. Although the small sample size may have some implication on the confidentiality of data, steps would be taken to protect the confidentiality as much as possible.

Your contact details will not be used for any other purpose.

The tape recordings of your answers to the questions will be erased / deleted immediately after they have been typed on to an electronic data file. This will be done on a weekly basis and the tape recordings will be stored securely until transcription. All data related to this study will be stored in locked cabinets and password protected electronic documents accessible only to the researchers for a period of 7 years after which they will be confidentially shredded and deleted respectively. The data we collect for this research project does not involve the establishment of a databank.

Publication of the findings of this study in a medical journal and/or conference presentation, will involve the information being presented as overall information provided by all participants. No individual identifying data will be publicised.

9. Can I access research information kept about me?

You would not be able to access any information you have provided as answers to the questions during the interview as we would not be collecting any identifying data during the discussion.

10. Is this research project approved?

This research project has been approved by the Human Research Ethics Committee, University of Melbourne, Australia and the Ethics Committee, Colombo North Teaching Hospital, University of Kelaniya, Ragama, Sri

Lanka. This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)* produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.

11. Who can I contact?

The person you may need to contact will depend on the nature of your query. Therefore, please note the following:

For further information :

If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact the principal researcher, Dr Asiri Rodrigo or any of the following researchers.

Name	Dr Asiri Rodrigo	Prof Harry Minas	Dr Ritsuko Kakuma
Role	Principal Researcher	Supervisor / Associate Researcher	Supervisor / Associate Researcher
Contact information	asirir2000@yahoo.com +94-11-2958039	h.minas@unimelb.edu.au +61 3 8344 0908	rkakuma@unimelb.edu.au +61 3 8344 0908

Name	Prof Richard Newton	Dr Piyanjali de Zoysa
Role	Supervisor / Associate Researcher	Supervisor / Associate Researcher
Contact information	Richard.Newton@austin.org.au +61 3 9496 6496	ptdz@sltnet.lk +94 11 2691688

For complaints:

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

Manager, Human Research Ethics, Research Ethics and Integrity Level 1, 780 Elizabeth Street The University of Melbourne Vic. 3010 Phone: +61 3 8344 2073; Fax +61 3 9347 6739 Email: research-integrity@unimelb.edu.au	AND / OR	Secretary Scientific and Ethical Review Committee, Faculty of Medicine, University of Kelaniya, 6, Thalagolla Road, Ragama, Sri Lanka Telephone :+94 112961142 Email : ercmedfac@kln.ac.lk

CONSENT FORM

Study Title: Culturally relevant psychotherapies for depression in Sri Lanka (Phase 1)

Principal Researcher: Dr Asiri Rodrigo
Associate Researchers: A/Prof Harry Minas, Dr Ritsuko Kakuma, A/Prof Richard Newton, Dr Piyanjali de Zoysa

Please tick '√' the relevant boxes.

- ☐ I have read or have had this document read to me in a language that I understand, and I understand the purposes, procedures and risks of this research project as described within it.
- ☐ I understand that my participation is voluntary and that I am free to withdraw consent at any time
- ☐ I understand taking part in this involves participation in an interview which will be audio recorded
- ☐ I understand that there are arrangements to protect the confidentiality of data although small sample size may have some implication on this
- ☐ I have had an opportunity to ask questions and I am satisfied with the answers I have received.
- ☐ I freely agree to participate in this research project, as described.
- ☐ I understand that I will be given a signed copy of this document to keep.
- ☐ I would like to receive a flyer with final results of the study, mailed to my postal address

Participant's name (printed) ……

Signature …… Date……/……../…….

Appendix 9 participant information phase 2

Participant Information (Plain Language Statement)

Full Project Title:
Pilot study on culturally relevant psychotherapies for depression in Sri Lanka

Short Title:

Culturally relevant psychotherapies for depression in Sri Lanka

Principal Researcher:
Dr Asiri Rodrigo
Department of Psychiatry, Faculty of Medicine, University of Kelaniya, Ragama, Sri Lanka
Global and Cultural Mental Health Unit, Centre for Mental Health (CMH) University of Melbourne, Melbourne Australia

Supervisors / Associate Researchers:

Prof Harry Minas, CMH, University of Melbourne, Melbourne, Australia

Dr Ritsuko Kakuma, CMH, University of Melbourne, Melbourne, Australia

Prof Richard Newton, Austin Health, Melbourne, Australia

Dr Piyanjali de Zoysa, Department of Psychological Medicine, University of Colombo, Sri Lanka

1.Introduction

You are invited to take part in this research project, which is called, 'Pilot Study on Culturally Relevant Psychotherapy for Depression in Sri Lanka'. You have been invited to participate because you are receiving treatment for depression as an outpatient.

This research project aims to test the feasibility of using modified psychotherapy, better-known as 'talking-therapy', to treat patients with depression in Sri Lanka. Depression is a common mental illness in Sri Lanka and psychotherapy is known to be a valuable treatment for depression. As psychotherapies have been developed in Western countries, it has been shown that the use of psychotherapies which have been modified to suit a particular culture are generally more effective than when used without modification. Researchers involved in this study developed a modified psychotherapy for depression to be used Sri Lankan context earlier this year.

This Participant Information and Consent Form tells you about the research project. It explains what is involved to help you decide if you wish to take part.

Please read this information carefully. Ask questions about anything that you do not understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or your family doctor.

Participation in this research is voluntary. If you do not wish to take part, you do not have to. Your decision will not affect your medical care in any way or the support you receive from the hospital staff. Even after agreeing to take part in the study, you can withdraw from it anytime.

If you decide you want to take part in the research project, you will be asked to sign a consent form. By signing it you are telling us that you:

- Understand what you have read
- Consent to take part in the research project
- Consent to the use of your personal and health information as described.

2.What is the purpose of this research project?

The aim of this particular study is to test the feasibility of using modified psychotherapy for management of depression in Sri Lankan patients.

The details we gather will be extremely helpful to us in expanding the treatment options available for depression in the future.
Ten participants will be recruited for this study. The study will be conducted at the Colombo North Teaching Hospital (CNTH), Ragama.

This study will form part of the principal researcher's (Dr. Asiri Rodrigo) research degree – PhD from University of Melbourne, Australia. The objective of the research degree is to design a culturally relevant psychotherapy for depression in Sri Lanka. This study will test the feasibility of the recently developed modified psychotherapy for depression in Sri Lanka .

No member of the research team will receive a personal financial benefit from your involvement in this research project.

3.What does participation in this research project involve?

If you are happy to participate in this study you will first need to sign the consent form..

Participation involves 6 modified psychotherapy sessions and 3 clinical assessments of your mental well-being. The psychotherapy sessions will be conducted by a clinical psychologist at CNTH, Ragama once every 2 weeks; each session will be for 30 minutes. Two of the clinical assessments will coincide with your psychotherapy sessions – first one before commencement of psychotherapy and the second on the last psychotherapy session date. The third assessment will be done 3 months after completion of the psychotherapy sessions. A doctor who is not directly involved in your medical care will facilitate the assessments which will take about 15-20 minutes. The questionnaires used for the assessments will ask you questions about your illness.

You will continue to receive your usual medical care from the hospital even during the period of attending psychotherapy sessions.

We will not require access to your personal records and no payments or incentives will be given for participation.

4. What are the possible benefits?

We cannot guarantee or promise that you will receive any benefits from this research. CBT has been shown to be effective in treating depression in other countries and we hope that this will also be the

same in Sri Lanka. If the CBT is found to be effective, then we hope to incorporate that as part of the usual care for all patients with depression in Sri Lanka. It is possible your depressive symptoms might improve earlier with the combination of usual treatment and psychotherapy.

5.What are the possible risks?

We do not anticipate you to face any risks by participating in this study.
If attending psychotherapy sessions or answering assessment questions is distressing or difficult, you can decline to attend further psychotherapy sessions or answer further assessment questions. Even during a session / assessment if you are distressed you can withdraw your participation. If you are feeling distressed during the study, you can mention this to the research team, your treating psychiatrist, or doctor at the OPD. They will assess you and discuss with you about the necessary actions. There are a team of psychologists in the hospital who are ready to help you in the unlikely event of you getting distressed due to the study.

6.Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any point.

If you decide to leave the project, the researchers would like to keep the information you have provided up to that point. This is to help them make sure that the results of the research can be measured properly. However, if you prefer we remove all of your unprocessed info, you have the right to do so. If you do not mind the researchers keeping the information collected up to that point, you must tell this to the researchers before you withdraw from the research project.

You will be given this Participant Information and Consent Form and you can discuss with your family and contact us on (Telephone number) if you wish to take part in the study. If you do decide to take part, you will be given a Consent Form to sign and you will be given a copy to keep.

Your decision whether to take part or not, or to take part and then withdraw, will not affect your care, support we provide you and your family, or relationship with the researchers and other health professionals. .

7.How will I be informed of the final results of this research project?

You will be informed of the overall final results of the study by way of a flyer posted to your address if you choose to provide us with your name and address. You have the option of choosing to know or not know the results of this study in this manner at the time you provide consent.

8.What will happen to information about me?

Minimal personal data will be recorded along with the answers you provided to the questions during the discussion. All records will be coded purely for the purposes of removing the data if you decide to withdraw.
Your contact details will not be used for any other purpose.

The questionnaires you have answered will be destroyed immediately after they have been typed on to an electronic data file. This will be done on a weekly basis and the questionnaires will be stored securely until transcription. CBT sessions will be audio recorded and audio tapes will be deleted / erased on two weekly basis. All data related to this study will be stored in locked cabinets and password protected electronic documents accessible only to the researchers for a period of 7 years after which they will be confidentially shredded and deleted respectively. The data we collect for this research project does not involve the establishment of a databank.

Publication of the findings of this study in a medical journal and/or conference presentation will involve the information being presented as overall information provided by all participants. No individual identifying data will be publicised.

9.Can I access research information kept about me?

You would be able to access any information you have provided, as answers to questions during the interview on request.

10.Is this research project approved?

The ethical aspects of this research project have been approved by the Office for Research Ethics and Integrity, University of Melbourne, Australia and the Ethics Committee, Faculty of Medicine, University of Kelaniya, Ragama, Sri Lanka. This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)* produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.

11. Whom can I contact?

If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project (for example, feelings of distress), you can contact the principal researcher, Dr Asiri Rodrigo.

Name	Dr. Asiri Rodrigo
Role	Principal Researcher
Contact information	asirir2000@yahoo.com +94-11-2958039

For complaints or concerns:

If you have any complaints or concerns about any aspect of the project then you may contact:

Manager, Human Research Ethics, Office for Research Ethics and Integrity, The University of Melbourne by phone +61 3 8344 2073 or email humanethics-complaints@unimelb.edu.au quoting HREC 1544442.1

AND

/ OR

Secretary
Scientific and Ethical Review Committee,
Faculty of Medicine,
University of Kelaniya,
6, Thalagolla Road,
Ragama, Sri Lanka

Telephone :+94 112961142

Email : ercmedfac@kln.ac.lk

Appendix 10 participant information phase 2

සහභාගී තොරතුරු (භාෂා ප්‍රකාශනය හා අනුමැතිය) ආකෘතිය

පූර්ණ ව්‍යාපෘතියේ මාතෘකාව

විශාදය සුවකිරීම සඳහා ශ්‍රී ලංකාවේ සංස්කෘතියට ගැලපෙන මනෝ චිකිත්සක ක්‍රම හඳුන්වා දීම පිළිබඳ නියමු අධ්‍යයනය

කෙටි මාතෘකාව:

ශ්‍රී ලංකාව තුළ මානසික අවපීඩනය සංස්කෘතික අදාළ මනෝ චිකිත්සක ක්‍රම

ප්‍රධාන පර්යේෂක

ආචාර්ය ආසිරි රොද්රිගු

මනෝ වෛද්‍ය දෙපාර්තමේන්තුව, වෛද්‍ය පීඨය, කැලණිය විශ්වවිද්‍යාලය,ශ්‍රී ලංකාව
මානසික සෞඛ්‍ය පිළිබඳ ජාත්‍යන්තර මධ්‍යස්ථානය(CIMH), මෙල්බර්න් විශ්වවිද්‍යලය, මෙල්බර්න්, ඔස්ට්‍රේලියාව

අධීක්ෂණය/ සහකාර සමීක්ෂකවරු:
මහාචාර්ය හැරී මිනාස්, මානසික සෞඛ්‍ය පිළිබඳ ජාත්‍යන්තර මධ්‍යස්ථානය (CIMH), මෙල්බර්න් විශ්ව විද්‍යාලය, මෙල්බර්න්, ඔස්ට්‍රේලියාව

අචාර්ය රිට්සුකෝ කකුමා, මානසික සෞඛ්‍ය පිළිබඳ ජාත්‍යන්තර මධ්‍යස්ථානය(CIMH), මෙල්බර්න් විශ්ව විද්‍යාලය , මෙල්බර්න්, ඔස්ට්‍රේලියාව,

මහාචාර්ය රිචඩ් නිව්ටන්, මෙල්බර්න්, ඔස්ට්‍රේලියාව

වෛද්‍ය ප්‍රියන්ජලි ද සොයිසා, මනෝ වෛද්‍ය දෙපාර්තමේන්තුව, වෛද්‍ය පීඨය, කොළඹ විශ්ව විද්‍යාලය, ශ්‍රී ලංකාව

1 හැඳින්වීම

“විශාදය සුවකිරීම සඳහා ශ්‍රී ලංකාවේ සංස්කෘතියට ගැලපෙන මනෝ චිකිත්සක ක්‍රම හඳුන්වා දීම පිළිබඳ නියමු අධ්‍යයනය” ලෙස හැඳින්වෙන මෙම සමීක්ෂණය සඳහා ඔබගේ සහභාගිත්වය අපි බලාපොරොත්තු වෙමු. මක්නිසාද යත් ඔබ දැනට විෂාදය සඳහා පහිකාර ලබා ගන්නා අයෙක් හෝ එවැනි රෝගියෙක් රැකබලා ගන්නා අයෙක් බැවිනි.

මෙම පර්යේෂණ ව්‍යාපෘතියේ ශ්‍රී ලංකා සන්දභර්ය ගැලපෙන මානසික අවපීඩනය 'කතා-චිකිත්සාව' ලෙස වඩා හොඳ පසිද්ධ විකරණය මනෝ චිකිත්සාව පිළිබඳ ශක්යතා පරීක්ෂා කිරීමට අපේක්ෂා කරයි මානසික අවපීඩනය ශ්‍රී ලංකාවේ බහුලව මානසික රෝග වන අතර, මනෝ චිකිත්සාව මානසික අවපීඩනය වටිනා පතිකාර කිරීමට හැඳින්වේ. මනෝ චිකිත්සක ක්‍රම බටහිර රටවල සංවධර්නය කර ඇති පරිදි, එය මෙම මනෝ චිකිත්සක ක්‍රම සුවිශේෂ සංස්කෘතික ගැලපෙන පරිදි වෙනස් කරන විට ඔවුන් සාමානයෙන් වෙනස් කිරීමකින් තොරව භාවිත කරන විට වඩා ඵලදායී බව පෙන්නුම් කර ඇත. මෙම වසර මුල දී මෙම අධයනයේ දී සම්බන්ධ පර්යේෂකයන් ශ්‍රී ලංකා සන්දභර්ය මානසික අවපීඩනය සඳහා විකරණය මනෝ චිකිත්සාව සංවධර්නය.

මෙම සහභාගිවන්නාගේ තොරතුරු හා අනුමැතිය ආකෘතිය පර්යේෂණ ව්යාපෘතිය ගැන ඔබට කියනවා. එය ඔබ සහභාගි වීමට කැමති නම්, ඔබ හට උදව් සම්බන්ධ දේ පැහැදිලි කරයි.

මෙම තොරතුරු හොඳින් කියවා බලන්න. ඔබ තේරුම් ගන්න එපා හෝ වැඩි විස්තර දැනගැනීමට අවශ්යය කිසිම දෙයක් ගැන ප්රශ්න අසන්න. සහභාගී වීමට ද නැද්ද යන්න තීරණය කිරීමට පෙර, ඔබ සාපේක්ෂ, මිතුරා හෝ ඔබේ පවුලේ වෛද්යවරයා සමග ඒ ගැන කතා කිරීමට ඔබට අවශ්යය විය හැකිය.

මෙම පර්යේෂණ සහභාගිත්වය ස්වේච්ඡා වේ. ගැනීමට ඔබ කර ඔබ අකමැති නම් ඔබ කළ යුතු නැත. ඔබේ තීරණය කිසිම ආකාරයකින් හෝ ඔබ රෝහල් කායර් මණ්ඩලය ලැබෙන සහයෝගය ඔබට භාර හානියක් නැත.

ඔබ පර්යේෂණ ව්යාපෘතිය සහභාගි වීම අවශ්යය තීරණය කරනවා නම්, ඔබ, කැමැත්ත න් අත්සන් කිරීමට ඉල්ලා සිටිනු ඇත. එය අත්සන් කිරීමෙන් ඔබ අපට කියන්නේ ඔබ ඇත:

• ඔබ කියවා ඇති දේ තේරුම්

• පර්යේෂණ ව්යාපෘතිය සහභාගී වීමට කැමැත්ත

• කැමැත්ත විස්තර පර්යේෂණ කටයුතු වලට සම්බන්ධ කිරීමට

• විස්තර කර ඇති ආකාරයට ඔබේ පෞද්ගලික සහ සෞඛ්ය තොරතුරු භාවිතා කිරීම සඳහා අනුමැතිය.

2. මෙම පර්යේෂණ ව්‍යාපෘතියේ අරමුණ කුමක්ද?

මෙම විශේෂිත පරීක්ෂණ ශ්‍රී ලංකා සංස්කෘතියට ගැලපෙන මානසික විශාදය සඳහා නිමර්ාණය කරන ලද හෝ වෙනස්කරන මනෝ චිකිත්සාව පිළිබඳ ශකයතා කිරීමේ අරමුණ.

අපි රැස් විස්තර අපට දැනට ලබා දෙන අවපාතයක් සඳහා පතිකාර ක්‍රම පුළුල් කිරීමට හා අනාගතයේ දී ලබා ඇත අප වෙත ඉතා පයෝජනවත් වනු ඇත

රෝගීන් දස මෙම සමීක්ෂණයේ දී සහභාගී වනු ඇත. එය, උතුරු කොළඹ ශික්ෂණ රෝහලේ, රාගම සිදු කිරීමට නියමිතය

මෙම සමීක්ෂණය ප්රධාන පර්යේෂකගේ (ආචාර්ය ආසිරි රොද්රිගු පර්යේෂණ උපාධියේ කොටසක් වනු ඇත - ඔස්ට්‍රේලියාව මෙල්බන් විශ්වවිද්යාලයේ ආචාර්ය උපාධිය. පර්යේෂණ උපාධිය අරමුණ ශ්‍රී ලංකාව තුළ මානසික අවපීඩනය සඳහා සංස්කෘතික අදාළ මනෝ චිකිත්සාව, නිමර්ාණය කිරීම වේ. සමීක්ෂණය පිළිබඳ මේ අදියර ලංකාවේ මානසික අවපීඩනය සඳහා මෑත දී වධර්නය විකරණය මනෝ චිකිත්සාව පිළිබඳ ශකතා පරීක්ෂා කරනු

3 මෙම පර්යේෂණ වියපෘතිය සහභාගිත්වය ඇතුළත් වන්නේ කුමක්ද ?

ඔබ මෙම සමීක්ෂණය සඳහා සහභාගි වීමට සතුටු වෙනවා නම්, ඔබ පළමුව පෙර කැමැත්ත න් අත්සන් කිරීමට අවශ්ය වනු ඇත

රාගම රෝහලේ දී පුහුණු සායනික මනෝ චිකිත්සකයන් විසින් පවත්වන විශේෂිත පරීක්ෂණ ශ්රී ලංකා සංස්කෘතිය ගැලපෙන මානසික විශාදය සඳහා නිමර්ාණය කරන ලද මනෝ චිකිත්සක සැසි සහභාගි වෙයි. එක් එක් සැසිවාරය විනාඩි 30 ක් ගත වනු සහ සෑම සති 2කට වරක් සිදු කිරීමට නියමිතය. මෙම මනෝ චිකිත්සක පතිකාර කිරීමට අමත, ඔබ එවැනි ඖෂධ, මානසික අධියපනය සහ මනෝ වෛද්ය කණ්ඩායමක් විසින් නිතිපතා සමාලෝචනයක් ලෙස මානසික අවපීඩනය වෙනත් ආකාරයකින් ලැබී ඇති වනු ඇත පතිලාභ ලබා ඇත. ඔයා මාස 3 සහ මාස 6 න් පසු මානසික රෝග ලක්ෂණ ඇති ප්රගතිය පිළිබඳව ඊළඟට අධියයනය ආරම්භයේදීම, ඔබ විසින් ඔබගේ අසනීප ගැන ප්රශ්න අසනු ඇත. එය සම්පූණර් කිරීම සඳහා විනාඩි 15-20 ගනු ඇත. ඔබගේ මානසික සෞඛ්ය නිෂ්පාදන සෘජුවම සම්බන්ධ නොවන වෛද්යවරයෙක් තක්සේරු සඳහා පහසුකම් සලසනු ඇත.

අපි අතර කිසිම ගෙවීම් ඔබේ පෞද්ගලික වාතර්ාවලින් පරවේශ අවශ්යය නැහැ හෝ දිරි සහභාගීත්වය සඳහා ලබා දී ඇත.

ඇති විය හැකි පතිලාභ මොනවාද?

අපි සහතික හෝ ඔබ මෙම පයෙර්ෂණ වලින් කිසිදු පතිලාභයක් ලැබෙන බව පොරොන්දු නො හැක; කෙසේ වෙතත්, එය ඔබගේ මානසික රෝග ලක්ෂණ සාමානය පතිකාර හා මනෝ චිකිත්සාව සංයෝජන සමග මීට පෙර වැඩි දියුණු විය හැකි හැකි ය. එය ශ්රී ලංකාව තුළ විශාදය සමඟ ජනතාව සඳහා වඩා හොඳ පතිකාර සංවධර්නය කිරීමට උපකාරී වනු ඇත.

5. හැකි අවදානම් මොනවාද

අපි මෙම සමීක්ෂණය සඳහා සහභාගී වන ඔබ අවදානම් මුහුණ දීමඅපේක්ෂා කරන්නේ නැහැ.

මනෝ චිකිත්සාව සැසි සහභාගි හෝ තක්සේරු ප්රශ්නවලට පිළිතුරු වේදනාකාරී හෝ අපහසු නම් ඔබට තවදුරටත් මනෝ චිකිත්සාව සැසිවාරයට සහභාගී හෝ තවදුරටත් තක්සේරු ප්රශ්න සඳහා පිළිතුරු දීම ප්රතික්ෂේප කළ හැකිය. ඊළඟ ප්රශ්නයට යම හෝ ඊළඟ සැසියට සහභාගී ඔබට නතර කල හැකිය.

6. මම මෙම පයෙර්ෂණ ව්යාපෘතිය සහභාගි යුතුද?

ඕනෑම පයෙර්ෂණ ව්යාපෘතියේ සහභාගිත්වය ස්වේච්ඡා වේ. ගැනීමට ඔබ කර ඔබ අකමැති නම් ඔබ කළ යුතු නැත. ගැනීමට ඔබ සහ පසුව ඔබගේ මනස වෙනස් කිරීමට තීරණය කරනවා නම්, ඔබ යම් අවස්ථාවක දී මෙම ව්යාපෘතිය ඉවත් කිරීමට නිදහස ඇත.

ඔබ මෙම ව්යාපෘතිය ඉවත් කිරීමට තීරණය කරනවා නම්, පයෙර්ෂකයන් ඔබ ඒ දක්වා ලබා ඇති තොරතුරු තබා ගැනීමට කැමතියි. මෙය ඔවුන්ට පයෙර්ෂණ ප්රතිඵල නිසි ගණනය කළ හැකි බව තහවුරු කර ගන්න උපකාර කිරීමයි. කෙසේ වෙතත්, ඔබ, අපි ඔබේ සැකසුම් නොකළ තොරතුරු සියල්ල ඉවත් කැමති නම්, ඔබ එසේ කිරීමට අයිතිය ඇත. ඔබ ඔවුන් මෙය කිරීමට අවශ්ය නොවේ නම්, ඔබ විසින් පයෙර්ෂණ ව්යාපෘතියේ ඉවත් පෙර ඔබ ඔවුන් කියන්න ඕනේ.

ගැනීමට ඔබ කර තීරණය කරන්නේ නම්, අත්සන් කිරීමට ඔබ මෙම සහභාගිවන්නාගේ තොරතුරු හා අනුමැතිය ආකෘතිය ලබා කරනු ඇති අතර එවිට ඔබට තබා ගැනීමට පිටපතක් ලබා දෙනු ඇත.

සහභාගි යන්න හෝ නොවේ, හෝ සහභාගි පසුව ඉල්ලා අස්කර ගැනීමට, ඔබේ සේවා හානියක් නැත, අපි ඔබ සහ ඔබේ පවුලේ සැපයීමට, පයෙර්ෂකයන් හා අනෙකුත් සෞඛ්ය වෘත්තිකයන් සමඟ සම්බන්ධතාව ඔබේ

තීරණය. .

7. මම මේ පර්යේෂණ ව්‍යාපෘතියේ අවසාන ප්‍රතිඵල දැනුම් දෙනු ලැබේ?

ඔබ ඔබේ නම, ලිපිනය සහ ලබා දෙනවා නෝරා නම්, ඔබ ඔබගේ ලිපිනයට තැපැල් මඟින් අධ්‍යයනය සමස්ත අවසන් ප්‍රතිඵල දැනුම් දෙනු ලැබේ. ඔබ කැමැත්ත ලබා දෙන අවස්ථාවේ දී මේ ආකාරයෙන් මෙම අධ්‍යයනයේ ප්‍රතිඵල දැන දැන හෝ නො නෝරා විකල්පයක් ඇත.

8. මා ගැන තොරතුරු සිදු වන්නේ කුමක්ද?

එවැනි නාමය ලෙස ඔබේ පෞද්ගලික තොරතුරු ඔබ මෙම සාකච්ඡාවට, ප්‍රශ්න වලට ලබා දී ඇති පිළිතුරු සමග කොහෙවත් සඳහන් වෙන්නේ නැහැ. ඒ නිසා ඔබ මෙම සාකච්ඡාවට ලබා දෙනවා කිසිදු තොරතුරක් සම්පූර්ණයෙන්ම නිනර්ාමික පවතිනු ඇත.

ඔබේ සබඳතා තොරතුරු වෙනත් කිසිදු අරමුණක් සඳහා භාවිතා නොහැකි වනු ඇත.

මෙම අධ්‍යයනය සම්බන්ධ සියලුම දත්ත ඔවුන් රහසිගතව පිළිවෙලින් කඩදාසි ඉරා මකා දමනු ඇත පසුව වසර 7 ක කාලයක් සඳහා පමණක් පර්යේෂකයන් සඳහා ප්‍රවේශවීමේ විද්‍යුත් ලේඛන ආරක්ෂා අගුලු දාලා කැබිනට්ටු හා මුර පදය තුළ ගබඩා වනු ඇත. අපි මේ පර්යේෂණ ව්‍යාපෘතිය සඳහා රැස්කරගත් දත්ත දත්ත ස්ථාපිත ඇතුළත් නොවේ.

වෛද්‍ය සඟරාවක සහ / හෝ සමුළුවක ඉදිරිපත් මෙම අධ්‍යයනයේ සොයා ගැනීම් ප්‍රකාශයට පත් කිරීම, සියලු සහභාගීවන්නන් විසින් සපයන සමස්ත තොරතුරු ඉදිරිපත් කරනු ලබන තොරතුරු ඇතුළත් වේ. දත්ත හඳුනා ගැනීම, කිසිම පුද්ගලයකු ප්‍රසිද්ධියක් ලැබේ.

9. මම මා ගැන තබා පර්යේෂණ තොරතුරු හැකිද?

ඔබට, අපි සාකච්ඡාවට ඕනෑම දත්ත හඳුනාගැනීම, එක් රැස් කළ නොහැකි බව ඔබට සම්මුඛ පරීක්ෂණයේදී ප්‍රශ්න වලට පිළිතුරු ලෙස සපයා ඇති ඕනෑම තොරතුරක් වෙත පිවිසිය හැකි වන්නේ නැහැ.

10. අනුමත මෙම පර්යේෂණ ව්‍යාපෘතිය ද?

මෙම පර්යේෂණ ව්‍යාපෘතිය සදාචාරාත්මක අංග පර්යේෂණ ආචාර ධර්ම සහ අඛණ්ඩතාව, මෙල්බර්න් විශ්ව විද්‍යාලය, ඔස්ට්‍රේලියාව සහ ආචාර ධර්ම කමිටුව සහ උතුරු කොළඹ ශික්ෂණ රෝහල, කැලණිය විශ්වවිද්‍යාලය, රාගම, ශ්‍රී ලංකාව සඳහා කායර්ාලය විසින් අනුමත කර ඇත.

11. මම කවුද හා සම්බන්ධ විය හැකිය?

ඔබ හා සම්බන්ධ කිරීමට අවශ්ය විය හැක පුද්ගලයා ඔබගේ විමසුමට ස්වභාවය මත රඳා පවතිනු ඇත. ඒ නිසා, පහත සඳහන් කරුණාවෙන් සලකන්න:

වැඩිදුර තොරතුරු සඳහා:

ඔබ මෙම ව්‍යාපෘතිය ගැන තවදුරටත් තොරතුරු අවශ්ය හෝ ඔබ මෙම ව්‍යාපෘතිය ඔබේ සම්බන්ධය (උදාහරණයක් ලෙස, ආපදා හැඟීම්) සම්බන්ධ විය හැක යම් ගැටලු ඇති නම්, ඔබ ප්‍රධාන පර්යේෂක ආචාර්ය ආසිරි රොද්රිගු හෝ සම්බන්ධ පහත සඳහන් පර්යේෂකයන් ඕනෑම හැකි නම් .

නම	තනතුර	සම්බන්ධ කර ගැනීමේ විස්තර
වෛද්‍ය ආසිරි රොඩ්‍රිගු	ප්‍රධාන සමීක්ෂක	asirir2000@yahoo.com +94-11-2958039

<u>පැමිණිලි සඳහා</u>

ඔබට මෙම ව්‍යාපෘතිය සම්බන්ධයෙන් යම්කිසි පැමිණිල්ලක් ඇතොත් පහත සඳහන් පුද්ගලයන් වෙත ඒ බව දැනුම් දිය හැකිය.

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Appendix 11 English questionnaire phase 1

Culturally relevant psychotherapies for depression in Sri Lanka (Phase 1)

Semi structured questionnaire for patients with depression

(Statements in italics are for the guidance of the researcher only)

1.1. Demographics

1.2. Age: _____ years

1.3. Occupation: _____

1.4. Marital status

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Other – *Please specify* .....

1.5. Number of children

1.5.1 Ages of the children *(in years)* .....

1.6 Do you have someone who cares for you?

- ☐ Yes
- ☐ No
- ☐ Not sure

1.7 What is your relationship with this person/s?

Spouse / partner / parent / other relative / friend / other person (*Please specify)*……

1.8 How does this person/s support you?

- ☐ assistance with day to day activities
- ☐ emotional support
- ☐ assistance with treatment
- ☐ financial support
- ☐ Other _____

2. Depression

2.1. When did you first develop symptoms of depression? _____

2.2. Have you had physical symptoms related to depression? What are they?

☐ Yes

☐ No

☐ Not sure

If 'Yes', What are they?

2.3. What was the duration between onset of symptoms and seeking of help?

_____

2.4. What form of help did you seek and why?

2.5. What forms of treatment have you had so far?

☐ Antidepressant medication

☐ ECT

☐ lay counselling

☐ traditional healing rituals

☐ talking therapy or counselling by a clinician practicing western medicine

☐Other

☐ none

☐Not sure

Please provide details:

2.6. What treatment did you find most beneficial?

2.7. If you sought traditional treatment, what made you do so?

2.8. Counselling involves advice or guidance, especially as solicited from a knowledgeable person. Talking therapies or psychotherapies involve talking to someone who is trained to help you deal with your mental health and emotional problems. Have you had counselling or talking therapy / psychotherapy? (If it was not mentioned before)

☐ Yes

☐ No

☐ Not sure

Can you please provide details of that treatment *(type / duration / number of sessions / by whom)?*

2.9. Do you believe psychotherapy or counselling can be useful in treating mental illness?

☐ Yes

☐ No

☐ Not sure

Can you please provide reasons for your answer?

2.10. What did you consider to be the most useful component in counselling/ talking therapy/ psychotherapy?

2.11. Were there components in therapy that were not useful at all? If so, please explain.

☐ Yes

☐ No

☐ Not sure

Can you please explain why?

2.12. Do you believe counselling or talking therapy/ psychotherapy is beneficial in treatment of depression?

☐ Yes

☐ No

☐ Not sure

Can you please explain why?

2.13. Psychotherapy is a time limited practice which involves a certain number of sessions between the therapist and patient. What do you think about the number of sessions required for psychotherapy?

2.14. The sessions can happen at various frequencies. In your opinion, what is the best frequency for psychotherapy in depression?

☐ no change

☐ daily

☐ weekly

☐ fortnightly

☐ monthly

☐other:_____

2.15. What do you think about the duration of each session; what would be the best duration for each?

- ☐ 0-15 min
- ☐ 15-30 min
- ☐ 30-45 min
- ☐ 45-60 min
- ☐ More than 60 min
- ☐ Other _____

Please give reasons for your choice

2.16. In your opinion, what do you think is more beneficial in counselling or psychotherapy- direct advice by the knowledgeable person or collaboration and negotiations with you regarding what type of activities / thought processes you need to engage in at home and how much of it etc.?

☐ Directive Advice

☐ Collaboration

☐ Both

☐ Not sure

☐ Other

Can you please explain why?

2.17. In your opinion, how can one strengthen what is learned during sessions?

2.18. Assignments in between sessions can be a part of psychotherapy. This will involve practising the new skills that you are learning and applying them to your daily life. What do you think about these assignments?

2.19. What would be the best method /s to ensure compliance with the above mentioned assignments?

2.20. In your opinion, what is more beneficial - involving only the patient in sessions or both patient and family? Why?

2.21. In your opinion, would usage of religious literature / folk tales or techniques be useful in counselling or talking therapy / psychotherapy?

2.22. Mindfulness is purposeful, nonjudgmental awareness of the present moment thereby allowing for increased recognition of mental events in the present moment. What do think about its use in counselling or talking therapy / psychotherapy?

2.23. What can be done to increase participation in sessions and reduce drop-outs?

2.24. What else can be done to make counselling or talking therapy/ psychotherapy more appealing?

2.25. What lessons can be learnt, or practices can be adopted from traditional healing rituals and religious counselling to allopathic / Western medicine psychotherapy?

Culturally relevant psychotherapies for depression in Sri Lanka (Phase 1)

Semi structured questionnaire for carers of patients with depression

(Statements in italics are for the guidance of the researcher only)

Demographics

3.1. Age: _____ years

3.2. Occupation: _____

3.3. Marital status

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Other – Please Specify .....

3.4. Number of children-_____

Ages of the children -_____

3.6 What is your relationship to the patient?

_____

3.7 How do you provide support to him /her?

- ☐ assistance with day to day activities
- ☐ emotional support
- ☐ assistance with treatment
- ☐ financial support
- ☐ Other _____

Depression

When asking the following questions use the name of the patient

4.1. When did *name of patient* first develop symptoms of depression?

_____

4.2. Has *name of the patient* had physical symptoms related to depression?

☐ Yes

☐ No

☐ Not sure

What are they?

4.3. What was the duration between onset of symptoms and seeking help?

_____

4.4. What form of help did *name of the patient* seek and why?

4.5. What forms of treatment has *name of the patient* had so far?

☐ Antidepressant medication

☐ ECT

☐ lay counselling

☐ traditional healing rituals

☐ talking therapy or counselling by a clinician practicing western medicine

☐Other

☐ none

☐Not sure

Please provide details:

4.6. What treatment did *name of the patient* find most beneficial?

4.7. If *name of the patient* sought traditional treatment, what made him/her do so?

4.8. Counselling involves advice or guidance, especially as solicited from a knowledgeable person. Talking therapies or psychotherapies involve talking to someone who is trained to help you deal with your mental health and emotional problems. Has *name of the patient* had counselling or talking therapy / psychotherapy? (If it was not mentioned before)

☐ Yes

☐ No

☐ Not sure

Can you please provide details of that treatment *(type / duration / number of sessions / by whom)?*

4.9. Do you believe psychotherapy or counselling can be used in treating mental illness?

☐ Yes

☐ No

☐ Not sure

Can you please provide reasons for your answer?

4.10. What did you consider to be the most useful component in counselling/ talking therapy/ psychotherapy?

4.11. Were there components in therapy that were not useful at all? If so, please explain.

☐ Yes

☐ No

☐ Not sure

Can you please explain why?

4.12. Do you believe counselling or talking therapy/ psychotherapy is beneficial in treatment of depression?

☐ Yes

☐ No

☐ Not sure

Can you please explain why?

4.13. Psychotherapy is a time limited practice which involves a certain number of sessions between the therapist and patient. What do you think about the number of sessions required for psychotherapy?

4.14. The sessions can happen at various frequencies. In your opinion, what is the best frequency in psychotherapy for depression?

☐ no change

☐ daily

☐ weekly

☐ fortnightly

☐ monthly

☐other:_____

4.15. What do you think about the duration of each session; what would be the best duration?

- ☐ 0-15 min
- ☐ 15-30 min
- ☐ 30-45 min
- ☐ 45-60 min
- ☐ More than 60 min
- ☐ Other _____

Please give your reasons for your choice

4.16. In your opinion, what do you think is more beneficial in counselling or psychotherapy- direct advice by the knowledgeable person or collaboration and negotiation regarding type of activities / thought processes you need to engage in at home and how much of it etc?

☐ Directive Advice

☐ Collaboration

☐ Both

☐ Not sure

☐ Other

Can you please explain why?

4.17. In your opinion, how can one strengthen what is learnt by *nameof patient* during sessions?

4.18. Assignments in between sessions can be a part of psychotherapy. This will involve practising the new skills that you are learning and applying them to your daily life. What do you think about these assignments?

4.19. What would be the best method /s to ensure compliance with the above mentioned assignments?

4.20. In your opinion, what is more beneficial - involving only the patient in sessions or involving both the patient and family? Why?

4.21. In your opinion, would usage of religious literature / folk tales or techniques be useful in counselling or talking therapy / psychotherapy?

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4.22. Mindfulness is purposeful, nonjudgmental awareness of the present moment thereby allowing for increased recognition of mental events in the present moment. What do think of its use in counselling or talking therapy / psychotherapy?

4.23. What can be done to increase participation in the sessions and reduce drop-outs?

4.24. What else can be done to make counselling or talking therapy/ psychotherapy more appealing?

4.25. What lessons can be learnt or practices can be adopted from traditional healing rituals and religious counselling to allopathic / Western medicine psychotherapy?

Culturally relevant psychotherapies for depression in Sri Lanka (Phase 1)

Semi structured questionnaire for psychiatrist, psychiatry trainees, psychiatry medical officers and psychologist

(Statements in italics are for the guidance of the researcher only)

1. Demographics

1.1. Age: _____ years

1.2. Gender

☐ Female

☐ Male

1.3. Designation

☐ Psychiatrist

☐ Psychiatry trainee

☐Psychiatry medical officers

☐Psychologists

☐ Other: _____

1.4. Places of work _____

1.5. Whether engaging in private practice or not?

☐ Yes

☐ No

2. Psychotherapy

2.1. Do you use psychotherapy in your everyday practice?

☐ Yes

☐ No

Please elaborate (why they use or don't use it).

2.2. Do you believe psychotherapy is beneficial in Sri Lankan context?

☐ Yes

☐ No

☐Not sure

Please explain why

2.3. If psychotherapy is modified do you think it might change your view regarding psychotherapy?

☐ Yes

☐ No

Please explain why

2.4. What form/s of psychotherapy do you practice?

Please mention names and therapeutic principles

2.4.1. Do you practice CBT?

☐ Yes

☐ No

2.4.2 What CBT therapeutic principles do you use?

2.5. Do you find psychotherapy to be useful in your practice?

☐ Yes

☐ No

☐Unsure

Please why or why not.

2.6. What elements of psychotherapy do you find (or do you think would be) most useful in clinical practice?

3. Depression

3.1. What is your main form of treatment for depression?

3.2. Do you use psychotherapy in patients with depression?

☐ Yes

☐ No

Please elaborate (why they use or don't use it). If yes, what form?

3.3. Do you believe psychotherapy is beneficial in the Sri Lankan context?

☐ Yes

☐ No

☐Unsure

Please why or why not.

3.4. If psychotherapy is modified do you think it might change you view regarding psychotherapy?

☐ Yes

☐ No

☐Unsure

Please why or why not.

3.5. Do you think CBT is a suitable therapy for depression in the Sri Lankan context?

☐ Yes

☐ No

☐Not sure

Please explain why

4. CBT for depression in Sri Lanka

(When asking the following questions use the word 'find' if the participant is already using CBT or use the word 'think' if he/she is not currently using CBT in everyday practice.)

4.1. What are your thoughts or experiences on the appropriateness of using CBT for treating depression in Sri Lanka?

4.2. What changes, if any, need to be made to make CBT more culturally appropriate for Sri Lankan patients with depression?

4.3. What are your thoughts or experiences on cognitive biases and changing negative thinking patterns for the Sri Lankan patient?

4.4. What are your thoughts or experiences on a positive reframe of helping the patient think more effectively and healthily?

4.5. What are your thoughts or experiences on the emphasis on problem-solving and behavioural activation?

4.6. What are your thoughts or experiences on resolving social conflicts and relationship problems?

4.7. What do you think would be more effective?

☐ Repeated usage of a few CBT techniques for a particular patient

☐ usage of several CBT techniques over the course of therapy?

☐ Unsure

Please elaborate on your response.

4.8. Which do you think would be more useful for CBT in Sri Lanka?

☐ instructional style

☐ collaborative style

☐ Unsure

Please elaborate on your response.

4.9. What are your thoughts or experiences on increased flexibility in the ordering of sessions and also on the speed in which one moves through them?

4.10. What are your thoughts or experiences on homework and encouragement to attend even if they were unable to complete their homework?

4.11. What are your thoughts or experiences on the use of different terminology such as exercise, practice rather than ‘homework’?

4.12. What are your thoughts or experiences on placing more emphasis on physical symptoms and their association with thoughts, mood and inclusion of physical complaints in the thought diary as a separate column?

4.13. What are your thoughts or experiences on the amount of education patient require regarding course of therapy and termination of therapy (e.g., what the patient's experience would be like in therapy, what to expect, achievable goals and how to terminate it).?

4.14. What are your thoughts or experiences on the presence of family members during sessions and active assistance from family in completion of homework?

4.15. What are your thoughts or experiences on using Sri Lankan folktales and Jataka stories and other examples from local literature?

4.16. What are your thoughts or experiences on having explicit discussion and exploration about local beliefs such as 'depression is due to fate or bad astrological periods' ?

4.17. How do you think interactions with faith healers affect psychotherapy delivery?

4.18. What do you think about using local awareness about 'mindfulness' in CBT?

4.19. What are your thoughts regarding increased emphasis on goal setting and markers of treatment progress in the Sri Lankan context?

4.20. What are your thoughts about the best duration and number of sessions?

Culturally relevant psychotherapies for depression in Sri Lanka (Phase 1)

Semi structured questionnaire for traditional healers and lay-counsellors

(Statements in italics are for the guidance of the researcher only)

1. Demographics

10.1. Age: _____ years

10.2. Gender

☐ Female

☐ Male

Traditional healers are practitioners of traditional or non-Western medicine. Lay counselling is psychosocial support provided by an individual who does not have a mental health background or formal degree in counselling.

10.3. Are you a traditional healer / lay counsellor / both?

☐ traditional healer

☐ lay counsellor

☐Both

☐ Other: _____

10.4. Frequency of engaging in healing rituals

☐ daily

☐ weekly

☐ fortnightly

☐ monthly

☐other:_____

☐ not relevant

10.5. Frequency of engaging in lay counselling

☐ daily

☐ weekly

☐ fortnightly

☐ monthly

☐other:_____

☐ not relevant

10.6. Do you request / accept payment for your services?

☐ Yes

☐ No

☐other:_____

11. Healing Practices and suggestions

11.1. How frequently do you engage in healing rituals / counsel individuals with mental health issues or mental distress?

☐ daily

☐ weekly

☐ fortnightly

☐ monthly

☐other:_____

11.2. Can you please provide details of the presentations of mental illness or distress you see? What sort of manifestations do the patients come with?

11.3. Do you usually see those people / family once or more than once?

☐ Yes

☐ No

☐other:_____

11.4. If more than once, how many [illegible] you see each affected individual / family on average?

11.5. How frequently would you see each affected individual / family?

☐ daily

☐ weekly

☐ fortnightly

☐ monthly

☐other:_____

Reasons for above duration 193

11.6. How long does each of your sessions last? (Approximate range / average)

- ☐ 0-15 min
- ☐ 15-30 min
- ☐ 30-45 min
- ☐ 45-60 min
- ☐ More than 60 min
- ☐ Other _____

Reasons for above duration

11.7. What sort of healing ritual / lay counselling do you provide for people with mental health issues or mental distress?

11.8. Do you use following techniques in your healing practices or lay counselling?

☐Exploration of thoughts, emotions and behaviour

If you do, how do you do that? (Keeping a record/ journal/diary of thoughts, behaviour, emotions)

☐Changing thinking patterns and behaviours

If you do, how do you do that? (Challenging negative thoughts such as self-critical thoughts /positive reframing/ daily activity scheduling/ behavioural experiments)

☐ Problem solving techniques

If you do, how do you do that?

☐ Involvement of family members

If you do, how do you do that?

☐ Request affected person to practice the techniques learned /taught in between sessions

If you do, how do you do that?

☐ Religious practices such as mindfulness, meditation, etc.

If you do, how do you do that?

☐ Using examples from folk tales / Jataka stories

If you do, on what occasions do you do that?

11.9. What elements of healing ritual / counselling do you find (or do you think would be) most useful in clinical practice?

11.10. What do you think is more beneficial - direct advice by you or collaboration and negotiations with client regarding interventions?

☐ Directive Advice

☐ Collaboration

☐ Both

☐ Not sure

☐ Other

Can you please explain why?

11.11. What elements of healing rituals / counselling can be used in Western Medical practice psychotherapy?

11.12 What are your beliefs and attitude towards allopathic mental health treatment

11.13 Have you referred patients to allopathic mental health practitioners?

☐ Yes

☐ No

☐other:_____

Explain reasons for your answer

11.14 Have you managed patients who are receiving allopathic mental health care

☐ Yes

☐ No

☐other:_____

Describe your experience reasons for your answer

Culturally relevant psychotherapies for depression in Sri Lanka (Phase 2)

Intake assessment questionnaire

Client Identification Number: ……..

4.1. Demographics

4.2. Age: _____ years

4.3. Occupation: _____

4.4. Marital status

☐ Single

☐ Married

☐ Living together

☐ Separated / divorced

☐ Widowed

4.5. Number of children _____

5. Depression

5.1. How long have you been having symptoms of depression? _____Weeks/ Months/ Years

5.2. Have you had following symptoms? (You may tick more than one)

☐ Inability to relax

☐ Thoughts of life is not worth living

☐ Hearing of unseen voices

☐ Thoughts of worthlessness, thoughts of guilt, thoughts of hopelessness

☐ unusual or worrying thoughts

5.3. Have you ever harmed yourself?

☐ Yes

☐ No

☐ Not sure

Please give details of self-harm act ……

When was the last time you harmed yourself? .....

5.4. Have you had physical symptoms related to depression? What are they?

☐ Yes

☐ No

☐ Not sure

What are they?

5.5. Do you find it difficult to engage in your daily activities because of your depressive symptoms?

☐ Yes

☐ No

☐ Not sure

How is it affected?

5.6. What forms of treatment have you had so far during this episode?

☐ Antidepressant medication

☐ ECT

☐ lay counselling including religious counselling

☐ traditional healing rituals

☐ talking therapy or counselling by a clinician practicing western medicine

☐Other. Please specify ……

☐ none

☐Not sure

What medication are you on?

How frequently do you have psychotherapy/ECT?

5.7. How compliant have you been with your treatment?

Medication-

☐ I take medication every day without failing

☐ I forget to take medication about once a week

☐ I forget to take medication 2-4 times a week

☐ I forget to take medication 5-7 time a week/ I forget to take medication almost daily

☐ I don't take medication at all

☐Not sure

Other treatment

☐ Very compliant

☐ Partially compliant

☐ Poorly compliant

5.8. When did you first develop symptoms of depression? (at what age / in which year)
_____

5.9. How many episodes have you had (including current one)?_____

5.10. How have you been in between episodes?

☐ Fully recovered and functioning as I was before

☐ Partially recovered, had some symptoms and was not 100% in between episodes

☐ Poorly recovered, had many symptoms and I have been incapable of doing what I used to do before

5.11. Have you had periods lasting at least for few days characterised by elated mood, raising thoughts, talking fast, feeling you are very special, spending too much, having poor concentration?

☐ Yes

☐ No

☐ Not sure

5.12. Do you now have following symptoms?

☐ Mood swings / easily changing moods

☐ Intense emotions

☐ Difficulty in controlling anger

☐ Frantic fear of being left alone or abandonment

☐ Impulsive behaviour

☐Chronic feeling of emptiness

☐ Transient paranoid thoughts/ dissociation/

☐Persistent poor sense of self

5.13. Have you had an injury to your head?

☐ Yes

☐ No

☐ Not sure

Can you please give details (what kind of injury, when it happened, loss of consciousness, had to go to hospital, memory problems following incident)?

5.14. Do you have medical illnesses?

☐ Yes

☐ No

☐ Not sure

Can you please give details?

5.15. Do you use alcohol?

☐ Yes

☐ No

Can you please give details (Type, amount, frequency, craving, withdrawal effects)

5.16. Do you use illicit drugs?

☐ Yes

☐ No

Can you please give details (Type, amount, frequency, how it is used (smoking/ injecting) , craving, withdrawal effects)

STRUCTURED INTERVIEW GUIDE FOR THE HAMILTON DEPRESSION SCALE

(Filled by the research assistant using the following guide)

Instruments Combined by Kenneth A. Kobak, Janet B.W. Williams, and A. John Rush

OVERVIEW: I'd like to ask you some questions about the past week. How have you been feeling since last (DAY OF WEEK)?
Have you been working? IF NOT: Why not?

What's your mood been like this past week (compared to when you feel OK)?
Have you been feeling down or depressed? Sad? Hopeless? Helpless? Worthless?
- IF YES: Can you describe what this feeling has been like for you? How bad is the feeling?
Have you been crying at all?

How have you been feeling about the future? (optimistic/pessimistic) Do you feel better with encouragement/reassurance from others? Do you feel things will get better, improve, work out?

IF DEPRESSED: In the past week, when something good, even small things have happened, did your mood brighten up? How long did this brightened mood last? Were there things that occurred that should have brightened your mood but did not?

In the last week, how often have you felt (OWN EQUIVALENT)? Every day? All day?

1. Depressed Mood (sadness, hopeless, helpless, worthless):
0 - Absent.
1 - Indicated only on questioning *(occasional, mild depression)*
2 - Spontaneously reported verbally *(persistent, mild to moderate depression)*
3 - Communicated non-verbally, i.e., facial expression, posture, voice, tendency to weep *(Persistent, moderate to severe depression)*
4 - VIRTUALLY ONLY those feeling states reported in spontaneous verbal and non-verbal communication *(Persistent, very severe depression, with extreme hopelessness or tearfulness)*

Have you been putting yourself down this past week, feeling you've done things wrong, or let others down?
IF YES: What have your thoughts been? Has this been more than is normal for you?
In the past week, how have you felt about yourself?
Have you noticed your self-esteem has been down in the past week? How would you rate your worth as a person compared to others?
Have you been feeling guilty about anything that you've done or not done? What about things that happened a long time ago?
Do you feel like you're being punished?
Have you thought that you've brought (THIS DEPRESSION) on yourself in some way?

2. Feelings of Guilt:

0 - Absent.
1 - Self-reproach, feels he/she has let people down *(or guilt over decreased productivity only)*
2 - Ideas of guilt or rumination over past errors or sinful deeds *(feelings of guilt, remorse, or shame)*
3 - Present illness is a punishment. Delusions of guilt *(severe, pervasive feelings of guilt)*
4 - Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations

This past week, have you had thoughts that life is not worth living? What about thinking you'd be better off dead or wishing you were dead? Have you had thoughts of hurting or killing yourself?
IF YES: What have you thought about?
How often do these thoughts come? How long do they stay? Have you thought of a plan in the last week?
Have you done anything to try to hurt yourself or taken any steps toward ending your life?
3. Suicide:
0 - Absent.
1 - Feels life is not worth living
2 - Wishes he/she were dead or any thoughts of possible death to self
3 - Suicidal ideas or gesture
4 - Attempts at suicide

Now let's talk about your sleep. What were your usual hours of going to sleep and waking up, before this began?
When have you been falling asleep and waking up over the past week?
Have you had any trouble falling asleep at the beginning of the night? (Right after you go to bed, how long has it been taking you to fall asleep?)
How many nights this week have you had trouble falling asleep?

4. Insomnia Early (Initial Insomnia):
0 - No difficulty falling asleep
1 - Complains of occasional difficulty falling asleep
(i.e., ½ hour or more, 2-3 nights)
2 - Complains of nightly difficulty falling asleep *(i.e., ½ hour or more, 4 or more nights)*

During the past week, have you been waking up in the middle of the night? IF YES: Do you get out of bed?
What do you do? (Only go to the bathroom?)
When you get back in bed, are you able to fall right back asleep?
How long do you stay awake?
How many nights this week have you had that kind of trouble?
(IF NO INSOMNIA) Has your sleep been restless or disturbed some nights?

5. Insomnia Middle:
0 - No difficulty
1 - Complains of being restless and disturbed during the night *(or occasional, i.e., 2-3 nights difficulty, ½ hour or more)*

2 - Waking during the night - any getting out of bed *(except to void); (often, i.e., 4 or more nights of difficulty, ½ hour or more)*

What time have you been waking up in the morning for the last time, this past week?
IF EARLY: Is that with an alarm clock, or do you just wake up yourself? What time do you usually wake up (that is, when you feel well)?
How many mornings this past week have you awakened early?
Are you able to go back to sleep?

6. Insomnia Late (Terminal Insomnia):
0 - No difficulty
1 - Waking in early hours of morning but goes back to sleep *(occasional, i.e., 2-3 nights, ½ hour or more)*
2 - Unable to fall asleep again if gets out of bed *(often, i.e., 4 or more nights difficulty, ½ hour or more)*

How have you been spending your time this past week (when not at work)?
Is that normal for you?
Have you felt interested in doing (THOSE THINGS), or do you feel you have to push yourself to do them?
How would you describe your level of interest and motivation to complete daily activities?
Have you stopped doing anything you used to do? (What about hobbies?) IF YES: Why?
About how many hours a day do you spend doing things that interest you?
Is there anything you look forward to?
Have you had any fun this past week? (IF NO), Has there been anything you enjoyed (meal, movie, spending time with friends)? **(IF YES)**, was the enjoyment you experienced at a normal level for you?
IF WORKING (IN OR OUT OF THE HOME): Have you been able to get as much (work) done as you usually do?

7. Work and Activities:
0 - No difficulty
1 - Thoughts and feelings of incapacity, fatigue or weakness related to activities, work or hobbies *(mild reduction in interest or pleasure; no clear impairment in functioning)*
2 - Loss of interest in activity, hobbies or work – by direct report of the patient or indirect in listlessness, indecision and vacillation *(feels he/she has to push self to work or activities; clear reduction in interest, pleasure, or functioning)*
3 - Decrease in actual time spent in activities or decrease in productivity (*Profound reduction in interest, pleasure, or functioning)*
4 - Stopped working because of present illness *(unable to work or fulfil primary role because of illness, and total loss of interest)*

RATING BASED ON OBSERVATION DURING INTERVIEW ONLY

8. Retardation (slowness of thought and speech; impaired ability to concentrate; decreased motor activity):
0 - Normal speech and thought
1 - Slight retardation at interview *(or mild psychomotor retardation)*
2 - Obvious retardation at interview *(i.e., moderate, some difficulty with interview; noticeable pauses and slowness of thought)*
3 - Interview difficult *(severe psychomotor retardation, interview very difficult, very long pauses)*
4 - Complete stupor *(extreme retardation; stupor; interview barely possible)*

RATING BASED ON OBSERVATION DURING INTERVIEW ONLY

9. Agitation:
0 - None *(movements within normal range)*
1 - Fidgetiness
2 - Playing with hands, hair, etc.
3 - Moving about, can't sit still
4 - Hand-wringing, nail biting, hair-pulling, biting of lips *(interview impossible)*

Have you been feeling especially tense or irritable this past week? IF YES: Is this more than is normal for you?
Have you been unusually argumentative or impatient? Have you found yourself becoming angry with others for little apparent reason? More so than normal for you? How much of the time in this past week?
Have you been feeling especially anxious, nervous or on edge in the past week? How much of the time?
Have you been worrying a lot about little things, things you don't ordinarily worry about?
IF YES: Like what, for example?

10. Anxiety Psychic:
0 - No difficulty
1 - Subjective tension and irritability *(mild, occasional)*
2 - Worrying about minor matters (*moderate, causes some distress; or excessive worrying about real problems)*
3 - Apprehensive attitude apparent in face or speech *(severe; impairment of functioning due to anxiety)*
4 - Fears expressed without questioning *(symptoms incapacitating)*

Tell me if you've had any of the following physical symptoms in the past week. (READ LIST)
GI - dry mouth, gas, indigestion, constipation, diarrhoea, stomach cramps, belching, urinary frequency
C-V - heart palpitations, headaches
RESP - hyperventilating, sighing, difficulty breathing (dyspnoea); sweating

OTHER - tremors; ringing in your ears (tinnitus); blurred vision; hot and cold flashes; chest pain
FOR EACH SYMPTOM ACKNOWLEDGED AS PRESENT:
How much has (THE SYMPTOM) been bothering you this past week? (How bad has it gotten? How much of the time, or how often, have you had it?)
NOTE: DO NOT RATE SYMPTOMS THAT ARE CLEARLY RELATED TO A DOCUMENTED PHYSICAL CONDITION.

11. Anxiety, Somatic
0 - Absent
1 - Mild *(symptom(s) present only infrequently, no impairment, minimal distress)*
2 - Moderate *(symptom(s) more persistent, or some interference with usual activities, moderate distress)*
3 - Severe *(significant impairment in functioning)*
4 – Incapacitating

How has your appetite been this past week? What about compared to your usual appetite? IF LESS: How much less?
Have you had to force yourself to eat?
Have other people had to urge you to eat? (Have you skipped meals?)
Have you found yourself eating more than usual? Every day? Have you noticed you eat more at meals? Have you noticed you are snacking or eating more in between meals? Have you felt driven to eat? Have you had eating binges?

12. Somatic Symptoms Gastrointestinal:
0 - None
1 - Loss of appetite but eating without encouragement
(Appetite somewhat less than usual)
2 - Difficulty eating without urging *(or appetite significantly less, with or without having to force self to eat)*

How has your energy been this past week?
IF LOW ENERGY: Have you felt tired? (How much of the time? How bad has it been?)
This week, have you had any aches or pains? (What about backaches, headaches, or muscle aches?)
How much of the time? How bad has it been?
During the past week, have you had feelings of being weighted down, like you had lead weights on your arms and legs? How many days? How much of the time? Do these symptoms interfere with your day-to-day activities?

13. Somatic Symptoms General
0 - None

1 - Heaviness in limbs, back, or head. Backaches, headaches, muscle aches. Loss of energy and fatigability *(somewhat less energy than usual; mild, intermittent loss of energy or muscle aches/heaviness)*
2 - Any clear-cut symptoms (persistent, significant loss of energy or muscle aches/heaviness)

Sometimes, along with depression or anxiety, people might lose interest in sex. This week, how has your interest in sex been? (I'm not asking about actual sexual activity, but about your interest in sex.)
Is sex something you've thought about this week?
Has there been any change in your interest in sex (from when you were feeling OK)?
IF YES: Is this unusual for you, compared to when you feel well? (Is it a little less or a lot less?)

14. Genital Symptoms (such as loss of libido, menstrual disturbances):
0 - Absent
1 - Mild *(somewhat less interest than usual)*
2 - Severe *(a lot less interest than usual)*

In the last week, how much have your thoughts been focused on your physical health or how your body is working (compared to your normal thinking)? (Have you worried a lot about being or becoming physically ill?
Have you really been preoccupied with this?)
Do you complain much about how you feel physically?
Have you found yourself asking for help with things you could really do yourself?
IF YES: Like what, for example? How often has that happened?

15. Hypochondriasis:
0 - Not present *(absence of inappropriate worry OR completely reassured)*
1 - Self-absorption *(bodily, some inappropriate worry about his/her health OR slightly concerned despite reassurance)*
2 - Preoccupation with health *(often has excessive worries about his/her health OR definitely concerned has specific illness despite medical reassurance)*
3 - Frequent complaints, requests for help, etc. *(is certain there is a physical problem which the doctors cannot confirm; exaggerated or unrealistic concerns about body and physical health)*
4 - Hypochondriacal delusions *(e.g., feels parts of body decaying or rotting away; occurs rarely in outpatients)*

Have you lost any weight since this (DEPRESSION) began? IF YES: Did you lose any weight this last week?
(Was it because of feeling depressed or down?) How much did you lose?
IF NOT SURE: Do you think your clothes are any looser on you?
How much has your weight changed in the past 2 weeks?
AT FOLLOW-UP: Have you gained any of the weight back?

16. Loss of Weight within the Last Week
When rating by history:
0 - No weight loss or weight loss NOT caused by present illness
1 - Probable weight loss due to current depression
2 - Definite (according to patient) weight loss due to depression

RATING BASED ON OBSERVATION DURING INTERVIEW

17. Insight:
0 - Acknowledges being depressed and ill OR not currently depressed
1 - Acknowledges illness but attributes cause to bad food, overwork, virus, need for rest, etc. *(denies illness but accepts possibility of being ill, e.g. "I don't think there's anything wrong, but other people think there is".)*
2 - Denies being ill at all *(complete denial of having an illness, e.g., "I'm not depressed; I'm fine".)*

Global Assessment of Functioning (GAF) Scale

(Filled by the research assistant using the following guide)

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations

Code (Note: Use intermediate codes when appropriate, e.g., 45, 68, 72.)
100 - 91
Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.

90 - 81
Absent or minimal symptoms (e.g., mild anxiety before an exam)**, good functioning in all areas, interested and involved in a wide range of activities. socially effective, generally satisfied with life, no more than everyday problems or concerns** (e.g. an occasional argument with family members).

80 - 71
If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); **no more than slight impairment in social, occupational or school functioning** (e.g. temporarily failing behind in schoolwork).

70 - 61
Some mild symptoms (e.g. depressed mood and mild insomnia)
OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household)**, but generally functioning pretty well, has some meaningful interpersonal relationships.**

60- 51
Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks)
OR moderate difficulty in social, occupational, or school functioning (e.g. few friends, conflicts with peers or co-workers).

50 - 41
Serious symptoms (e.g. suicidal ideation, severe obsessional rituals, frequent shoplifting)
OR any serious impairment in social, occupational, or school functioning (e.g. no friends, unable to keep a job).

40 - 31
Some impairment in reality testing or communication (e.g., speech is at times, illogical, obscure, or irrelevant)

OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

30- 21
Behaviour is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability to function in almost all areas** (e.g., stays in bed all day; no job, home, or friends).

20 - 11
Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement)
OR occasionally fails to maintain minimal personal hygiene (e.g., smears faeces) **OR gross impairment in communication** (e.g. largely incoherent or mute).

10 - 1
Persistent danger of severely hurting self or others (e.g., recurrent violence) **OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.**

0 Inadequate information.

The Beck Depression Inventory

(Self-administered and would be filled by the participant)

1. Sadness

0 I do not feel sad.

1 I feel sad much of the time.

2 I am sad all of the time.

3 I am so sad or unhappy that I can't stand it.

2. Pessimism

0 I am not discouraged about my future.

1 I feel more discouraged about my future than I used to be.

2 I do not expect things to work out for me.

3 I feel my fortune is hopeless and will get only worse.

3. Past Failure

0 I do not feel like a failure.

1 I have failed more than I should have.

2 As I look back I see a lot of failures.

3 I feel I am a total failure as a person.

4. Loss of Pleasure

0 I get as much pleasure as I ever did from the things I enjoy.

1 I don't enjoy things as much as I used to.

2 I get very little pleasure from the things I used to enjoy.

3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

0 I don't feel particularly guilty.

1 I feel guilty over many things I have done or should have done.

2 I feel quite guilty most of the time.

3 I feel guilty most of the time.

6. Punishment Feelings

0 I don't feel I am being punished.

1 I feel I may be punished.

2 I expect to be punished.

3 I feel I am being punished.

7. Self-Dislike

0 I feel the same about myself as ever.

1 I have lost confidence in myself.

2 I am disappointed in myself.

3 I dislike myself.

8. Self-Criticisms

0 I don't criticize or blame myself more than usual.

1 I am more critical of myself than I used to be.

2 I criticize myself for all of my faults.

3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.

1 I have thoughts of killing myself, but I would not carry them out.

2 I would like to kill myself.

3 I would kill myself if I had the chance.

10. Crying

0 I don't cry any more than I used to.

1 I cry more than I used to.

2 I cry over every little thing.

3 I feel like crying, but I can't.

11. Agitation

0 I am no more restless or would up than usual.

1 I feel more restless or would up than usual.

2 I am so restless or agitated that it's hard to stay still.

3 I am so restless that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.

1 I am less interested in other people or things than before.

2 I have lost most of my interest in other people or things.

3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.

1 I find it more difficult to make decisions than usual.

2 I have much greater difficulty in making decisions than usual.

3 I have trouble making any decision.

14. Worthlessness

0 I do not feel I am worthless.

1 I don't consider myself as worthwhile and useful as I used to.

2 I feel more worthless as compared to other people.

3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.

1 I have less energy than I used to have.

2 I don't have enough energy to do very much.

3 I don't have enough energy to do anything.

16. Changes in Sleeping Patterns

0 I have not experienced any change in my sleeping pattern.

1 I sleep somewhat more/less than usual.

2 I sleep a lot more/less than usual.

3 I sleep most of the day.

I wake up 1-2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.

1 I am more irritable than usual.

2 I am much more irritable than usual.

3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1 My appetite is somewhat greater/lesser than usual.

2 My appetite is much greater/lesser than usual.

3 I crave food all the time or I have no appetite at all.

19. Concentration Difficulty

0 I can concentrate as well as ever.

1 I can't concentrate as well as usual.

2 It's hard to keep my mind on anything for very long.

3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.

1 I get more tired or fatigued more easily than usual.

2 I am too tired or fatigued to do a lot of the things I used to do.

3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be.

2 I am much less interested in sex now.

3 I have lost interest in sex completely.

CLIENT SCORE: _____

Culturally relevant psychotherapies for depression in Sri Lanka (Phase II)

Subsequent assessment questionnaire

Client Identification Number: ……..

1.1. Have you harmed yourself since you enrolled in this study?

☐ Yes

☐ No

☐ Not sure

If yes

Please give details of self-harm act/s

When was the last time you harmed yourself? .....

1.2. Have you had hospital admission/s or presentation/s to OPD since you enrolled in this study?

☐ Yes

☐ No

☐ Not sure

If yes

Please give details of hospital admission/s or presentation/s to OPD (reason and treatment)

1.3. Have there been changes to your treatment since you enrolled in this study?

☐ Yes

☐ No

☐ Not sure

If yes

Please give details of treatment changes

1.4. How compliant have you been with your treatment?

Medication-

☐ I take medication every day without failing

☐ I forget take medication about once a week

☐ I forget to take medication 2-4 times a week

☐ I forget to take medication 5-7 time a week/ I forget to take medication almost daily

☐I rarely take medication

☐ I don't take medication at all

☐Not sure

Other treatment

☐ Very compliant

☐ Partially compliant

☐ Poorly compliant

1.5. How would you evaluate the psychotherapy sessions?

☐ Very useful

☐ Useful

☐ Ok

☐ No effect, but I don't mind attending

☐I don't find them useful and don't want to attend

☐ My condition is worse because of them

☐Not sure

Please give details why it is useful or not useful (e.g.- My symptoms got better/ I like someone talk to/etc)

1.6. What is the best thing about these psychotherapy sessions?

1.7. What is the worst thing about these psychotherapy sessions?

1.8. In your opinion, how can one strengthen what is learned during these sessions?

1.9. What do you think about the duration of the sessions and frequency of the sessions?

1.10. In your opinion, what is more beneficial - involving patient alone in sessions or involving patient and family? Why?

1.11. In your opinion, is usage of religious literature / folk takes useful in psychotherapy?

1.12. In your opinion, is usage of techniques such as mindfulness (state of active, open attention on the present) useful in psychotherapy?

1.13. If this kind of psychotherapy was offered to all patients with depression, do you think they will want to receive this intervention?

☐ Yes

☐ No

☐ Not sure

If yes /no Please give reasons

1.14. If this kind of psychotherapy was offered to all patients with depression, do you think many people will drop out from this treatment?

☐ Yes

☐ No

☐ Not sure

If yes /no Please give reasons

1.15. What other things can be done to make this kind of psychotherapy more appealing than usual treatment?

Appendix 12 HDRS and GAF Sinhala phase 2

<u>හැමිල්ටන් අවපාතය පරිමාණ හගත සම්මුඛ පරීක්ෂණය නියමුව</u>

(පහත සඳහන් මඟ පෙන්වීමක් භාවිතා කරමින් පර්යේෂණ සහකාර විසින් සම්පූර්ණ කරන ලද)

දළ විශ්ලේෂණය: මම ඔබ පසුගිය සතිය ගැන ප්‍රශ්න කිහිපයක් ඇසීමට කැමතියි. කොහොමද පසුගිය (දවස සතියේ) සිට ඔබ දැනෙන්නේ වී ඇති බවත්;

ඔබ වැඩ කර තිබේද? එසේ නොවේ නම්: ඇයි නැත්තේ?

ඔබේ මනෝභාවය පසුගිය සතියේ (ඔබ හරි හැඟෙන විට හා සසඳන විට) වැනි ය?

ඔබ හිතෙද්දී කර හෝ මානසික අවපීඩනයෙන් පෙළෙන කර තිබෙනවාද? දුකින් බලාපොරොත්තු රහිත? අසරණ? වැදගැම්මකට නැති?

- ඔව් නම්: ඔබ මෙම හැඟීම මොන වගේ වී ඇති දේ විස්තර කළ හැකිද? හැඟීමක් මොන තරම් නරක ද?

ඔබ සියලු දී අඬන්නේ කර ඇති බවත්;

කොහොමද අනාගතය ගැන ඔබ දැනෙන්නේ වී ඇති බවත්; (සවර් ශුභවාදී / අශුභවාදී) ඔබ අන් අයට දිරිගැන්වීම / බිය සැක දුරු සමඟ වඩා හොඳ සිතනවාද? ඔබ දේවල්, වඩා හොඳ ලබා වැඩි දියුණු, පිටතට වැඩ කරනු ඇත සිතනවාද?

මානසික අවපීඩනයෙන් පෙළෙන නම්: පසුගිය සතියේ දී, හොඳ දෙයක්, කුඩා දේවල් පවා සිදු වූ විට, ඔබේ මනෝභාවය ආලෝකමත් කළේ ඇයි? කොපමණ කල් මෙම මනෝගතිය පවතිනු ඒකාලෝක කළේ ඇයි? ඔබේ මනෝභාවය ඒකාලෝක නමුත් විය හැකිව සිදු වන දේවල් එහි හිටියා ද?

පසුගිය සතියේ දී, කෙසේ බොහෝ විට ඔබ (Own සමාන) දැනෙන්න ඇති? සෑම දිනම? දවස?

1. මානසික ස්වභාවයේ (දුක, බලාපොරොත්තු රහිත, අසරණ, කිසි කමකට නැති) මානසික අවපීඩනයෙන් පෙළෙන:

0 - නැති කල.

1 - පමණි (ඉඳ හිට, සුළු ලෙස විෂාදය) ප්රශ්න මත සඳහන්

2 - ස්වයංසිද්ධව වාචිකව වාතර්ා (නොනැසී, මානසික අවපීඩනය දියුණු කිරීමට මaදු)

3 - අඩන්න i.e., වක්ත්ර අභිනය, මවා පෑමට, හඬ, සන්නිවේදනය-වාචිකව නොවන, ප්රවනතාව

(දිගුකල් පවත්නා දැඩි මානසික අවපීඩනය කිරීම මධ්යම)

4 - පාහේ පමණක් එම දැනෙන්නේ රාජ්යයන් (අන්ත බලාපොරොත්තු රහිත හෝ tearfulness සමග දිගුකල් පවත්නා, ඉතා දරුණු මානසික අවපීඩනය,) ස්වයංසිද්ධ වාචික හා රාජ්ය නොවන සංන්නිවේදනය වාතර්ා

ඔබ පසුගිය සතියේ බිඳ දමා තිබුණු අතර, ඔබ දේවල් වැරදි කරලා තියෙන්නෙ දැනෙන්නේ, හෝ අනිත් අයට ඉඩ දෙන්නේ?

ඔව් නම්: ඔබේ සිතුවිලි ඇත්තේ ඇයි? මෙය ඔබට සාමාන්ය වඩා තිබේද?

පසුගිය සතියේ දී, ඔබ ඔබ ගැන දැනෙන්න ඇති?

ඔබ ඔබේ ආත්ම අභිමානය පසුගිය සතියේ බිඳ කර ඇති දැක තිබෙනවාද? ඔබ අන් අයට සාපේක්ෂව පුද්ගලයෙකු ලෙස ඔබේ වටිනාකම ශ්රේණිගත කරන්නේ කෙසේද?

ඔබ අපට කළ හෝ සිදු නොවේ තියෙනවා කිසිම දෙයක් ගැන වරද දැනෙන්නේ කර තිබෙනවාද? කුමක්ද බොහෝ කලකට පෙර සිදු වූ දේවල් ගැන?

ඔබ දඩුවම් කරනවා වගේ ඔබට හැඟෙන්නේ කුමක්ද?

ඔබ ඔබ වෙනුවෙන් යම් ආකාරයකින් ඔබ ගෙනාවා කියලා කර ඇත (මෙය මානසික අවපීඩනය)?

විටකදී 2. හැඟීම්:

0 - නැති කල.

1 - ස්වයං-නින්දා අපහාස, ඔහු / ඇය (ඵලදායිතා පමණක් අඩු වැඩි හෝ වරද) මිනිසුන් පහලට ඇත දැනෙනවා

2 - අතීත වැරදි හෝ පව්කාර ක්රියාවන් වැඩි වරදකාරී බව හෝ rumination ක අදහස් (වරද කනස්සල්ලක් හෝ ලජ්ජාව හැඟීම්)

3 - වතර්මාන රෝගී දඩුවමක් ඇත. වරද විහාරය රාවණාගේ උරුමය (වරද දැඩි, පැතිරෙන හැඟීම්)

4 - accusatory හෝ denunciatory හඬ සහ / හෝ දaශ්ය දශර්නද තජර්නය අත්දැකීම් දැනගන්න ලැබෙනවා

පසුගිය සතියේ දී, ඔබ ඔබේ ජීවිතයේ ජීවත් වීම වටී නොවන බව සිතුවිලි තිබුණා? ඔබ මිය ගිය හෝ ඔබ මිය ගොස් සිටි ක්ෂණිව වඩා හොඳ ජීවිතයක් ගත කරනවා කල්පනා ගැන? ඔබ රිදීමක් හෝ ඝාතනය සිතුවිලි කර තිබෙනවාද?

ඔව් නම්: ඔබ ගැන කල්පනා කර?

කොහොමද බොහෝ විට මෙම අදහස් ආවේ? ඔවුන් කෙතරම් කලක් රැඳී තිබේද? ඔබ පසුගිය සතියේ සැලැස්මක් කල්පනා කර තිබෙනවාද?

ඔබ කරදර කිරීමට උත්සාහ කිරීම කිසිම දෙයක් කරලා හෝ ඔබේ ජීවිතය අවසන් වීමට තිබෙන පියවර ගෙන තිබෙනවාද?

3. මරාගෙන මැරෙන:

0 - නැති කල.

1 - ජීවිතයක් වටිනා නොවේ දැනෙයි

2 - ඔහු / ඇය මිය ගොස් සිටි හෝ ස්වයං හැකි මරණ ඕනෑම සිතුවිලි පැතුම්

3 - ජීවිතේ නැති කරගන්න අදහස් හෝ අභිනය

4 - මරාගෙන මැරෙන දී උත්සාහ

දැන් අපි ඔබේ නින්ද ගැන කතා කරමු. නින්දට යාමෙන් මෙම ආරම්භ වීමට පෙර, අවදි ඔබේ සුපුරුදු පැය මොනවාද?

ඔබ නිදි විට පහත වැටී ඇති පසුගිය සතිය පුරා අවදි වී ඇති බවත්;

ඔබ රාත්රී ආරම්භයේ දී නින්ද ඕනෑම කරදර කර තිබෙනවාද? (ඔබ නින්දට යන්න අයිතිය පසු, කොපමණ කාලයක් එය ඔබ නින්ද වෙත ගෙන ඇත?)

ඔබ කරදර නින්ද රාත්රී කොපමණ මේ සතියේ තිබුණා?

4. ආදායමක් මුල් (මූලික ආදායමක්):

0 - නෑ අමාරුවෙන් නින්ද

1 - නින්ද විටින් අපහසුතාවයක් පැමිණිලි

(I.e., ½ ක පැය හෝ ඊට වැඩි, 2-3 රාත්රී)

2 - රාත්රි අමාරුවෙන් නින්ද (i.e., ½ ක පැය හෝ ඊට වැඩි, 4 හෝ ඊට වැඩි රාත්රී) ක පැමිණිලි

පසුගිය සතිය තුල, ඔබ මධ්‍යම රාත්‍රියේදී අවදි වී ඇති බවත්; ඔව් නම්: ඔබ ඇදෙන් ලබා ගන්නේ කෙසේද?

ඔයා මොකද කරන්නේ? (පමණක්, නාන කාමරය වෙත යන්න?)

ඔබට නැවත ඇඳේ ලබා විට, ඔබ හරි නැවත නින්ද කිරීමට හැකි ද?

ඔබ අවදි කෙතරම් කලක් රැඳී නිබේද?

ඔබ කරදර ඒ වගේ රාත්‍රී කොපමණ මේ සතියේ තිබුණා?

(නම් නැත නින්ද නොයාම) ඔබේ නින්ද විට බෙල්ල වී හෝ රාත්‍රී බාධා කර තිබේ ද?

5. ආදායමක් මැද:

0 - නෑ අමාරුවෙන්

1 - රාත්‍රී (හෝ ඉඳ හිට, i.e., 2-3 රාත්‍රී අමාරුවෙන් ½ ක පැයක් හෝ ඊට වැඩි) තුළ නොසන්සුන් වීම හා බාධා වීම පැමිණිලි

2 - රාත්‍රී කාලයේ අවධි - ඕනෑම ඇදෙන් ලබා (අඩුව හැර); (බොහෝ විට, i.e., 4 හෝ ඊට වැඩි අපහසුතාවයක් රාත්‍රී, ½ ක පැයක් හෝ ඊට වැඩි)

කාලය කුමක්ද ඔබ අවසන් වරට උදෑසන අවදි පසුගිය සතියේ වී ඇති බවත්;

මුල් නම්: ඒ එලාම් ඔරලෝසුවක් සමඟ ද, හෝ ඔබ ඔබ අවදි කරන්නේ කෙසේද? ඔබ සාමාන්‍යයෙන් අවදි වන්නේ කුමක්ද කාලය (ඔබ හොඳින් දැනෙන්නේ එනම්,)?

ඔබ උදේ කොපමණ පසුගිය සතියේ මුල් අවදි ද?

ඔබ නිදා ආපසු යන්න පුළුවන් ද?

6. ආදායමක් දිවංගත (පයර්න්තය ආදායමක්):

0 - නෑ අමාරුවෙන්

1 - අද උදෑසන මුල් පැය අවධි නමුත් (ඉඳ හිට, i.e., 2-3 රාත්‍රී, ½ ක පැයක් හෝ ඊට වැඩි) නිදා දක්වා දිව යන

2 - ඇඳ (බොහෝ විට, i.e., 4 හෝ ඊට වැඩි රාත්‍රී අමාරුවෙන් ½ ක පැයක් හෝ ඊට වැඩි) බැහැලා නම් නැවත නින්ද කිරීමට නොහැකි විය

ඔබ මෙම පසුගිය සතිය ඔබේ කාලය වැය කර ඇත (නැත වැඩ විට)?

ඔබ උදෙසා සාමාන්ය?

ඔබ (එම දේවල්) ඔබ උනන්දු වුණා ඇති, හෝ ඔබ ඔවුන්ට කරන්න ක්රියා කරන්න ඕන හැහෙන්නේ කුමක්ද?

ඔබ කොහොමද දෛනික කටයුතු සම්පූර්ණ කිරීම සඳහා උනන්දුවක් හා උද්යෝගය මට්ටම විස්තර කරන්නේ කෙසේද?

ඔබ ඒ සඳහා ඔබ කළ භාවිතා දෙයක් සිදු කිරීම නතර කර තිබෙනවාද? (කුමක් විනෝදාංශ ගැන?) ඔව් නම්: ඇයි?

ඔබ පොලී ඔබ දේවල් ගත කරන්නේ කෙසේද බොහෝ දිනකට පැය ගැන?

ඔබ බලාපොරොත්තු යමක් තිබේද?

ඔබ මෙම පසුගිය සතිය ඕනෑම විනෝද කර තිබෙනවාද? (නම් නැත), (මිතුරන් සමග කාලය ගත ආහාර වේලක්, සිනමා,) ඔබ භුක්ති කිසිවක් සිදු වී තිබේද? (ඔව් නම්), ඔබ ඔබ වෙනුවෙන් සාමාන්ය මට්ටමින් මුහුණ දීමෙන් නොබැඳි ද?

කම්කරු (හෝ පිටත නිවසේ) නම්: ඔබ තරම් (කායර්ය) ලබා ගැනීමට හැකි වී තිබෙනවාද සිදු ඔබ සාමාන්යයෙන් සිදු කරන පරිදි?

7. වැඩ හා ක්රියාකාරකම්:

0 - නෑ අමාරුවෙන්

1 - කටයුතු, වැඩ හා විනෝදාංශ (; ක්රියාකාරීත්වය කිසිදු පැහැදිලි හානිකරණ පොලී හෝ සතුටක් මෘදු ඔක්සිහරණය) සම්බන්ධ සිතුවිලි සහ නොහැකියාවයි, තෙහෙට්ටුව හෝ දුවර්ල හැඟීම්

2 - ක්රියාකාරකම් පොලී අඩු කිරීමට, විනෝදාංශ හෝ රැකියා - listlessness, indecision හා අතරමං දී රෝගියා හෝ වක්ර සෘජු වාතර්ාව මගින් (ඔහු / ඇය වැඩ හෝ ක්රියාකාරකම් ස්වයං තල්ලු කිරීමට ඇති දැනෙනවා; පොලී, සතුට, හෝ ක්රියාත්මක පැහැදිලි අඩු)

3 - ඵලදායිතාව කටයුතු හෝ අඩු මුදලක් වැය සැබෑ කාලය තුළ අඩු (ොපොලී ප්රගාඪ අවම කිරීම, සතුටක්, හෝ ක්රියාකාරීත්වය)

4 - නිසා වත්මන් රෝග සඳහා (පොලී නිසා රෝගී මූලික භූමිකාව වැඩ හෝ ඉටු කිරීමට නොහැකි අතර, සමස්ත අලාභය) වැඩ කරන බාධාවක්

පමණක් සම්මුඛ පරීක්ෂණයේදී පදනම් වී ඇත්තේ නිරීක්ෂණ ණය ෙශ්ණිය

8. දුවර්ලතා, (චින්තනය හා කතා කිරීමේ මවිතයට පත්වන; අවධානය යොමු කිරීම පලුදුවී හැකියාව; මෝටර් ක්රියාකාරකම් අඩු):

0 - සාමාන්ය කථාව හා චින්තනය

1 - සම්මුඛ පරීක්ෂණයේදී සුළු වශයෙන් දුවර්ලතා, (හෝ මෘදු psychomotor දුවර්ලතා)

2 - සම්මුඛ පරීක්ෂණයේදී පැහැදිලි දුවර්ලතා, (i.e., මධ්යස්ථ, සමහර සම්මුඛ පරීක්ෂණ සමග අමාරුවෙන්; සැලකිය නරඹමින් හා චින්තනයේ මවිතයට පත්වන)

3 - සම්මුඛ පරීක්ෂණ දුෂ්කර (දැඩි psychomotor දුවර්ලතා, සම්මුඛ පරීක්ෂණ ඉතා දුෂ්කර, ඉතා දිගු නරඹමින්)

4 - සම්පූර්ණ දෙනෙත් මෙන් (අන්ත දුවර්ලතා; දෙනෙත් මෙන්; සම්මුඛ පරීක්ෂණය යන්තම් විය හැකි)

පමණක් සම්මුඛ පරීක්ෂණයේදී පදනම් වී ඇත්තේ නිරීක්ෂණ ණය ෙශ්ණිය

9. උද්ඝෝෂණයක්:

0 - කිසිවක් නැත (සාමාන්ය පරාසය තුළ ව්යාපාර)

1 - Fidgetiness

2 -, හිසකෙස් ආදිය අත් ධාවනය

3 - ගැන යනවාද, තවමත් සිටිය නො හැකි

4 - අත්-wringing, නිය සපා, හිසකෙස්-ඇද තොල්වල සපා (සම්මුඛ පරීක්ෂණ නොහැකි)

ඔබ මෙම පසුගිය සතිය, විශේෂයෙන් උණුසුම් හෝ නොසන්සුන් දැනෙන්නේ කර තිබෙනවාද? ඔව් නම්: ඔබ වෙනුවෙන් සාමාන්ය වඩා මෙය වඩාත් ද?

ඔබ අසාමාන්ය ඩී හෝ නොඉවසිලිමත්ව වී තිබෙනවාද? ඔබ ටිකක් පැහැදිලි හේතුව සඳහා අන් අය සමඟ කෝප බවට පත් වෙමින් සොයා ගෙන ඇත? වැඩි වැඩියෙන් එසේ සාමාන්ය තත්වයට වඩා ඔබ වෙනුවෙන්? කොපමණ පසුගිය සතියේ දී කාලය කවෙදර්;

ඔබ පසුගිය සතියේ දී, විශේෂයෙන්, කනස්සලු ස්නායු හෝ අද්දර දැනෙන්නේ වී ඇති බවත්; කොපමණ කාලයක්?

ඔබ සුළු සුළු දේවල්, ඔබ සාමාන්යයෙන් ගැන කරදර වෙන්න එපා දේවල් ගැන ගොඩක් දේවල් නින්දට වඩා කර ඇති බවත්;

ඔව් නම්: උදාහරණයක් දේ, වගේ?

තමන් සතුව අධ්යාත්මික 10. සාංකා:

0 - නෑ අමාරුවෙන්

1 - විෂයානුබද්ධ ආතතිය හා නුරුස්නා (මෘදු, ඉඳ හිට)

2 - සුළු කරුණු ගැන කනගාටු (මධ්යම, සමහර පීඩාව ඇති, හෝ අධික සැබෑ ප්රශ්න ගැන වද වෙන)

3 - භීතියට පත්වෙයි මුහුණ හෝ කතාවේ දී පැහැදිලි ආකල්පයක් (බරපතල කනස්සල්ල නිසා කි්රයා හානිකරණ)

4 - බිය (අඩපන රෝග ලක්ෂණ) ප්රශ්න තොරව ප්රකාශ

ඔබ පසුගිය සතියේ දී පහත සඳහන් භෞතික ලක්ෂණ ඕනෑම තිබුනා නම් මට කියන්න. (ලැයිස්තුව කියවන්න)

GI - මුඛය වියළි වීම, ගෑස්, ඇතුලට, මලබද්ධය, පාචනය, බඩ කැක්කුම, belching, මුත්රා සංඛ්යාත

C-V - හදවත අමාරු, හිසරදය

RESP ක් - අධිකතර, සැනසිල්ලේ ජීවත් අමාරුවෙන් හුස්ම (ඩයිෙපන්සා); දහඩියෙන් තෙත් වී

වෙනත් - භූ කම්පන; ඔබගේ කන් දී නාද (tinnitus); නොපැහැදිළි දශර්නය; උණුසුම් හා සිසිල් කාන්තිය විහිදුවන; පපුවේ වේදනාව

වතර්මාන ලෙස සැලකේ? සෑම රෝග ලක්ෂණයක් කිරීමට:

කොපමණ (THE රෝග ලක්ෂනයකි) පසුගිය සතියේ ඔබ කරදර කර ඇති බවත්; (මොන තරම් නරක එය ඇවිත් ද? කොපමණ කාලයක්, කෙතරම් බොහෝ විට, ඔබ එය තිබුණා?)

සටහන: පැහැදිලිව ලේඛනගත භෞතික තත්ත්වය සම්බන්ධ බව රෝග ලක්ෂණ අනුපාතය නොකරන්න.

11. සාංකා, ජීවී

0 - නැති කල

1 - මෘදු (රෝග ලක්ෂණ (ව) දැනට පමණක් වන්නේ බොහෝ කලාතුරකින්, කිසිදු දුවර්ලතාවයන් අවම ආපදා)

2 - මධ ස්ථ (රෝග ලක්ෂණ (ව) නොනැසී පවත්නා, හෝ සුපුරුදු කටයුතු සමහර මැදිහත්වීම්, මධ්යස්ථ ආපදා)

3 - දරුණු (ක්රියාකාරීත්වය සැලකිය යුතු ණය හානිකරණ)

4 - අඩපන

ඔබේ රුචිය පසුගිය සතියේ වී තිබෙන්නේ කෙසේද? ඔබේ සුපුරුදු ආහාර රුචිය සාපේක්ෂව ගැන?

අඩුවෙන් නම්: කොපමණ අඩු?

ඔබ කන්න ඔබ බල කිරීම සඳහා කර තිබෙනවාද?

අනෙක් අය කෑමට ගැනීමට ඔබට කියා සිටිමි කර තිබෙනවාද? (ඔබ ආහාර හැරී තිබෙනවාද?)

ඔබ ගණනට වඩා වැඩි කෑම සොයාගෙන ඇත? සෑම දිනම? ඔබ ආහාර ගන්නා වඩා ආහාර දැක තිබෙනවාද? ඔබ අතුරු ආහාරයක් හෝ ඊට වඩා වැඩි ආහාර අතර කන දැක තිබෙනවාද? ඔබ කන්න පෙළඹී කර තිබෙනවාද? ඔබ binges කන කර තිබෙනවාද?

ආමාශ ආන්ත්රික ජීවී රෝග ලක්ෂණ 12.:

0 - කිසිවක් නැත

1 - දිරිගැන්වීම තොරව අඩු කිරීමට, ආහාර රුචිය නමුත් කන

(සාමාන්ය ප්රමාණයට වඩා වැඩි තරමක් අඩු ආහාර රුචිය)

2 - අපහසුතා කන ඉල්ලා තොරව (හෝ ආහාර රුචිය සැලකිය යුතු ලෙස අඩු, හෝ කන්න ස්වයං බල කිරීමට තොරව)

ඔබේ ශක්තිය ගෙවී ගිය සතියේ වී තිබෙන්නේ කෙසේද?

පහළ ඇති ශක්ති නම්: ඔබ වෙහෙසට පත් දැනී තිබෙනවාද? (කොපමණ වී ඇත මොන තරම් නරක කාලය? ක?)

මේ සතියේ, ඔබට ඕනෑම ඇගපත වේදනාව හෝ ඇසීමේ තිබුණා? (කුමක් backaches, හිසරදය, හෝ මාංශ පේශි ඇගපත වේදනාව ගැන?)

කොපමණ කාලයක්? එය මොන තරම් නරක වී තිබෙන්නේ කෙසේද?

පසුගිය සතිය තුල, ඔබ ඔබගේ අත් සහ කකුල් පෙරමුණ පටවන බර තිබුණා වගේ, පහළ බර වෙමින් හැඟීම් තිබුණා? දවස් කීයක්ද? කොපමණ කාලයක්? මේ රෝග ලක්ෂණ ඔබේ එදිනෙදා කටයුතු මැදිහත් වෙන්නේ ඇයි?

13. ජීවී රෝග ලක්ෂණ සාමාන්ය

0 - කිසිවක් නැත

1 - අත් පා ගැන බ්රහ්මයා වෙමි, නැවත, හෝ හිස. Backaches, හිසරදය, මාංශ පේශි හතරැස් උනා. බලශක්ති හා fatigability අඩු වීම (සාමාන්ය ප්රමාණයට වඩා වැඩි ශක්ති තරමක් අඩු; / බ්රහ්මයා ශක්තිය ොහෝ මාංශ පේශි ඇගපත මෘදු, වරින්වර අලාභ)

2 - ඕනෑම පැහැදිලි-සැපයුම අත්හිටුවන රෝග ලක්ෂණ (ශක්තිය හෝ මාංශ පේශි ඇගපත යහලුවෙකුගේ, සැලකිය යුතු අලාභයක් / බ්රහ්මයා වෙමි)

සමහර විට, මානසික අවපීඩනය හෝ සාංකාව සමග, ජනතාව ලිංගික පොලී අහිමි වනු ඇත. මේ සතියේ, කොහොමද ලිංගික ඔබේ පොළී වී තිබෙන්නේ කෙසේද? (මම නමුත් ලිංගික ඔබගේ පොලී ගැන සැබෑ ලිංගික ක්රියාකාරකම් ගැන අහනවා නෑ,)

ඔබ මේ සතියේ ගැන කල්පනා කළා ලිංගික දෙයක්ද?

ලිංගික ඔබේ පොළී යම් වෙනසක් (ඔබ හරි දැනෙන්නේ විට සිට) වී ඇති බවත්;

ඔව් නම්: ඔබ හොඳින් දැනෙන්නේ සමග සසඳන කල, ඔබ වෙනුවෙන් මෙම අසාමාන්ය ද? (එය ටිකක් අඩු හෝ ගොඩක් අඩු ද?)

14. ලිංගික ලක්ෂණ (එවැනි libido අහිමි වීම, ඔසප් කලබල ලෙස):

0 - නැති කල

1 - මෘදු (සාමාන්ය ප්රමාණයට වඩා වැඩි තරමක් අඩු පොලිය)

2 - දරුණු (සුපුරුදු වඩා ගොඩක් අඩු පොලිය)

පසුගිය සතියේ දී, කොපමණ ඔබේ සිතුවිලි ඔබේ ශාරීරික සෞඛ්යය පිළිබඳ ඔබේ ශරීරය වැඩ කරන ආකාරය (ඔබගේ සාමාන්ය චින්තනය හා සසඳන විට) අවධානය යොමු හෝ වී ඇති බවත්; (ඔබ වීම හෝ ශාරීරිකව රෝගී බවට පත් වෙමින් ගැන ගොඩක් දේවල් කනස්සල්ලට කර තිබෙනවාද?

ඔබ ඇත්තටම මේ සමග දැකීමේ හැකියාවක් ඇති බවත්;)

ඔබ ශාරීරිකව හැඟෙන්නේ ගැන බොහෝ පැමිණිලි කරනවාද?

ඔබ ඔබ ඇත්තටම ඔබ කරන්න පුළුවන් දේවල් සමග උදව් කරන්න කියලා සොයා ගෙන ඇත?

ඔව් නම්: උදාහරණයක් දේ, වගේ? ඒ කොහොමද බොහෝ විට සිදුවී ඇත්තේ කුමක්ද?

15. Hypochondriasis:

0 - දැනට නොව (නුසුදුසු කනස්සල්ල නොමැති හෝ සම්පූර්ණයෙන්ම කිහිපදෙනකුගෙන්)

1 - ස්වයං-අවශෝෂණය (ශාරීරික, බිය සැක දුරු වුවද ඔහුගේ / ඇයගේ සෞඛ්ය හෝ තරමක් සැලකිලිමත් ගැන සමහරක් නුසුදුසු කනස්සල්ල)

2 - සෞඛ්ය සිත යොමු කිරීමෙන් (බොහෝ විට වෛද්ය බිය සැක දුරු වුවද ඔහුගේ / ඇයගේ සෞඛ්ය හෝ අනිවාර්යයෙන්ම සැලකිලිමත් විශේෂිත රෝග ඇති පමණ අධික කරදර ඇති)

3 - ආදිය නිතර නිතර පැමිණිලි, උදව් සඳහා ඉල්ලීම්, (වෛද්යවරුන් තහවුරු කර ගත නොහැකි ශාරීරික ගැටලුවක් පවතී නිශ්චිත ය; ශරීරය හා ශාරීරික සෞඛ්යය ගැන අතිශයෝක්තියට හෝ යථාර්ථවාදී නොවන කනස්සල්ල)

4 - Hypochondriacal විභාරය රාවණාගේ උරුමය (උදා, දැනෙනවා ශරීර කොටස් දිරාපත් වෙමින් පවතින හෝ ඉවත් කුනුවෙන; බාහිර රෝගීන් තුළ කලාතුරකින් සිදුවේ)

මෙම අවපීඩනය () ආරම්භ වූ නිසා ඔබ යම් බර අහිමි කර තිබෙනවාද? ඔව් නම්: ඔබ මෙම පසුගිය සතියේ ඕනෑම බර අඩු කළාද?

(එය මානසික අවපීඩනයෙන් පෙළෙන නොසිතමු හෝ පහලට නිසා ද?) ඔබ කොපමණ අහිමි වුණේ ඇයි?

ෂුවර් නැති නම්: ඔබ ඔබේ ඇඳුම් ඔබ ඕනෑම තිබීමත් ය සිතනවාද?

පසුගිය සති 2, ඔබේ බර කොපමණ වෙනස් වී ඇත්තේ කෙසේද?

ඒටී පසු විපරම්: ඔබ ආපසු බර ඕනෑම ලබා තිබේද?

අවසාන සතිය තුළ සිරුරේ බර 16. අඩු කිරීමට

ඉතිහාසය විසින් විට ඇගයුම:

0 - දැනට අසනීප නිසා නොවේ මෙයට සිරුරේ බර අඩු කිරීමට හෝ සිරුරේ බර අඩු කිරීමට

1 - වත්මන් අවපාතය හේතුවෙන් අනුමාන සිරුරේ බර අඩු කිරීමට

2 - හේතුවෙන් විෂාදය (රෝගියා අනුව) නිශ්චිත සිරුරේ බර අඩු කිරීමට

සම්මුඛ පරීක්ෂණයේදී පදනම් වී ඇත්තේ නිරීක්ෂණ ණය ෙශ්ණිය

17. තීක්ෂ්ණ බුද්ධිය:

0 - මානසික අවපීඩනයෙන් පෙළෙන සහ කaaර සහ අමානුෂික හෝ නොවේ දැනට මානසික අවපීඩනයෙන් පෙළෙන වීම පිලිගනී

1 - ආදිය අසනීප පිලිගනී නමුත් ගුණාංග නරක ආහාර, අධික වැඩ, වෛරසය කිරීමට හේතු, විවේක සඳහා අවශ්ය, (අසනීප ප්රතික්ෂේප කරයි නමුත් රෝගාතුර වීම හැකියාව පිළිගන්නා, උදා: "මම හිතන්නේ නැහැ වරදක් තිබේද, නමුත් අනෙක් අය සිතන්නේ".)

2 - සියලු දී රෝගාතුර වීම (අසනීපයක් ඇති සම්පූර්ණ ප්රතික්ෂේප, උදා, "මම අධෛයර්යට ඉන්නේ, මම හොඳින්".) ප්රතික්ෂේප කරයි

කටයුතු කිරීම (GAF) පරිමාණ ගෝලීය තක්සේරු

(පහත සඳහන් මහ පෙන්වීමක් භාවිතා කරමින් පයෙර්ෂණ සහකාර විසින් සම්පූණර් කරන ලද)

මානසික සෞඛ්‍ය-රෝගී උපකල්පිත සන්තති මත, මානසික, සමාජීය, සහ වෘත්තීය ක්‍රියාකාරීත්වය සලකා බලන්න. නිසා භෞතික (හෝ පාරිසරික) සීමාවන් ක්‍රියාකාරිත්වයන් හානිකරණ අඩංගු නොකරන්න

කේතය (සටහන: සුදුසු අවස්ථාවලදී භාවිත අතරමැදි කේත, උදා, 45, 68, 72.)

100 - 91

කටයුතු විශාල ප්‍රමාණයක් සුපිරි ක්‍රියාකාරිත්වය, ජීවිතයේ ගැටලු අනින් ලබා ගැනීමට පෙනේ කවදාවත්, පිටතට අන් අය විසින් නිසා ඔහුගේ හෝ ඇයගේ හෝ සාධනීය ගුණාංග උත්සාහ කර ඇත. රෝග ලක්ෂණ නැත.

90 - 81

නැතිවීම හෝ අවම රෝග ලක්ෂණ (උ.දා., විභාගයට පෙර මෘදු කාංසාව), හොඳ සියලු ප්‍රදේශවල උනන්දුවක් හා ක්‍රියාකාරකම් පුළුල් පරාසයක සම්බන්ධ ක්‍රියාකාරීත්වය. එදිනෙදා ප්‍රශ්න හෝ ප්‍රශ්න (පවුලේ සාමාජිකයන් සමඟ උදා ඉඳ හිට තකර්ය) වඩා වැඩි, සමාජීය ඵලදායී ජීවිතය සාමාන්‍යයෙන් තෘප්තිමත්.

80 - 71

රෝග ලක්ෂණ පවතියි නම්, ඔවුන් මනෝ සමාජීය stressors කිරීමට තාවකාලික හා expectable ප්‍රතික්‍රියා (උදා, අමාරුවෙන් පවුල් ආරවුලක් පසු අවධානය යොමු) ය; , සමාජ වෘත්තීය හෝ පාසැල් දී සුළු ණය හානිකරණ (පාසැල් වැඩ ගැන උදා තාවකාලිකව පිටුපස අසමත්) ක්‍රියාත්මක කටත් අඩු කාලයක්.

70 - 61

සමහරු මද ලක්ෂණ (උදා මානසික අසහනය හා මෘදු නින්ද නොයාම)

හෝ, සමාජ වෘත්තීය, හෝ පාසල කටයුතු (උදා: ඉඳ හිට truancy, හෝ ගෘහ තුළ සොරකම) දී කිසියම් අපහසුතාවයක්, නමුත් සාමාන්‍යයෙන් ඉතා හොඳින් ක්‍රියාත්මක වන සමහර අර්ථවත් අන්තර් සබඳතා

ඇත.

60- 51

මධ්‍යස්ථ රෝග ලක්ෂණ (උදා, පැතලි කතාව, ඉඳ හිට සන්ත්‍රාසය ප්‍රහාර බලපාන්නේ හා පරියේෂණාත්මක)

සමාජ, වෘත්තීය, හෝ පාසලේ හෝ මධ්‍යස්ථ අමාරුවෙන් (උදා කිහිපයක් මිතුරන්, මිතුරන් හෝ සම-කම්කරුවන් සමග ගැටුම්) ක්‍රියාත්මක.

50 - 41

බරපතල රෝග ලක්ෂණ (උදා සියදිවි නසාගැනීමට සංකල්පනය, දැඩි obsessional චාරිත්ර, නිතර නිතර බඩු සොරකම්)

හෝ සමාජ, වෘත්තීය තුළ කිසිදු බරපතල දුර්වර්ලතාවයන් හෝ පාසැල් (උදා මිතුරන්, රැකියාවක් තබා ගැනීමට නොහැකි කිසිදු) ක්‍රියාත්මක.

40 - 31

යථාර්ථය පරීක්ෂා කිරීම හෝ සන්නිවේදනය සමහර ණය හානිකරණ (උදා, කතා, තකර්කානුකූල අපැහැදිලි කිරීම හෝ අනදාල අවස්ථාවලදී මිල)

එම කටයුතු හෝ පාසැල්, පවුලේ සබඳතා, විනිශ්චය, චින්තනය, හෝ මනෝභාවය ලෙස කිහිපයක් ප්‍රදේශ, හෝ ප්‍රධාන ණය හානිකරණ (උදා, මානසික අවපීඩනයෙන් පෙළෙන මිනිසා, මිතුරන් මගහැරෙන පවුලේ නොසලකා හරින, සහ වැඩ කිරීමට නොහැකි ය; දරුවා නිතර නිතර බාල දරුවන් අභිබවමින්, ගෙදර නොබියව වේ , හා පාසැල් අසමත් ඇත).

30- 21

සන්නිවේදන හෝ විනිශ්චය විභාරය රාවණාගේ උරුමය හෝ ව්යාජ දශර්න වලට හෝ බරපතල හානිකරණ (උදා: සමහර විට නොකලයුතු, බෙහෙවින්ම නුසුදුසු, ක්‍රියා සියදිවි නසාගැනීමට සිත යොමු කිරීමෙන්) හෝ පාහේ සියලු ප්‍රදේශවල (උදා: තුළ කටයුතු කිරීමට නොහැකි වීම ගැන හැසිරීම සැලකිය යුතු බලපෑමක් වේ, දවස ඇඳේ නගී; කිසිදු රැකියාවක්, නිවසක්, හෝ මිතුරන්).

20 - 11

ස්වයං හෝ අන් අය කටුවල සමහර අනතුර (මරණය පිළිබඳ පැහැදිලි බලාපොරොත්තුවක් නොමැතිව

උදා මරාගෙන මැරෙන උත්සාහය; නිතර ප්‍රචණ්ඩ; manic ජනතා උද්යෝගය)

හෝ ඉඳහිට (උදා බොහෝ දුරට නොකලයුතු හෝ ගොළු) සන්නිවේදන අවම සනීපාරක්ෂාව (උදා, ආශ්‍රිත මල) හෝ දළ ණය හානිකරණ පවත්වා ගැනීමට අපොහොසත් වෙයි.

10 - 1

ස්වයං හෝ අන් අය (උදා, පුනරාවතර්න ප්‍රචණ්ඩත්වය) හෝ මරණය පිළිබඳ පැහැදිලි බලාපොරොත්තුවක් සමඟ අවම සනීපාරක්ෂාව හෝ බරපතල සියදිවි නසාගැනීමට පනත පවත්වා ගැනීමට දිගටම පවතින නොහැකියාව දැඩි කටුවල දිගටම පවතින අනතුර.

0 නොවූ තොරතුරු.

Appendix 13questionnaire Sinhala phase 2

<u>විශාදය සුවකිරීම සඳහා ශ්‍රී ලංකාවේ සංස්කෘතියට ගැලපෙන මනෝ චිකිත්සක ක්‍රම හඳුන්වා දීම පිළිබඳ නියමු අධ්‍යනය</u>

<u>බඳවා ගැනීම සඳහා වූ පශ්නාවලිය</u>

1. සේවාලාභියා හඳුනාගැනීම් අංකය: ....
2. ජන විකාශනය
3. වයස: _____
4. රැකියාව: _____
5. විවාහක අවිවාහක බව

A☐තනි

B☐විවාහක

C☐එකට ජීවත් වෙන

D☐වෙන් වෙන් / දික්කසාද

E☐වැන්දඹු

6. ළමුන් ගණන _____

7. ඔබ විශාදය රෝග ලක්ෂණ සහිතවකල; _____ සති / මාස / අවුරුදු

8. රෝග ලක්ෂණ පහත සඳහන් කර තිබේ ද? (එකකට වඩා වැඩි වියද හැක)

A☐ලිහිල් කිරීමට නොහැකියාව

B☐ජීවත්වීම වටිනා නොවේ යන සිතුවිලි

C☐නොපෙනෙන හඬ අසයි

D☐වටින්නේ නැති සිතුවිලි, වරද සිතුවිලි, බලාපොරොත්තු රහිත වූ සිතුවිලි

E☐අසාමානයය සිතුවිලි

9. ඔබ කවදා හෝ ඔබ හානියක් කර තිබෙනවාද?

A☐ඔව්

B☐නොමැත

C☐නොදනි

10. ස්වයං-හානියක් පනත විස්තර සපයන්න .....

11. ඔබ හානියක් අවසන් වතාවට කතා කළේ කවදාද? ....

12. ඔබ විශාදය සම්බන්ධ භෞතික ලක්ෂණ කර තිබෙනවාද?

A☐ඔව්

B☐නොමැත

C☐නොදනි

13. ඒවා කුමක් ද?

14. ඔබට මානසික රෝග ලක්ෂණ නිසා ඔබගේ දෛනික ක්‍රියාකාරකම්වල නිරතවීමට දුෂ්කර වෙනවාද?

A☐ඔව්

B☐නොමැත

C☐නොදනී

15 එය කෙසේ බලපාන්නේ කෙසේද?

16 ඔබ මේ සඳහා මෙතෙක් කර ඇති ප්‍රතිකාර ක්‍රම මොනවාද?

A☐ඖෂධ

B☐ECT

C☐ආගමික උපදේශන / ගිහි උපදේශන

D☐සම්ප්‍රදායික සුව කිරීමේ චාරිත්‍ර

E☐බටහිර වෛද්‍යවරයකු වූ විශේෂඥ වෛද්‍යවරුන් විසින් ප්‍රතිකාර හෝ උපදේශන කතා

F☐වෙනත්. සඳහන් කරන්න .....

G☐කිසිවක් නොවේ

H☐නොදනී

17 ඔබ ලබා ඇති ඖෂධ මොනවාද?

18 ඔබ ලබා ඇති මනෝ චිකිත්සාව / යනාදිය මොනවාද?

19 ඔබ ඔබේ ප්‍රතිකාර සඳහා කෙතරම් අනුකූලද?

ඖෂධ -

A☐මම අසමත් තොරව ඖෂධ එදිනෙදා ගත

B☐මම සතියකට වරක් පමණ ඖෂධ ගැනීමට අමතක

C☐මම ඖෂධ සතියකට 2-4 වතාවක් ගැනීමට අමතක

D☐මම සතියක් ඖෂධ 5-7 කාලය ගත කිරීමට අමතක / මම දිනපතා ම පාහේ ඖෂධ ගැනීමට අමතක

E☐මම කොහෙත්ම බෙහෙත් ගන්නේ නැහැ

F☐නොදනි

20 වෙනත් ප්‍රතිකාර

A☐ඉතාමත් අනුකූල

B☐අධර්වශයෙන් අනුකූල

C☐දුවර්ල ලෙස අනුගත

21 ඔබට පළමු මානසික පීඩනය රෝග ලක්ෂණ කළේ ඇයි? (කුමක් වයස අවුරුදු / කුමන වසරේ දී)
_____

22(වත්මන් එක් ඇතුළුව) කථාංග කීයක් තිබුණා? _____

23ඔබ කොහොමද කථාංග අතර ඇත්තේ ඇයි?

A☐සම්පූණර්යෙන් සුවය ලබා මම කලින් තිබූ ලෙස ක්‍රියාත්මක

B□අධර්වශයෙන් ක්, කථාංග අතර ඇතැම් රෝග ලක්ෂණ තිබූ අතර 100% ක් නොවේ

C□දුවර්ල ලෙස සොයා ගෙන, බොහෝ රෝග ලක්ෂණ මෙහිදී මම කලින් වැඩක් කරන්න භාවිතා කරන්නේ කුමක් කිරීමට අසමත් වී ඇත

24ඔබ අවම වශයෙන් උද්දාමයෙන් මනෝභාවය ලක්ෂණ දින කිහිපයක්, සිතුවිලි මතු,, ක්ෂණික කතා, ඔබ ඉතා විශේෂ වේ දැනෙන්නේ, දුප්පත් සාන්ද්රණය සහිත, ඕනෑවට වඩා වියදම් කල් පවත්නා කාල කර තිබෙනවාද?

A□ඔව්

B□නොමැත

C□නොදනි

25ඔබ දැන් රෝග ලක්ෂණ පහත සඳහන් කර ඇත කරන්නේ කෙසේද?

A□හැඟීමක් / පහසුවෙන් මනෝභාවයන් වෙනස්

B□බලවත් හැඟීම්

C□කෝපය පාලනයඅපහසුතා

D□පමණක් ඉතිරි කරනු ලැබීමේ වියරු බිය හෝ අතහැර දැමීම

E□ආවේගශීලී හැසිරීම්

F□උදහස්වලනිදන්ගත හැඟීම

G□අනිත්ය paranoid සිතුවිලි / විඝටනය /

H□ස්වයං දිගුකල් පවත්නා දුප්පත් අථර්යෙන්

26 ඔබ ඔබේ හිස තුවාල කර තිබෙනවාද?

A□ඔව්

B□නොමැත

C□නොදනි

කරුණාකර ඔබට විස්තර කළ හැකිය (තුවාල මොන වගේ, එය සිදු වුණේ විට, විඥානය නැතිවීම, පහත සඳහන් සිද්ධිය රෝහල්, මතක ගැටලු යන්න තිබුණා)

27 ඔබ වෛද්ය රෝග තිබේද?

A☐ඔව්

B☐නොමැත

C☐නොදනී

28 කරුණාකර ඔබට විස්තර කළ හැකිද

29 ඔබ මත්පැන් භාවිතා කරනවාද?

A☐ඔව්

B☐නොමැත

30 කරුණාකර ඔබට විස්තර (වගර්ය, ප්රමාණය, සංඛ්යාතය, තණ්හාවට, ඉවත් ඵල) ලබා දිය හැක

31ඔබ නීති විරෝධී මත්ද්රව්ය භාවිතා කරනවාද?

A☐ඔව්

B☐නොමැත

31කරුණාකර ඔබට විස්තර (වගර්ය, ප්රමාණය, සංඛ්යාතය, එය භාවිතා කරන ආකාරය (දුම්පානය /

එන්නත්), තණ්හාවට, ඉවත් එල) ලබා දිය හැක

Appendix 14 semi structured questionnaire for cares of patients with depression phase 1

Culturally relevant psychotherapies for depression in Sri Lanka (Phase I)

Semi structured questionnaire for carers of patients with depression
(Statements in italics are for the guidance of the researcher only)

Demographics

6.1. Age: _____ years

6.2. Occupation: _____

6.3. Marital status

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Other – Please Specify .....

6.4. Number of children-_____

Ages of the children -_____

3.6 What is your relationship to the patient?

_____

3.7 How do you provide support to him /her?

- ☐ assistance with day to day activities
- ☐ emotional support
- ☐ assistance with treatment
- ☐ financial support
- ☐ Other _____

Depression

When asking the following questions use the name of the patient

7.1. When did *name of patient* first develop symptoms of depression?

_____

7.2. Has *name of the patient* had physical symptoms related to depression?

☐ Yes

☐ No

☐ Not sure

What are they?

7.3. What was the duration between onset of symptoms and seeking help?

_____

7.4. What form of help did *name of the patient* seek and why?

7.5. What forms of treatment has *name of the patient* had so far?

☐ Antidepressant medication

☐ ECT

☐ lay counselling

☐ traditional healing rituals

☐ talking therapy or counselling by a clinician practicing western medicine

☐Other

☐ none

☐Not sure

Please provide details:

7.6. What treatment did *name of the patient* find most beneficial?

7.7. If *name of the patient* sought traditional treatment, what made him/her do so?

7.8. Counselling involves advice or guidance, especially as solicited from a knowledgeable person. Talking therapies or psychotherapies involve talking to someone who is trained to help you deal with your mental health and emotional problems. Has *name of the patient* had counselling or talking therapy / psychotherapy? (If it was not mentioned before)

☐ Yes

☐ No

☐ Not sure

Can you please provide details of that treatment *(type / duration / number of sessions / by whom)?*

7.9. Do you believe psychotherapy or counselling can be used in treating mental illness?

☐ Yes

☐ No

☐ Not sure

Can you please provide reasons for your answer*?*

7.10. What did you consider to be the most useful component in counselling/ talking therapy/ psychotherapy?

7.11. Were there components in therapy that were not useful at all? If so, please explain.

☐ Yes

☐ No

☐ Not sure

Can you please explain why?

7.12. Do you believe counselling or talking therapy/ psychotherapy is beneficial in treatment of depression?

☐ Yes

☐ No

☐ Not sure

Can you please explain why?

7.13. Psychotherapy is a time limited practice which involves a certain number of sessions between the therapist and patient. What do you think about the number of sessions required for psychotherapy?

7.14. The sessions can happen at various frequencies. In your opinion, what is the best frequency in psychotherapy for depression?

☐ no change

☐ daily

☐ weekly

☐ fortnightly

☐ monthly

☐other:_____

7.15. What do you think about the duration of each session; what would be the best duration?

☐ 0-15 min

☐ 15-30 min

☐ 30-45 min

☐ 45-60 min

☐ More than 60 min

☐ Other _____

Please give your reasons for your choice

7.16. In your opinion, what do you think is more beneficial in counselling or psychotherapy- direct advice by the knowledgeable person or collaboration and negotiation regarding type of activities / thought processes you need to engage in at home and how much of it etc.?

☐ Directive Advice

☐ Collaboration

☐ Both

☐ Not sure

☐ Other

Can you please explain why?

7.17. In your opinion, how can one strengthen what is learnt by *name of patient* during sessions?

7.18. Assignments in between sessions can be a part of psychotherapy. This will involve practising the new skills that you are learning and applying them to your daily life. What do you think about these assignments?

7.19. What would be the best method /s to ensure compliance with the above mentioned assignments?

7.20. In your opinion, what is more beneficial - involving only the patient in sessions or involving both the patient and family? Why?

7.21. In your opinion, would usage of religious literature / folk tales or techniques be useful in counselling or talking therapy / psychotherapy?

7.22. Mindfulness is purposeful, nonjudgmental awareness of the present moment thereby allowing for increased recognition of mental events in the present moment. What do think of its use in counselling or talking therapy / psychotherapy?

7.23. What can be done to increase participation in the sessions and reduce drop-outs?

7.24. What else can be done to make counselling or talking therapy/ psychotherapy more appealing?

7.25. What lessons can be learnt, or practices can be adopted from traditional healing rituals and religious counselling to allopathic / Western medicine psychotherapy?

Appendix 15 semi structured interview guide for health care professionals phase 1

Culturally relevant psychotherapies for depression in Sri Lanka (Phase I)

Semi structured questionnaire for psychiatrist, psychiatry trainees, psychiatry medical officers and psychologist

(Statements in italics are for the guidance of the researcher only)

2. Demographics

4.21. Age: _____ years

4.22. Gender

☐ Female

☐ Male

4.23. Designation

☐ Psychiatrist

☐ Psychiatry trainee

☐Psychiatry medical officers

☐Psychologists

☐ Other: _____

4.24. Places of work _____

4.25. Whether engaging in private practice or not?

☐ Yes

☐ No

5. Psychotherapy

5.1. Do you use psychotherapy in your everyday practice?

☐ Yes

☐ No

Please elaborate (why they use or don't use it).

5.2. Do you believe psychotherapy is beneficial in Sri Lankan context?

☐ Yes

☐ No

☐Not sure

Please explain why

5.3. If psychotherapy is modified do you think it might change your view regarding psychotherapy?

☐ Yes

☐ No

Please explain why

5.4. What form/s of psychotherapy do you practice?

Please mention names and therapeutic principles

5.4.1. Do you practice CBT?

☐ Yes

☐ No

2.4.2 What CBT therapeutic principles do you use?

5.5. Do you find psychotherapy to be useful in your practice?

☐ Yes

☐ No

☐Unsure

Please why or why not.

5.6. What elements of psychotherapy do you find (or do you think would be) most useful in clinical practice?

6. Depression

6.1. What is your main form of treatment for depression?

6.2. Do you use psychotherapy in patients with depression?

☐ Yes

☐ No

Please elaborate (why they use or don't use it). If yes, what form?

6.3. Do you believe psychotherapy is beneficial in the Sri Lankan context?

☐ Yes

☐ No

☐Unsure

Please why or why not.

6.4. If psychotherapy is modified do you think it might change you view regarding psychotherapy?

☐ Yes

☐ No

☐Unsure

Please why or why not.

6.5. Do you think CBT is a suitable therapy for depression in the Sri Lankan context?

☐ Yes

☐ No

☐Not sure

Please explain why

7. CBT for depression in Sri Lanka

(When asking the following questions use the word 'find' if the participant is already using CBT or use the word 'think' if he/she is not currently using CBT in everyday practice.)

7.1. What are your thoughts or experiences on the appropriateness of using CBT for treating depression in Sri Lanka?

7.2. What changes, if any, need to be made to make CBT more culturally appropriate for Sri Lankan patients with depression?

7.3. What are your thoughts or experiences on cognitive biases and changing negative thinking patterns for the Sri Lankan patient?

7.4. What are your thoughts or experiences on a positive reframe of helping the patient think more effectively and healthily?

7.5. What are your thoughts or experiences on the emphasis on problem-solving and behavioural activation?

7.6. What are your thoughts or experiences on resolving social conflicts and relationship problems?

7.7. What do you think would be more effective?

☐ Repeated usage of a few CBT techniques for a particular patient

☐ usage of several CBT techniques over the course of therapy?

☐ Unsure

Please elaborate on your response.

7.8. Which do you think would be more useful for CBT in Sri Lanka?

☐ instructional style

☐ collaborative style

☐ Unsure

Please elaborate on your response.

7.9. What are your thoughts or experiences on increased flexibility in the ordering of sessions and also on the speed in which one moves through them?

7.10. What are your thoughts or experiences on homework and encouragement to attend even if they were unable to complete their homework?

7.11. What are your thoughts or experiences on the use of different terminology such as exercise, practice rather than 'homework'?

7.12. What are your thoughts or experiences on placing more emphasis on physical symptoms and their association with thoughts, mood and inclusion of physical complaints in the thought diary as a separate column?

7.13. What are your thoughts or experiences on the amount of education patient require regarding course of therapy and termination of therapy (e.g., what the patient's

experience would be like in therapy, what to expect, achievable goals and how to terminate it).?

7.14. What are your thoughts or experiences on the presence of family members during sessions and active assistance from family in completion of homework?

7.15. What are your thoughts or experiences on using Sri Lankan folktales and Jataka stories and other examples from local literature?

7.16. What are your thoughts or experiences on having explicit discussion and exploration about local beliefs such as ‘depression is due to fate or bad astrological periods’ ?

7.17. How do you think interactions with faith healers affect psychotherapy delivery?

7.18. What do you think about using local awareness about ‘mindfulness’ in CBT?

7.19. What are your thoughts regarding increased emphasis on goal setting and markers of treatment progress in the Sri Lankan context?

7.20. What are your thoughts about the best duration and number of sessions?

Appendix 16 semi structured interview guide for traditional healers and lay counselors

Culturally relevant psychotherapies for depression in Sri Lanka (Phase I)

Semi structured questionnaire for traditional healers and lay-counsellors
(Statements in italics are for the guidance of the researcher only)

12. Demographics

12.1. Age: _____ years

12.2. Gender

☐ Female

☐ Male

Traditional healers are practitioners of traditional or non-Western medicine. Lay counselling is psychosocial support provided by an individual who does not have a mental health background or formal degree in counselling.

12.3. Are you a traditional healer / lay counsellor / both?

☐ traditional healer

☐ lay counsellor

☐Both

☐ Other: _____

12.4. Frequency of engaging in healing rituals

☐ daily

☐ weekly

☐ fortnightly

☐ monthly

☐other:_____

☐ not relevant

12.5. Frequency of engaging in lay counselling

☐ daily

☐ weekly

☐ fortnightly

☐ monthly

☐other:_____

☐ not relevant

12.6. Do you request / accept payment for your services?

☐ Yes

☐ No

☐other:_____

13. Healing Practices and suggestions

13.1. How frequently do you engage in healing rituals / counsel individuals with mental health issues or mental distress?

☐ daily

☐ weekly

☐ fortnightly

☐ monthly

☐other:_____

13.2. Can you please provide details of the presentations of mental illness or distress you see? What sort of manifestations do the patients come with?

13.3. Do you usually see those people / family once or more than once?

☐ Yes

☐ No

☐other:_____

13.4. If more than once, how many times do you see each affected individual / family on average?

13.5. How frequently would you see each affected individual / family?

☐ daily
☐ weekly
☐ fortnightly
☐ monthly
☐other:_____

Reasons for above duration

13.6. How long does each of your sessions last? (Approximate range / average)

- ☐ 0-15 min
- ☐ 15-30 min
- ☐ 30-45 min
- ☐ 45-60 min
- ☐ More than 60 min
- ☐ Other _____

Reasons for above duration

13.7. What sort of healing ritual / lay counselling do you provide for people with mental health issues or mental distress?

13.8. Do you use following techniques in your healing practices or lay counselling?

☐Exploration of thoughts, emotions and behaviour

If you do, how do you do that? (Keeping a record/ journal/diary of thoughts, behaviour, emotions)

☐Changing thinking patterns and behaviours

If you do, how do you do that? (Challenging negative thoughts such as self-critical thoughts /positive reframing/ daily activity scheduling/ behavioural experiments)

☐ Problem solving techniques

If you do, how do you do t 251

☐ Involvement of family members

If you do, how do you do that?

☐ Request affected person to practice the techniques learned /taught in between sessions

If you do, how do you do that?

☐ Religious practices such as mindfulness, meditation, etc.

If you do, how do you do that?

☐ Using examples from folk tales / Jataka stories

If you do, on what occasions do you do that?

13.9. What elements of healing ritual / counselling do you find (or do you think would be) most useful in clinical practice?

13.10. What do you think is more beneficial - direct advice by you or collaboration and negotiations with client regarding interventions?

☐ Directive Advice

☐ Collaboration

☐ Both

☐ Not sure

☐ Other

Can you please explain why? 252

13.11. What elements of healing rituals / counselling can be used in Western Medical practice psychotherapy?

2.12 What are your beliefs and attitude towards allopathic mental health treatment

2.13 Have you referred patients to allopathic mental health practitioners?

☐ Yes

☐ No

☐other:_____

Explain reasons for your answer

2.14 Have you managed patients who are receiving allopathic mental health care

☐ Yes

☐ No

☐other:_____

Describe your experience reasons for your answer

Appendix 17 semi structured questionnaire for patients with depression

Culturally relevant psychotherapies for depression in Sri Lanka (Phase I)

Semi structured questionnaire for patients with depression
(Statements in italics are for the guidance of the researcher only)

7.26. Demographics

7.27. Age: _____ years

7.28. Occupation: _____

7.29. Marital status

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Other – *Please specify* .....

7.30. Number of children

1.5.1 Ages of the children *(in years)* .....

1.6 Do you have someone who cares for you?

- ☐ Yes
- ☐ No
- ☐ Not sure

1.7 What is your relationship with this person/s?

Spouse / partner / parent / other relative / friend / other person (*Please specify)*……

1.8 How does this person/s support you?

- ☐ assistance with day to day activities
- ☐ emotional support
- ☐ assistance with treatment
- ☐ financial support
- ☐ Other _____

8. Depression

8.1. When did you first develop symptoms of depression? _____

8.2. Have you had physical symptoms related to depression? What are they?

☐ Yes

☐ No

☐ Not sure

If 'Yes', What are they?

8.3. What was the duration between onset of symptoms and seeking of help?

_____

8.4. What form of help did you seek and why?

8.5. What forms of treatment have you had so far?

☐ Antidepressant medication

☐ ECT

☐ lay counselling

☐ traditional healing rituals

☐ talking therapy or counselling by a clinician practicing western medicine

☐Other

☐ none

☐Not sure

Please provide details:

8.6. What treatment did you find most beneficial?

8.7. If you sought traditional treatment, what made you do so?

8.8. Counselling involves advice or guidance, especially as solicited from a knowledgeable person. Talking therapies or psychotherapies involve talking to someone who is trained to help you deal with your mental health and emotional problems. Have you had counselling or talking therapy / psychotherapy? (If it was not mentioned before)

☐ Yes

☐ No

☐ Not sure

Can you please provide details of that treatment *(type / duration / number of sessions / by whom)?*

8.9. Do you believe psychotherapy or counselling can be useful in treating mental illness?

☐ Yes

☐ No

☐ Not sure

Can you please provide reasons for your answer*?*

8.10. What did you consider to be the most useful component in counselling/ talking therapy/ psychotherapy?

8.11. Were there components in therapy that were not useful at all? If so, please explain.

☐ Yes

☐ No

☐ Not sure

Can you please explain why?

8.12. Do you believe counselling or talking therapy/ psychotherapy is beneficial in treatment of depression?

☐ Yes

☐ No

☐ Not sure

Can you please explain why?

8.13. Psychotherapy is a time limited practice which involves a certain number of sessions between the therapist and patient. What do you think about the number of sessions required for psychotherapy?

8.14. The sessions can happen at various frequencies. In your opinion, what is the best frequency for psychotherapy in depression?

☐ no change

☐ daily

☐ weekly

☐ fortnightly

☐ monthly

☐other:_____

8.15. What do you think about the duration of each session; what would be the best duration for each?

☐ 0-15 min

☐ 15-30 min

☐ 30-45 min

☐ 45-60 min

☐ More than 60 min

☐ Other _____

Please give reasons for your choice

8.16. In your opinion, what do you think is more beneficial in counselling or psychotherapy- direct advice by the knowledgeable person or collaboration and negotiations with you regarding what type of activities / thought processes you need to engage in at home and how much of it etc.?

☐ Directive Advice

☐ Collaboration

☐ Both

☐ Not sure

☐ Other

Can you please explain why?

8.17. In your opinion, how can one strengthen what is learned during sessions?

8.18. Assignments in between sessions can be a part of psychotherapy. This will involve practising the new skills that you are learning and applying them to your daily life. What do you think about these assignments?

8.19. What would be the best method /s to ensure compliance with the above mentioned assignments?

8.20. In your opinion, what is more beneficial - involving only the patient in sessions or both patient and family? Why?

8.21. In your opinion, would usage of religious literature / folk tales or techniques be useful in counselling or talking therapy / psychotherapy?

8.22. Mindfulness is purposeful, nonjudgmental awareness of the present moment thereby allowing for increased recognition of mental events in the present moment. What do think about its use in counselling or talking therapy / psychotherapy?

8.23. What can be done to increase participation in sessions and reduce drop-outs?

8.24. What else can be done to make counselling or talking therapy/ psychotherapy more appealing?

8.25. What lessons can be learnt or practices can be adopted from traditional healing rituals and religious counselling to allopathic / Western medicine psychotherapy?

Appendix 18 traditional healers and lay counselors' information and consent form phase 1

පාරම්පරික රෝග සුව කරන්නන් සහ සාමාන්‍ය මනෝ උපදේශකවරු සඳහා වන විස්තර පත්‍රිකාව සහ සමීක්ෂණයට කැමැත්ත ප්‍රකාශ කිරීමේ පත්‍රිකාව.

<u>ව්‍යාපෘතියේ නම:</u>
විශාදය සුවකිරීම සඳහා ශ්‍රී ලංකාවේ සංස්කෘතියට ගැලපෙන මනෝ චිකිත්සක ක්‍රම හඳුන්වා දීමේ සමීක්ෂණය (අදියර 1)

<u>ප්‍රධාන සමීක්ෂණ නිලධාරි:</u>
වෛද්‍ය ආසිරි රුද්‍රිගු
මනෝ වෛද්‍ය දෙපාතර්මේන්තුව, වෛද්‍ය පීඨය, කැලණිය විශ්වවිද්‍යාලය, ශ්‍රී ලංකාව
මානසික සෞඛ්‍ය පිළිබඳ ජාත්‍යන්තර මධ්‍යස්ථානය(CIMH), මෙල්බනර්ඊ විශ්වවිද්‍යාලය, මෙල්බනර්ඊ, ඔස්ට්‍රේලියාව

<u>අධීක්ෂණය/ සහකාර සමීක්ෂකවරු:</u>
මහාචාර්ය හැරී මිනාස්, මානසික සෞඛ්‍ය පිළිබඳ ජාත්‍යන්තර මධ්‍යස්ථානය(CIMH), මෙල්බනර්ඊ විශ්වවිද්‍යාලය, මෙල්බනර්ඊ, ඔස්ට්‍රේලියාව
අචාර්ය රිට්සුකෝ කකුමා, මානසික සෞඛ්‍ය පිළිබඳ ජාත්‍යන්තර මධ්‍යස්ථානය(CIMH), මෙල්බනර්ඊ විශ්වවිද්‍යාලය, මෙල්බනර්ඊ, ඔස්ට්‍රේලියාව
මහාචාර්ය රිචඩ් නිව්ටන්, මෙල්බනර්ඊ, ඔස්ට්‍රේලියාව
වෛද්‍ය ප්‍රියන්ජලි ද සොයිසා, මනෝ වෛද්‍ය දෙපාතර්මේන්තුව, වෛද්‍ය පීඨය, කොළඹ විශ්වවිද්‍යාලය, ශ්‍රී ලංකාව

<u>1. හැඳින්වීම</u>

"විශාදය සුවකිරීම සඳහා ශ්‍රී ලංකාවේ සංස්කෘතියට ගැලපෙන මනෝ චිකිත්සක ක්‍රම හඳුන්වා දීම" ලෙස හැඳින්වෙන මෙම සමීක්ෂණය සඳහා ඔබගේ සහභාගිත්වය අපි බලාපොරොත්තු වෙමු. මක්නිසාද යත් ඔබ දැනට මානසික රෝග වලින් පෙළෙන රෝගීන් සඳහා ප්‍රතිකාර කරන අයෙක් බැවිනි.

මෙම සමීක්ෂණයේ අරමුණ වන්නේ ශ්‍රී ලංකාව තුල විෂාදය සඳහා ප්‍රතිකාර වශයෙන් භාවිතා වන මනෝ චිකිත්සක ක්‍රම හෙවත් "ඖෂධ වලින් තොර ප්‍රතිකාර" සම්බන්ධයෙන්, ඔවුන්ට ප්‍රතිකාර කරන ඔබ වැනි අයගේ අදහස්, සහ අත්දැකීම් පිළිබඳව තොරතුරු එක්රැස් කිරීමයි. මෙහිදී එම මනෝ චිකිත්සක ක්‍රම ශ්‍රී ලංකාවේ සංස්කෘතියට කෙසේ අනුකූල වන්නේ දැයි පිළිබඳව ඔබගේ ආකල්ප, අදහස් සහ සම්ප්‍රදායික විශ්වාසයන් පිළිබඳව සවිස්තරාත්මකව කරුණු විමසනු ඇත.

ශ්‍රී ලංකාව තුල තරමක සුලභ රෝගයක් ලෙස විෂාදය හැඳින්විය හැකි අතර ඒ සඳහා ඉතා වටිනා ප්‍රතිකාර ක්‍රමයකි මනෝ චිකිත්සාව. නමුත් බොහෝ මනෝ චිකිත්සක ක්‍රම ගොඩනගා ඇත්තේ බටහිර

රට වල වන අතර ඒවා වෙනත් රටවලදී භාවිත කිරීමට පෙර ඒ ඒ රටවල සංස්කෘතික ප්‍රවණතා අනුව ඒවාට යම් යම් වෙනස්කම් කිරීම වඩා ඵලදායි බව පෙනී ගොස් ඇත.
මෙම විස්තර පත්‍රිකාව සහ සමීක්ෂණයට කැමැත්ත ප්‍රකාශ කිරීමේ පත්‍රිකාව ඔබට සමීක්ෂණය පිළිබඳව වැඩිදුර තොරතුරු සපයනවා ඇත.
මෙම විස්තර ඉතා අවධානයෙන් කියවන්න. ඔබට තේරුම් ගැනීමට අපහසු හෝ තවදුරටත් විස්තර අවශ්‍ය තැනක් වෙතොත් ඔබ වෙත එන සමීක්ෂණ නිලධාරියාගෙන් ප්‍රශ්න කරන්න. ඔබ මෙම සමීක්ෂණයට සහභාගි වන බවට කැමැත්ත ප්‍රකාශ කිරීමට පෙර මේ පිළිබඳව ඔබගේ ප්‍රධානියාගෙන් (එවැනි අයෙක් සිටියි) නම් විමසීමට අවශ්‍ය නම් ඒ සඳහා ඔබට පූර්ණ නිදහස ඇත.
ඔබ මෙම සමීක්ෂණයට සහභාගී වන්නේ ස්ව කැමැත්තෙන් පමණක් වන අතර මෙයට සහභාගි නොවී සිටීමට ඔබට පූර්ණ නිදහස ඇත. මෙයට සහභාගී වීම හෝ නොවීම යන ඔබගේ තීරණය, අපි ඉතා සතුටින් භාර ගනිමු.
ඔබ මෙයට සහභාගි වීමට කැමැති නම් පහත ඇති කැමැත්ත ප්‍රකාශ කිරීමේ පත්‍රිකාව අත්සන් කළ යුතුය. එසේ අත්සන් කිරීමෙන් ඔබ

-මෙම පත්‍රිකාව හොඳින් කියවූ බවත්
-සමීක්ෂණයට ස්ව කැමැත්තෙන් සහභාගී වන බවත්
-සමීක්ෂණයේ රැඳී සිටීමට කැමති බවත්

හැඟවේ.

2. මෙම සමීක්ෂණයේ අරමුණ කුමක්ද?

මෙහි පළමු අදියරේ අරමුණ වන්නේ මානසික රෝග වලින් පෙලෙන, විශේෂයෙන්ම විෂාදයෙන් පෙලෙන අයට ප්‍රතිකාර වශයෙන් මනෝ චිකිත්සක ක්‍රම භාවිතයේදී ඔබ ලත් අත්දැකීම් පිළිබඳව අථර්වත් අවබෝධයක් ලබා ගැනීමයි. එහිදී සාථර්ක සහ අසාථර්ක ක්‍රම, ඒවායේ සාථර්කත්වයට බලපෑ සාධක පිළිබඳවද සමීක්ෂණයෙන් අවධානය යොමු කෙරේ.
බටහිර රටවල භාවිත වන ක්‍රමයේ මනෝ චිකිත්සක ගැන ඔබ දරන ආකල්ප පිළිබඳවද අපි ඔබගේ අදහස් බලාපොරොත්තු වන්නෙමු. ඔබ ලබා දෙන විස්තර දැනට විෂාදය සඳහා ලබා දෙන ප්‍රතිකාර ක්‍රම සහ අනාගතයේ ගොඩනැංවීමට බලපොරොත්තු වන ප්‍රතිකාර ක්‍රම වඩා සාථර්ක කර ගැනීමට උදව් වේ.
මෙම සමීක්ෂණයට පාරම්පරික රෝග සුව කරන්නන්/සාමාන්‍ය මනෝ උපදේශකවරු දොළොස් දෙනකු, විෂාදයට ප්‍රතිකාර කරන වෛද්‍යවරු විසිදෙනෙකු සහ රෝගීන් හෝ ඔවුන් රැකබලා ගන්නන් විසි දෙනෙකු සහභාගී කර ගැනීමට බලාපොරොත්තුවේ. සමීක්ෂණය ඔබට පහසු තැනක සිදුකරනු ඇත.
මෙම සමීක්ෂණය ප්‍රධාන සමීක්ෂක (වෛද්‍ය ආසිරි රුද්‍රිගු) ගේ ආචාර්ය උපාධිය (ඔස්ට්‍රේලියාවේ මෙල්බර්න් විශ්වවිද්‍යාලය මගින් පිරිනමනු ලබන) සඳහා වන උපාධි පරීක්ෂණයේද කොටසක් වනු ඇත. එම උපාධි පරීක්ෂන්යේද අරමුණ ශ්‍රී ලංකාවේ සංස්කෘතිකාංග වලට ගැලපෙන වඩා හොඳ මනෝ චිකිත්සා ක්‍රමයක් ගොඩනැංවීමයි.
බටහිර රටවල බහුලව භාවිත කරන ප්‍රජානන චර්යාත්මක චිකිත්සාව (cognitive behavior therapy) හෙවත් චර්යාත්මක ක්‍රම වලින් මානසික රෝග සුව කිරීමේ ක්‍රම ශ්‍රී ලංකාවට හඳුන්වා දීමේදී ඒවාට මොනයම් ආකාරයේ වෙනස්කම් සිදු කල යුතුද යන්න පිළිබඳවද ඉතා වැදගත් තොරතුරු මෙම සමීක්ෂණයෙන් සොයාගැනීමට බලාපොරොත්තුවේ.
සමීක්ෂණයේ මෙම පළමු අදියර සහ උපාධි පරීක්ෂණය සඳහා කිසිදු රාජ්‍ය හෝ රාජ්‍ය නොවන සංවිධානයකින් මූල්‍යමය ආධාර ලබා දෙනු නොලැබේ. මෙම සමීක්ෂණය සඳහා ඔබ ලබා දෙන සහභාගිත්වය නිසා සමීක්ෂණ කණ්ඩායමේ කිසිවකුට මූල්‍යමය හෝ වෙනත් ප්‍රතිපාදන මඟින් ලාභ ප්‍රයෝජන අත්නොවේ. නමුත් මෙම සමීක්ෂණයේ දෙවන කොටස වන අහඹු සායනික පරීක්ෂණය (Randomized clinical trial) සඳහා වන වියදම් සඳහා වෛද්‍ය රොද්‍රිගු විසින් යම් මූල්‍ය ප්‍රතිපාදන ලබා ගැනීමට ඉඩ ඇත.

3. මෙම සමීක්ෂණ ව්‍යාපෘතියට සහභාගී වනවා යනු කුමක්ද?

ඔබ මෙම සමීක්ෂණයට සහභාගී වීමට කැමති නම් පළමුව ඒ සඳහා වන කැමැත්ත ප්‍රකාශ කිරීමේ පත්‍රිකාව අත්සන් කලයුතු වේ. පසුව ඔබගෙන් තනි තනිව කෙරෙන සාකච්ඡා මාගර්යෙන් ප්‍රශ්න කීපයක්

අසනු ඇත. එම සාකච්ඡා ඔබට පහසු තැනක සිදු කරනු ලැබේ. සාකච්ඡාව සඳහා මිනිත්තු 15-20ක කාලයක් ගතවනු ඇත. ප්‍රධාන සමීක්ෂක හෝ වෙනත් සුදුසුකම් ලත් වෛද්‍යවරයෙක් විසින් සාකච්ඡාව මෙහෙයවනු ලබයි. මෙහිදී ඔබට ප්‍රශ්න පත්‍රයකට පිළිතුරු ලිවීමට සිදු නොවේ. සමීක්ෂක විසින් අසනු ලබන ප්‍රශ්න වලට ඔබ ලබා දෙන පිළිතුරු හඬ පටයක් මඟින් පටිගත කරනු ඇත.
මෙම සහභාගිත්වය වෙනුවෙන් ඔබට මුදල් ගෙවීමක් හෝ වෙනත් දීමනාවක් ලබා දෙනු නොලැබේ.

4. සමීක්ෂණයට සහභාගී වීමෙන් ලැබෙන ප්‍රතිලාභ මොනවාද?

මෙමගින් ඔබට සෘජු ප්‍රතිලාභයක් ලැබෙන බවට සහතික විය නොහැක. නමුත් මෙම සමීක්ෂණය මඟින් විෂාදය සඳහා අනාගතයේ යෙදවීමට බලාපොරොත්තු වන ප්‍රතිකාර, විශේෂයෙන් ශ්‍රී ලංකාවේ මනෝ චිකිත්සක ප්‍රතිකාර වල වැඩිදියුණුව සඳහා තොරතුරු ලැබෙනු ඇත.

5. මෙහිදී මුහුණ දීමට සිදුවිය හැකි අවදානම් තත්ත්ව මොනවාද?

මෙම සමීක්ෂණයට සහභාගී වීම මඟින් ඔබට කිසිදු අවදානම් තත්වයකට මුහුණ දීමට සිදු වනු ඇතැයි අපි අපේක්ෂා නොකරමු. යම් කිසි ප්‍රශ්නයකට පිළිතුරු දීමට අපහසු නම් හෝ පිළිතුරු දීමට ඔබ අකමැතිනම් එම ප්‍රශ්නය මඟ හැර ඊළඟ ප්‍රශ්නයට යන ලෙස ඔබට ඉල්ලා සිටිය හැකිය. එසේම ඔබ කැමති ඕනෑම අවස්ථාවක සාකච්ඡාව නවත්වන ලෙස සමීක්ෂකගෙන් ඉල්ලා සිටීමට ඔබට පුණර් අයිතිය ඇත.

6. මම අනිවාර්යෙන්ම මෙම සමීක්ෂණයට සහභාගී විය යුතුද?

මෙයට සහභාගී වීම ස්ව කැමැත්තෙන් පමණක් සිදුවන්නකි. ඔබ සහභාගී වීමට අකමැති නම් සහභාගී නොවී සිටිය හැක. මුලින් ඔබ සහභාගී වීමට කැමැත්ත ප්‍රකාශ කර පසුව එම අදහස වෙනස් වුයේ නම් ඔබ කැමති ඕනෑම අවස්ථාවක සමීක්ෂණයෙන් ඉවත් වීමට ඔබට නිදහස ඇත. එසේ ඔබ පසුව ඉවත් වීමට තීරණය කලේ නම් ඒ දක්වා ඔබ ලබා දුන් තොරතුරු සමීක්ෂක කණ්ඩායම සතුව තබා ගැනීම පසුව සිදු කරන ප්‍රතිපල ඇගයීම් වලට පහසුවක් වෙයි. නමුත් එසේ තබා ගැනීමට ඔබ විරුද්ධ නම් සමීක්ෂණයෙන් ඉවත් වීමට ප්‍රථම ඒ බව සමීක්ෂකවරයාට දන්වන්න.

ඔබ ස්ව කැමැත්තෙන් සහභාගී වූ බවට ඔබ අත්සන් කල කැමැත්ත ප්‍රකාශ කිරීමේ පත්‍රිකාවේ පිටපතක් ඔබට අවශ්‍ය නම් ලබා දිය හැකිය.

සමීක්ෂණය සම්පුණර් කල පසු ඔබ ලබා දුන් පිළිතුරු හා තොරතුරු ඉවත් කිරීමේ හැකියාවක් නොමැත. මන්ද යත් එක් එක් අය සඳහා හඳුනාගැනීමේ තොරතුරු අප ලබා නොගන්නා බැවිනි. සමීක්ෂණයට සහභාගී වීම, නොවීම, හෝ අතරමඟ හැරයාම නිසා ඔබ සහ සමීක්ෂක කණ්ඩායම අතර ඇති සුහදතාවයට හානියක් සිදු නොවන බව කරුණාවෙන් සලකන්න.

7. මෙම සමීක්ෂණ ව්‍යාපෘතියේ අවසන් ප්‍රතිපල මා දැනගන්නේ කෙසේද?

මෙම සමීක්ෂණය අවසානයේ, දැනට පවතින මනෝ චිකිත්සක ක්‍රම සඳහා සුදුසු වෙනස්කම් ඇතුලත් යෝජනාවලියක් සැකසීමෙදි ඔබගේ අදහස්ද සලකා බලනු ඇත. මෙම සමීක්ෂණයේ අවසන් ප්‍රතිපල ඔබට තැපැල් මඟින් ලබාදීමේ හැකියාවක් ඇත. නමුත් එය සිදුවන්නේ ඔබගේ කැමැත්ත මත හා ඔබගේ පෞද්ගලික ලිපිනය අපට ලබා දීමට කැමති නම් පමණි. අවසන් ප්‍රතිපල දැනගැනීමේ හෝ නොදැනගැනීමේ අයිතිය ඔබ සතු වේ.

8. මා පිළිබඳව ලබා ගත් තොරතුරු වලට කුමක් වේද?

ඔබගේ නම සහ ලිපිනය ලබා ගැනීම ඔබගේ කැමැත්ත මත පමණක් සිදුවේ. ලිපිනය ලබා ගනුයේ මෙහි අවසන් ප්‍රතිපල ඔබට දැනගැනීමට අවශ්‍ය නම් පමණි. එසේ දැනගැනීමට අනවශ්‍ය නම් ඔබගේ නම, ලිපිනය ලබා දීම අවශ්‍ය නැත.

ඔබ එසේ නම, ලිපිනය ලබා දුන්නත් එම තොරතුරු ඔබ සමඟ කල සාකච්ඡාවේ තොරතුරු සමඟ සම්බන්ධ කර සුරක්ෂිත කරන්නේ නැත. එනිසා සාකච්ඡාවේදී ලබාගත් තොරතුරු සම්පුණර්යෙන්ම නිනර්ාමිකව පවතී. ඔබගේ නම, ලිපිනය වෙනයම් කටයුත්තක් සඳහා භාවිත කරනු නොලැබේ.

සාකච්ඡාවේදී පටිගත කල ඔබගේ හඬ පටයේ අඩංගු තොරතුරු පරිගණක ගත දත්ත ගොනුවකට ඇතුලත් කල වහාම අදාල හඬ පටය මකා දමනු ලැබේ. සාමාන්‍යයෙන් සතියකට වරක් පමණ මෙම මකා

දැමීම් සිදු කරන අතර ඊට පෙර ඒවා ඉතා ආරක්ෂිතව ගබඩා කර තබනු ලැබේ. මෙම සමීක්ෂණයට අදාළ අනික් සියලුම තොරතුරු, සමීක්ෂණ කණ්ඩායමට පමණක් පිවිසිය හැකි ලෙස සැකසූ ආරක්ෂිත පරිගණක තුල සාමාන්‍යයෙන් වසර හතක පමණ කාලයක් තබාගනු ඇත. පසුව ඒවා ඉතා ආරක්ෂාකාරී ක්‍රමවේදයකට අනුව මකා දමනු ලැබේ.

යම් දිනක මෙම සමීක්ෂණයේ සමස්ත ප්‍රතිපලය ශ්‍රී ලංකාවේ හෝ ලෝකයේ පිළිගත් වෛද්‍ය සඟරාවක පළකිරීම හෝ ප්‍රසිද්ධ වෛද්‍යමය සැසිවාරයකදී ඉදිරිපත් කිරීම සිදුවිය හැකි අතර එහිදී ඔබගේ පෞද්ගලික තොරතුරු අනාවරනය කරනු නොලැබේ.

9. මා විසින් සමීක්ෂණය සඳහා ලබා දෙන ලද තොරතුරු නැවත මා හට පරිශීලනය කළ හැකිද?

ඔබට එම තොරතුරු කිසිවක් නැවත ලබා ගත නොහැක.මන්දයත් අප විසින් ඔබගෙන් තොරතුරු ලබා ගැනීමේදී ඔබේ පුද්ගලික අනන්‍යතාවය සටහන් කර නොගන්නා බැවිනි.

10. මෙම සමීක්ෂණව්‍යාපෘතිය සඳහා අනුමැතිය ලැබී තිබේද?

මෙම ව්‍යාපෘතියේ ආචාර ධර්ම පිළිබඳ අනුමැතිය ඕස්ට්‍රේලියාවේ මෙල්බර්න් විශ්ව විද්‍යාලයේ සමීක්ෂණආචාර ධර්ම හා සම්පූර්ණත්වය පිළිබඳ ආයතනයෙන් හා ශ්‍රී ලංකාවේ කැළණිය විශ්ව විද්‍යාලයේ උතුරු කොළඹ ශික්ෂණ රෝහලේ ආචාර ධර්ම කමිටුව විසින් ලබා දී ඇත.මෙම සමීක්ෂණයසිදුකරගෙන යනු ලබන්නේ ඕස්ට්‍රේලියාවේ ජාතික සෞඛ්‍ය හා වෛද්‍ය පර්යේෂණආයතනයේ (National Statement on Ethical Conduct in Human Research 2007) ප්‍රඥප්තියට අනුකූලවය. මෙම ප්‍රඥප්තිය ගොඩනඟා ඇත්තේ මානව අධ්‍යයනයන් සඳහා සහභාගී වන පුද්ගලයන්ගේ ආරක්ෂාව සඳහා ය.ජාතික සෞඛ්‍යවෛද්‍ය හා පර්යේෂණකවුන්සිලයේ ප්‍රතිපත්ති වලට අනුකූලව පර්යේෂණ ආචාර ධර්ම කමිටුව විසින් කලින් කලට ව්‍යාපෘතිය වලට අදාළ විගණනයන් සිදු කරනු ලබයි.එනිසා ඔබවිසින් අත්සන් කරන ලද සහභාගී වීමේ කැමැත්ත ප්‍රකාශ කරනු ලබන ලිපියේ පිටපතක් මානව සමීක්ෂණආචාර ධර්ම කමිටුව මඟින් ඉල්ලා සිටීමටද හැකිය.

11.මා හට ඇති ප්‍රශ්ණ පිළිබඳ විමසිය යුත්තේ කාගෙන්ද?

එය ඔබට ඇති ප්‍රශ්ණයේ ස්වභාවය මත වෙනස් වේ.ඒ සඳහා පහත විස්තර අනුව ක්‍රියා කරන්න.

වැඩි විස්තර සඳහා

ඔබට මෙම ව්‍යාපෘතියසම්බන්ධයෙන් වැඩිදුර තොරතුරු දැන ගැනීමට අවශ්‍ය නම් හෝ මෙයට අදාළ වෙනත් ගැටළු තිබෙනම් ප්‍රධාන සමීක්ෂක වෛද්‍යආසිරි රොඩ්‍රිගු හෝ පහත ඕනෑම සමීක්ෂණනිලධාරියෙක් සමඟ සම්බන්ධ විය හැකිය.

නම	තනතුර	සම්බන්ධ කර ගැනීමේ විස්තර
වෛද්‍යආසිරි රොඩ්‍රිගු	ප්‍රධාන සමීක්ෂක	asirir2000@yahoo.com +94-11-2958039
මහාචාර්ය හැරී මිනාස්	අධීක්ෂක/ සහකාර සමීක්ෂක	h.minas@unimelb.edu.au +61383440908

වෛද්‍යරිට්සුකෝ කකුමා	අධීක්ෂක/ සහකාර සමීක්ෂක	rkakuma@unimelb.edu.au +61383440908
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පැමිණිලි සඳහා
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<u>සමීක්ෂණයට සහභාගි වීමට කැමැත්ත ප්‍රකාශ කිරීමේ පත්‍රිකාව</u>

<u>අධ්‍යයන මාතෘකාව</u>: විශාදය සුවකිරීම සඳහා ශ්‍රී ලංකාවේ සංස්කෘතියට ගැලපෙන මනෝ චිකිත්සක ක්‍රම හඳුන්වා දීම.
<u>-ප්‍රධාන සමීක්ෂක</u>:වෛද්‍යආසිරි රොඩ්‍රිගු
<u>සහකාර සමීක්ෂකවරු</u>: මහාචාර්ය හැරී මිනාස් ,වෛද්‍යරිට්සුකෝ කකුමා, මහාචාර්රිචඩ් නිව්ටන්,වෛද්‍යපියන්ජලී ද සොයිසා

- ✓ ලකුණ අදාළ කොටුව තුළ යොදන්න.

මා විසින් මට අවබෝධ කර ගතහැකි භාෂාවකින් මෙම සමීක්ෂණ ව්‍යාපෘතියේ අරමුණු , ක්‍රියාපටිපාටියන් ,අවදානම් මොනවාද යන්න කියවා දැන ගතිමි.

මට ප්‍රශ්ණ ඇසීමේ අවස්ථාවක් ලැබුණු අතර එම ප්‍රශ්ණ වලට ලැබුණු පිළිතුරු පිළිබඳ මම සෑහීමකට පත්වෙමි.

මේ සමීක්ෂණය සඳහා කැමැත්තෙන් සහභාගි වෙමි.

මම ලියවිල්ලේ සහතික කරන ලද පිටපතක් මා හට ලබා දෙන බව මම දනිමි.
මසමීක්ෂණයේ අවසාන ප්‍රතිඵල තැපෑලෙන් මා වෙත දන්වන්නේ නම් කෘතඥ වෙමි.
මා විසින් ඕස්ට්‍රේලියාවේ මෙල්බනර් විශ්ව විද්‍යාලයේසමීක්ෂණආචාර ධර්ම හා සම්පූර්ණත්වය පිළිබඳ කාර්යාලයට හා ශ්‍රී ලංකාවේ කැළණිය විශ්ව විදයාලයට අනුබද්ධ උතුරු කොළඹ ශික්ෂණ රෝහලේ ආචාර ධර්ම කමිටුව වෙත මෙම සමීක්ෂණය සඳහා අවශ්‍ය තොරතුරු ලබා ගැනීම සඳහා වූ අවසරය ලබා දෙමි.
සහභාගි වන්නාගේ නම:
අත්සන : දිනය :
සාක්ෂිකරුගේ නම:
අත්සන : දිනය :
සමීක්ෂකගේ ප්‍රකාශය: මා විසින් මෙම සමීක්ෂණ ව්‍යාපෘතියපිළිබඳව හා එහි අරමුණු , ක්‍රියාපටිපාටියන් ,අවදානම් පිළිබඳවවාචික විග්‍රහයක් සහභාගි වන්නන් වෙත ලබා දී ඇත.ඔවුන් විසින් එය පැහැදිලිව අවබෝධ කර ගෙන ඇත යන්න මාගේ විශ්වාසයි.

Appendix 19

Culturally modified Cognitive Behavioural Therapy (MCBT) Manual

PhD project - Culturally relevant psychotherapies for depression in Sri Lanka (Phase 2)

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Introduction

This culturally modified cognitive behavioural therapy manual is meant to be a guideline for each session of MCBT, but not an inflexible, invariant step-by-step procedure for treating depression in this study. It is understood that it may be necessary to vary the content of sessions to some degree in order to address the particular needs of each patient. However, the treatment must stay within the generally accepted framework for CBT.

Therapeutic alliance

As is true for any psychotherapeutic intervention, Modified CBT can be conducted only within the context of a working alliance between the patient and the therapist. An alliance with the family may also be necessary, considering strong involvement of family in Sri Lankan context. At times

he therapist who works with patients must maintain an alliance both with the patient and with the family in the face of conflict between the patient and the family. Key requirements for CBT therapists include capacity for accurate empathy, warmth, genuineness, and rapport with diverse patients. In addition, collaboration in setting the agenda for sessions, in testing the accuracy of cognitions, and in implementing "homework" assignments with the patient is essential for the conduct of CBT.

Both Beck (1979, Chapter 3) and Brent and Poling (1997) have written about the therapeutic relationship in cognitive therapy. In summary, the essential personal characteristics of the therapist, first described by Rogers (1951) are described below. Essential Characteristics of the Therapist. These are equally applicable to therapists who are carrying out MCBT in Sri Lanka.

1. Accurate Empathy:
   This refers to the therapist's ability to take the patient's perspective, see things as the patient does, and understand the patient's distress. The therapist recognises and verbalises an understanding of what the patient is feeling. Challenges to empathy with patients can occur in the form of sympathising with (rather than empathizing with) the patient or becoming irritable towards the (oppositional/angry) patient.

2. Warmth:
   This refers to the therapist's ability to convey a caring concern for the patient. Tone of voice, manner, phrasing of comments can all convey warmth. Challenges to warmth occur when the therapist is too demonstrative or active in conveying concern or too abrupt or distant. In the former case, the patient may perceive the therapist as lacking in genuineness, as not appreciating the negative aspects of the patient, or as "too close" emotionally. In the latter case, the patient may feel rejected or "disrespected."

3. Genuineness:
   This refers to the therapist's honesty with self and with patient. Genuineness requires self-awareness and self-monitoring on the part of the therapist. As Beck (1979) points out, genuineness must be accompanied by the ability to convey feedback to the patient without

being too blunt o*r* perceived as critical. Promises about "cure" or recovery can threaten the therapeutic relationship on the grounds of lack of genuineness.

In addition to characteristics of the therapist, characteristics of a positive therapeutic relationship have been outlined by Beck (1979) and by Brent and Poling, (1997).

Characteristics of a positive therapeutic relationship

1. Rapport:

   This refers to the therapist's ability to establish "harmonious accord" (Beck, 1979, p. 51) with the patient. There is a lack of defensiveness on the part of each party, and the patient feels accepted (despite all his or her faults) by the therapist, and able to express himself or herself without belabouring feelings, explanations or comments. Developing rapport is facilitated by the therapist factors mentioned above, and by behaviours such as courtesy, timeliness, appearance, active listening, eye contact, tone of voice, and timing of verbalisations during sessions. Brent and Poling (1997) note other therapist initiatives that can facilitate the development of rapport. The therapist can ask the patient to discuss his or her interests, hobbies, or activities.

   During treatment the therapist should explain the rationale for specific interventions. In particular the rationale for homework assignments needs to be explained, so that the patient can see how these might be of benefit to him or her. Rapport is also enhanced when the therapist explains any transitions in sessions introduced by the therapist. These include changes of topic or agenda items under discussion and shifts from one part of the session to the next.

   It is even more important in Sri Lankan context to explain the therapeutic nature of relationship between the therapist and the patient considering that Sri Lankan patients are not familiar with psychotherapy.

2. Collaborative empiricism:

This refers to the therapist's ability to "work with" the patient in looking for evidence regarding accuracy of thoughts, establishing the session agenda (issues and incidents), choosing and planning homework. An active, interactive model of conducting sessions helps to develop collaborative empiricism.

In carrying out CBT with Sri Lankan patients the therapist may be required to adopt a more didactic role and instructional style. This is in the context of social structures and expectations of patients. Sri Lanka has a more hierarchal society than the western world and patients expect doctors / health care professionals to give them guidance. Therefore, a more instructional style could be adopted without being coercive or dismissive. The treatment methods and approach should still be tailored to patients considering their presentations, problems and needs. Therapist should take examples from the patient and explain the treatment so patient would be able to relate to the treatment. Patient should be consulted about their treatment and therapist should show due respect to the patient's opinion in decision making. The balance of activity and responsibility, however, changes over the course of treatment, with the therapist assuming more directive responsibility early and the patient assuming more over time.

Socratic questioning-

Socratic questioning is an essential part of CBT which will help patients to reevaluate their thinking. This is an empirical process of gathering data, looking at data in a different way with the patient and inviting patient to come up with their own plan for information examined. In MCBT too therapist will use this technique but will be more directive in the process.

Homework

Homework tasks are an essential part of CBT, and homework compliance is associated with improvement in treatment outcome. Homework provides the patient with an opportunity to practice new skills and incorporate them into his or her daily routine. It is an important part of treatment for Sri Lankan patients just as it is for the patients elsewhere. However, when assigning homework in these patients, there are a few things to keep in mind. Research shows that there are several factors that affect a patient's compliance with homework tasks. These include the patient's

ability to complete the assignment and the task's characteristics. This means you should tailor assignments according to the patient's needs. Homework should be relevant to the topics covered in a given session and should help the patient build on the skills and behaviours practiced during therapy. It should encourage the patient to engage in the kinds of changes necessary while still being realistic and manageable for the patient. Furthermore, homework should be assigned in graded steps so that the degree of difficulty slowly increases over the course of treatment and each assignment builds one after another to provide continuity from session to session.

Considering strong family involvement in Sri Lanka, therapist can get the support of family in completing homework tasks, if appropriate. Family may be able to remind, encourage and assist patients with completing homework. However, involvement of family, like other aspects of CBT, should only be considered with the patient's agreement.

Improving compliance with homework can be further achieved by:

- Involving the patient in deciding what tasks he or she will be doing outside the session. Most patients find tasks more enjoyable and useful if they are involved in this decision-making process.
- Setting tasks that provide a no-loss situation. While you want to encourage the patient to complete all homework tasks, being "successful" at homework is not what's at stake here. Keep in mind and work to make the patient understand that homework is a skill building process and that there are no "failures".
- Confirm that the patient clearly understands what the task entails. As above, understand that the task is of key importance in compliance. Do the task with patient if there are any doubts whether patient understands the task.
- Confirm that the patient clearly understands the rationale for the task. This is slightly different from understanding the task itself. Since homework should be a method for resolving symptoms it is important to help the patient understand how each assignment is a part of that process.
- Inform the patient about benefits and importance of doing the homework tasks. Explaining to the patient the specific benefits he or she may achieve through homework is likely to encourage the patient to complete a given assignment.

Set the Agenda

"Cognitive therapy sessions are structured. No matter what the diagnosis or stage of treatment, the cognitive therapist tends to adhere to a set structure in every session...checks the patient's mood, asks for a brief review of the week, collaboratively sets an agenda for the session, elicits feedback about the previous session, reviews homework, discusses the agenda items, sets new homework, frequently summarises, and seeks feedback at the end of each session. Following a set format makes the process of therapy more understandable for both the patient and his/her therapist and increases the likelihood that the patient will be able to do self-therapy after termination. This format also focuses attention on what is more important to the patient and maximises use of therapy time (J.S. Beck 1995, p. 8)".

At the start of each session the therapist will set an agenda. This is done in collaboration with the patient. A simple question like "How have you been since the last session or over the last two weeks?" can be used as an opening question. Such an inquiry helps the patient open up and discuss items he or she wishes to address during the session while also providing the therapist with an opening to go over the learning points and any homework tasks from the previous session. Addressing these items early in the session will help the therapist and the patient develop the agenda.

Sri Lankan patients may not take the lead and the therapist will need to take a proactive approach in setting the agenda. Therapist should always consult the patient and patient could be given a number of choices about items you may wish to address together during the session.

Structure of therapy

MCBT is moderately structured. MCBT permits more tailoring of the treatment to suit the individual patient. Therapist may go slowly at the beginning of the therapy or emphasize more on particular aspect of the therapy if the individual needs of the patient demands so.

The therapist strives to balance skills training with supportive, empathic listening and instilling hope. At the same time, there is an emphasis on learning skills, activity scheduling and on the exploration and modification of distorted depressive cognitions. This necessitates use of sufficient structure to ensure efficient use of time.

Sessions are fortnightly and 30 minutes in length (30 minutes of contact time), except for the first session which is 45 minutes in length.

Following the guidelines used by Carroll (1998), each session could be divided into three portions. Skills-training occupies the middle portion and should take 20 minutes of the time. Components of each portion are outlined below.

1. In the first part (at least 5 minutes), the therapist devotes some time to review of the homework assignment, setting the agenda with the patient (issues and incidents) and checking on how the patient has been feeling since the last session. Using the mood diary, this can be accomplished by asking about incidents that have occurred since the previous session and looking for situations that have been associated with changes in mood. The therapist checks with the patient on progress towards the broader goals they have agreed to work on in treatment. After the patient's concerns have been elicited, the therapist and patient work together to put these in priority, so they can be addressed as the session proceeds. The therapist should be alert to topics or concerns of the patient that can be tied directly to the skills training section of the session.

2. The middle third of the session is typically devoted to learning skills, techniques or strategies pertaining to CBT. New skills may be introduced, or the patient may continue to work on a skill previously introduced. The therapist seeks to link the skill to the issues, incidents, or concerns raised earlier in setting the agenda for the session. In general, the therapist should use a combination of didactic teaching, modeling, role-play, and questioning to convey the material, checking with the patient to assure that he or she understands the skill and its relevance.

3. The final third of the session is devoted to completing the items on the session agenda (working on issues and incidents), and to planning the homework assignment (homework).

Adherence to Protocol and Flexibility

In manual-guided treatment, there can be tension between therapist, flexibility and adherence to the manual. MCBT is designed to enable mental health clinicians who are trained in CBT to conduct treatment with a range of patients suffering from major depression. Individual differences of patients require flexibility. A number of features are incorporated into the treatment to enhance flexibility. Although certain skill training modules are required, other skill training modules are optional depending on the needs of the patients. Even within the required modules, therapists are encouraged to apply the skill to material that this particular patient has brought up in the present session or in previous sessions.

Deviation from the proposed timing of skill training can be expected to occur with some patients. Significant crisis or suicidal ideation will take priority over scheduled skill training components of sessions. Under such circumstances, the therapist may defer a planned skill training component until the following session or at least until the crisis has been reasonably addressed in the session. The clinical judgment of the therapist will guide this decision. Some of the optional skill training modules can be brought to bear in these circumstances, such as relaxation and affect regulation for anxious or impulsive patients. Whenever possible, the therapist should use skills included in the MCBT manual to address problems brought into sessions by the patient. In addition, the therapist should make it clear to the patient what skills may be helpful in dealing with the problem at hand. This is intended to help the patient to become his or her own therapist over time, and to internalise the learning of skills.

Significant deviation from the manual should be avoided for the study purposes. Significant deviations will risk the occurrence of substantial differences in the interventions making assessment difficult.

Cognitive formulations-

With the help of the individual seeking treatment, the therapist puts together a model of the individual's problems and what may be contributing to them. The formulation looks to the links among thoughts, emotions, behviours, physiological sensations, beliefs, rules and events to explain what keeps a problem going (other elements such as past experience, are also considered. There can be several formulations if the individual has more than one problem (for example, depression and a fear of going out in public). Formulations can change as the individual presents new information and experiences through the course of treatment.

Within the first 2 sessions, the therapist will establish a cognitive formulation of the participant that consistently informs and guides the therapist's decisions over the course of the case. The therapist shares the formulation with the participant and engages him/her in discussions about the adequacy of the formulation.

Considering the time limitations and more didactic nature of MCBT, therapist will not dwell a lot on formulation. While it is essential to understand the problems and their precipitating and maintaining factors, detailed and more sophisticated formulation may neither be feasible nor useful in MCBT. Basic formulation will inform this relative short and less complicated therapy when compared to 'normal stream' CBT. Therapist will share his/her thoughts with the patient and inform the patient about how it is going to inform treatment. Therapist will seek patient's input to modify formulation and thereby the treatment.

See sample formulation

First session

Psychoeducation-

Introduce yourself and check their understanding about their diagnosis, referral and CBT. It is very important that the therapist provides the patient with clear and succinct information about

depression, treatment options for depression and CBT. Please refer to annex 1 and 2 for information for patients on depression and treatment options of it.

It is very important that the therapist adequately explains the indication, concept and process of CBT adequately to Sri Lankan patients and family as this may determine the success of the therapy. In doing so the therapist should use local and culturally appropriate concepts. Some of such concepts are listed below.

- "Mano pubbangama dhamma"- As dawn precedes the sunrise, thought precedes all speech, emotions and actions
- You are the architect of your own emotions
- Mind is everything what you think you become
- We are what we think. All that we are arises with our thoughts. With our thoughts, we make the world.

Therapist will decide the most appropriate way of explaining CBT to the patient. Some people may prefer a theoretical explanation, but most Sri Lankans may prefer a simple and clear explanation with examples. Inquire about a recent time when they noticed a change in their mood (felt sad / anxious or more sad / anxious than usual). Discuss about the event, what went through their mind and how it impacted on their mood and how it subsequently impacted on their behaviour. Follow this by further explanations that had the patient thought differently about the event the patient may have felt and acted differently. Use the drawing to explain how thoughts, mood, behaviour and physiological sensations are intricately connected.

Therapist- *Darshanie, today I would like to discuss more about talking therapy for depression. You have been referred for Cognitive Behavioural Therapy. Have you heard about Cognitive Behavioural therapy which is referred to as CBT for short?*

Patient- *I have heard about it. I think I have read somewhere about psychotherapy. But I don't understand how it is going to help me.*

Therapist - *Shall we start with what you know about CBT, so we can build up on that.*

Patient - *To tell you the truth I don't really know much about it apart from it being a type of talking therapy.*

Therapist *- That's okay. We'll go over it. First, I'd like to find out how your thinking affects how you feel. Can you think of any situation in the past few days when you noticed your mood change? For example, an instance when you became particularly upset or distressed.*

Patient *- Yes, I think so*

Therapist *– Can you tell me a little bit more about that situation?*

Patient- *I was having lunch with a couple of students from our university and I started to feel a little nervous. They were talking about something the lecturer had said in the lecture which I didn't understand.*

Therapist *- When they were talking about what the lecturer said, just before you began to feel nervous, do you remember what was going through your mind?*

Patient *– I was thinking that I didn't understand but also couldn't let them know it.*

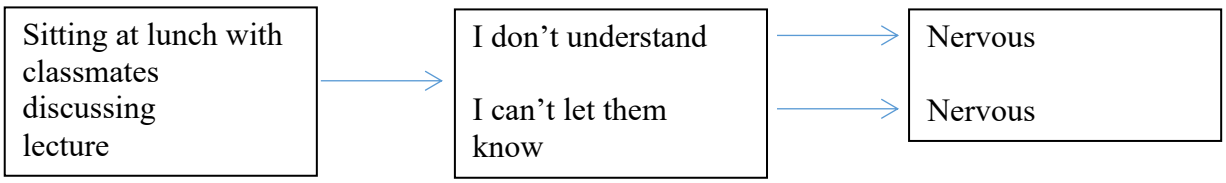
Therapist *- So you had the thoughts "I don't understand" and "I can't let them know"*

Patient *- Yes*

Therapist *- And that made you feel nervous?*

Patient *– Yes*

Therapist *- Ok. How about if we draw a diagram of this situation? You just gave a good example of how your thoughts influence your emotions. Is that clear to you? How you viewed this situation led to a thought which then influenced how you felt.*



Patient *- I think so.*

Therapist *– Let's see if we can gather one more example from the past few days. Can you think of any other instance when your mood changed?*

Patient *– This morning I saw an old friend from school on the way here at the train station and I felt kind of sad...*

Therapist *– So what was going through your mind at the time?*

Patient *– I don't remember exactly.*

Therapist *– Can you imagine yourself back in the train station right now? And can you imagine seeing your friend. Try to describe the scene to me as if it is happening right now.*

Patient *– I am standing on the platform. My friend comes in. She is looking kind of smiley and talks to another girl. She is joking, looking happy and normal.*

Therapist *- And how are you feeling?*

Patient *– Sad*

Therapist *– What is going through you mind?*

Patient *– She is happy; she is not depressed; I will never be like that again.*

Therapist *– Ok. Again, we have an example of how what you were thinking – "I'll never be like that again" influenced how you felt. It made you sad. Is that clear to you?*

Patient *– I think so*

Therapist *– Can you tell me in your own words about the connection between thoughts and feelings?*

Patient *– Well it seems that my thoughts do affect how I feel.*

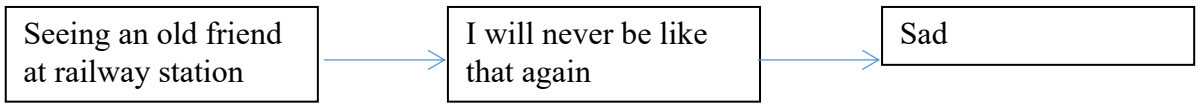
Therapist *– Yes, that's right. So, in CBT we believe that negative or unhelpful thoughts make us feel sad or anxious. If we can change the way we think we can change the way we feel. What CBT therapy would do is help you to change your thinking pattern so that you will feel less depressed or anxious. Does that make sense?*

Patient *– Yes, I think so.*

Therapist *– Do you think you will be happy to try CBT and see whether it can help you?*

Patient *– Now that you have explained it to me – I think I will give it a go.*

Therapist *– That's very good.*



Therapist could use **how patient feels and thinks during the session** as an example

Therapist: *Thanks for coming today. As you know, we are going to be using an approach called cognitive behavioural therapy (or CBT) to help with your problems. Would you like to hear a little about this approach and how it works?*

Patient: *By all means.*

Therapist: *The basic idea in CBT is that how we think affects how we feel -and also what we do - and vice-versa. Does that make sense?*

Patient: *I'm not sure. What do you mean exactly?*

Therapist: *Well, let's start with how we think, affecting how we feel. What are you thinking at the moment?*

Patient: *Well, to be honest I'm a bit skeptical about CBT! Will it work for me? Can you really think your way to happiness?*

Therapist: *And what emotion are you experiencing when you think "CBT might not work for me?"*

Patient: *Rather down, a bit hopeless, I guess.*

Therapist: *And what emotion might another client be experiencing if they were thinking "CBT makes a lot of sense"*

Patient*: Probably more hopeful.*

Therapist: *So here we have the same situation - a client coming for CBT for the first time, two different thoughts "CBT might not work for me" and "CBT makes sense" and two different emotions.*

Does the idea that how and what you think affects what you feel make more sense now?

Patient: *Yes, it does actually. I do see how my thinking affected my feelings today.*

Therapist: *And what are you feeling now?*

Patient: *Rather more hopeful, actually!*

Therapist: *That's a great start then. Now shall we see how this might help with the problems you'd like help with ....*

If they are unable to come up with an example or if they do not understand the CBT model with the their example attempt to explain to them with **an example of your own**, such as, he sees one of his friends walking on the other side of road and greets him, but the friend walks away without returning his greetings. Ask for the possibilities, resultant mood, behaviour and physiological sensations.

Figure 1

Possibility or explanation or thought	*Friend was angry with me/ disappointed with me/ deliberately ignored me*	*Friend did not hear me*	*Friend was in his own world. Looked to be having a problem.*
Mood	*Sad, upset or angry*	*No change*	*Sympathetic, concerned*
Behaviour	*Would not talk to him again, ignore him when I meet him again*	*Greet him again*	*Will cross the road and talk to him*
Physiological sensation	*Heaviness in the heart, headache,*	*No change*	*No change*

Using a diagram similar to table 1 therapist could explain to the patient that how he/she perceived the event will change the resultant mood, behaviour and physiological sensations. Therapist will put emphasis on the main focus of the patients such as bodily symptoms, mood, etc. and individualise it to the patient.

Therapist should explain;

Change takes time: It is important to stay in the MCBT therapy for the whole six sessions. The patient may not see an appreciable improvement in depression after one or two sessions and think CBT is ineffective or he/she may see improvement during the early part of treatment and think that treatment is over, or no longer necessary. However, depression is a recurring disease. While patients may require more than one or two sessions to see a big improvement and t it is critical for them to stay in treatment for the whole program, to learn the skills needed to combat depression, and to learn more realistic ways of thinking about stressful events that may come up in the future.

Perfectionism Can Get in the Way: To be successful in CBT, it is not necessary to feel "completely better" after a few sessions of Cognitive Behavior Therapy. Of course, this would be the best outcome in such a short period. However, some improvement is better than no improvement. Particularly in MCBT after 6 sessions

Continued Improvement CBT sessions: The patient will have new skills at the end of sessions that he or she can continue to use in later stages of the study and after treatment has ended. In this way, the patient can better cope with situations that could otherwise lead to depression in the future. These skills can continue to improve the patient's mood in the time period after treatment has ended.

Development of therapeutic alliance

See above

Establish the day and time of therapy sessions.

Highlight the importance of punctuality and consistent attendance. Tell family members that it is important and if they want to meet, they would need to wait at the clinic when the patient's session is over. Inform them that sessions should only be cancelled in case of emergencies and if possible with 24 hours' notice. Explain how this treatment has different educational and skill building components that follow a logical sequence based on weekly sessions and can be affected by frequent absences or lateness.

Assessment and formulation-

Goal setting:

It is important that the therapist assists in setting goals. Therapist will facilitate patient to think specifically about changes they would like to make at work, at home, in their relationships with family, friends, co-workers, and others. Patients will be encouraged to think about what symptoms have been bothering them and which ones they would like to decrease or eliminate. Patient and therapist will explore other areas that the patient would like to see an improvement in: pursuing spiritual/intellectual/cultural interests, increasing exercise, decreasing bad habits, learning new interpersonal skills, improving management skills at work or at home. The therapist, patient and family, if relevant will collaboratively develop a goal list and decide which goals could be addressed in MCBT and how other goals could be achieved.

<u>Examples of questions to use during goal-setting:</u>

"What would you like to get out of this therapy or treatment?"
“What would you like most to change as we work together in this treatment?”
"If things could be different, what would they be like?"
“What changes do you want to see in yourself as a person?”
“If someone asked you in three months or six months, how therapy had helped you, how would you like to answer?”
“Without worrying about how it could happen, what would you like your life to be like in 3 months from now?”

Second session-

Agenda – review of last session, mood check
Homework-Problems with homework are addressed in a supportive fashion. If homework is not done, considerable time of the session should be devoted completing at least one aspect of homework. This will help to establish the importance of the assignments and the therapist’s commitment to seeing the assessment done.
“We will continue using the outline for sessions that we used last week. “
As you may remember the first part of the session involves setting an agenda of things you want to talk about, and reviewing the homework"
"What things would you like to talk about and work on today?"
"Have some things come up this week which you would like to discuss and work on today?"
"What problems do you want to work on today?"
"How have you been feeling this week? What kinds of things have gotten you down? Has anything happened to make you feel better?"

Monitoring of mood

Mood Monitoring is a basic CBT skill the patient needs to learn as a way to track how they are feeling. This kind of monitoring facilitates the patient’s learning as to which situations lead to

him/her feeling more or less depressed (or irritable, lonely, etc.) and what kinds of thoughts and activities may be connected to those emotions. Then, instead of having a vague sense of what contributes to feeling better or worse, patients will understand their depression better and feel more empowered to do something about it. Once situations have been identified that are associated with feeling better, the goal will be to increase such activities. Thus, Mood Monitoring leads naturally into activity scheduling which is the next skill they are going to learn in the 2nd session. In addition, Mood Monitoring often sets the stage for cognitive work in 3rd and subsequent sessions by allowing teens to realize that they are not "always" feeling bad.

The mood monitoring form is the most important tool used in the mood monitoring component. Therapist will discuss with the patient about different emotions such as feelings of happiness, sadness, anxiety, anger, fear, surprise, disgust, shame, etc. taking examples from patient's own life. Different Sinhalese words should be used in describing emotions or mood states. (annex) It is important to note Sri Lankan patients may use different yet related concepts to describe mood states such as loneliness for sad mood. They may not be very forthcoming with certain emotions such as anger or irritability. Therefore, therapist should make sure that patients understand it is ok to have different emotional states.

Therapist will discuss how patients can know they feel different emotions looking at physiological sensations, thoughts and behviours in relation to each of those emotions. In MCBT a prominent place would be given to physical symptoms and physiological sensations considering importance of somatic symptoms in emotional states in Sri Lanka. Therapist will discuss that not only do different people feel different emotions, but the emotions also vary in strength. Patients are encouraged to appreciate not only the type of emotions but also the strength of emotions they feel. Therapist can discuss with the patient about rating emotions on a scale. To provide concrete anchor points for the scale, the therapist asks the patient to recall two or three experiences in which they felt sad, and two or three in which they felt happy, and to rate these experiences. Patients are encouraged to generate experiences that vary in intensity so that the whole range can be used. This may provide an opportunity to demonstrate to the patient that feelings range from happy to happier, and sad to worse, At the same time, this will highlight that even though it might seem like they feel sad all the time, by monitoring mood they can see how their emotions or mood vary over time.

Family members could help the patient to rate the mood by letting him know what they thought of his/her mood was. This should be done only if patient is comfortable with it, patient has a difficulty in rating the mood and family members are capable and willing to do so.

Figure 2-

Date and Time	Mood/ emotions
Thursday morning	Sad
Friday morning	Sad and anxious
Friday midday	Angry

If patient is comfortable with mood monitoring, therapist will introduce a 3-column mood-event form as a way to track what situations and events are connected with feeling different emotions (figure 1). Using several examples, patients are taught to identify (and rate, if possible) their mood using the mood diary/monitor. It is helpful to use examples that the patient has brought up in the session to illustrate how to use the mood monitor.

Figure 3-

Date and time	**Event**	**Feeling/ emotion**
Thursday morning	Could not get up on time	Sad
Friday morning	Went to the University	Sad and anxious
Friday midday	A friend did not return her phone calls	Angry

However, if therapist believe patient is not comfortable with 2 column-mood monitoring then it is prudent to postpone 3-column mood log for the third session. But, it should be noted that in such case thought monitoring may not be possible in third session.

Monitoring of physical symptom

It is not unusual for Sri Lankan patients with depression to present with bodily symptoms such as headache or burning sensation of body as their primary symptoms. In such patients, therapist should focus on monitoring of physical symptoms rather than monitoring of mood.

Therapist- *You told me that you have been troubled by your physical symptoms such as headache and other bodily pains over the last 4 years. There may be several reasons why someone would have physical symptoms. For example, can you remember the last time you had a sore throat?*
Patient- *Yes, may be few months ago.*
Therapist- *What was the reason?*
Patient- *I had inflamed tonsils I guess*
Therapist- *Have you had any other reason for pain or uncomfortable sensation in throat?*
Patient- *I am not sure*
Therapist- *Due to an injury or blow to your throat perhaps?*
Patient- *When I was young*
Therapist- *Have you ever felt that you had a lump in your throat when you were sad?*
Patient- *Yes*
Therapist- *If we were to consider it as a pain of some sort, there can be several reasons for pain in throat. The best way to know this is to monitor physical symptoms. So, can you please make a note of that? For example, can you record time and date of the body pain, type of body pain and what was happening at the time or just before? For example, can you remember the last time you had headache…….*

Date and time	**Event**	**Physical symptom/s**
Thursday morning	Husband said that cup of tea had too much sugar	Headache
Thursday afternoon	Son got late to come back from school	Burning sensation in heart and tummy
Friday evening	A came home after having alcohol with his friends	Heaviness in head

If both mood symptoms and physical symptoms are present therapist can encourage patients to monitor both. They may be able to observe associated mood changes with physical symptoms and vice versa.

Date and time	**Event**	**Physical sensation**	**Feeling/ emotion**
Thursday morning	Husband said that cup of tea had too much sugar	Headache	Not sure
Thursday afternoon	Son got late to come back from school	Burning sensation in heart and tummy	Not sure
Friday evening	A came home after having alcohol with his friends	Heaviness in head	Angry
Saturday morning	Argument with the husband about drinking	No physical symptom	Angry

Activity scheduling-

Daily activities are included on the agenda of the second session for most if not almost all patients. An activity schedule is filled out for the past 24 hours. Therapist will use examples from patient to explain the functional relationship between enjoyable activities and improved mood and periods of inactivity and low mood.

Therapist *– Darshanie, let me ask what activities you have been doing yesterday.*
Patient *– I spent a lot of time in my bed.*
Therapist *– Did you do anything else?*
Patient *– Well, I read a chapter from my module book – that was hard.*
Therapist *– Anything else?*
Patient *– I had dinner with my family.*
Therapist *– Darshanie, there are two types of activities I would like to focus on. One type is the pleasurable activities that give you enjoyment and the other type is what gives you a sense of satisfaction although you might not necessarily enjoy doing it. Can you identify any such activities that you did yesterday?*

Patient *– I guess having dinner with my family was enjoyable and I felt good after reading the chapter although it was dry and boring at the time.*
Therapist *– And what about staying in bed?*
Patient *– Quite the opposite – I felt miserable and I felt guilty afterwards.*
Therapist *– So spending time in bed didn't help your mood whereas the other two activities lifted your mood.*
Patient *– I guess so.*
Therapist *– What if we can do more pleasurable or satisfying activities and less of unhelpful activities.*
Patient *– Well it will lift my mood on paper - but I don't have the energy or motivation to do it.*
Therapist *– We will do it gradually. So first of all, can you tell me any other pleasurable activities or those that give you a sense of accomplishment?*
Patient *– Cleaning my room will certainly make me feel better afterwards and spending time with friends after lectures would be enjoyable.*
Therapist *– Would it be too much if I ask you to clean your room once next week and have meals with your family once or twice before we meet again?*
Patient *– I guess I can do that.*
Therapist *– We'll see how it has helped your mood next time; if it has a positive impact we will try to build up the momentum gradually and fill up your week with more and more of these kinds of activities.*
Patient *– Ok*

If they understand the rationale introduce activity scheduling and graded tasks. Depending on the patient therapist may have to choose more family oriented activities, religious activities or physical activities. For example, physical exercises may be a suitable activity for younger patients while religious activities may be preferable for more senior patients.

The patient should be encouraged to do things others view as useful or are expected of the patient. For Sri Lankan patients engaging in culturally appropriate activities such as going to temple/kovil/church, bodipooja, alms giving, spending time with family, visiting relatives, watching a cricket match with friends and family could be considered where appropriate.

Concomitants of depression such as social withdrawal, self-isolation, poor energy levels, lack of drive and anhedonia may lead to period of inactivity which in turn will maintain low mood. This relationship will be demonstrated to patient and encouraged to take steps to improve the mood.

"The fewer pleasant activities people do, the more depressed they feel. Do people stop doing things because they feel depressed? or do they feel depressed because they stop doing things?

The most probable answer is both. The fewer things they do, the more depressed they feel. The more depressed they feel, the fewer things they do. This forms a vicious cycle. To break the vicious cycle, they can increase those activities that make them feel better. These activities can be called pleasant. Pleasant activities do not need to be special activities. They are mostly everyday activities such as listening to music, watching TV, reading a book, talking to someone, being with family and friends."

Some people may find it difficult to come with any suggestions. In that case it is necessary for therapist to prompt them.

Following list may be used if the patient is unable to generate activities:-

Hobbies, religious activities, alms giving, going to temple, visiting relatives, spending time with family, work, holiday, sports, going places with friends, outdoor activities, phone calls/conversations, watching a cricket match, watching a tele-drama, music-related activities, writing (poetry/stories), cooking, crafts, parties, driving, mechanical activities games, religious activities, shopping, making things, art/photography, entertainment/movies/concerts, everyday activities (bath/shower/dressing/shaving)

"At this point we are going to practice another new skill. You are already working on two important skills. The new skill involves becoming more active, especially by doing things that you find enjoyable."

"When we are depressed, not only do we feel bad and think negative thoughts. We also stop doing pleasant activities. Often, we withdraw, lie around, avoid people, and stay in our room. If we listen to music, it may be depressing music that just makes us feel even more down."

"Increasing pleasant activities is a simple but powerful way to change our behaviour, which will then have a powerful positive effect on our thoughts and emotions. It is a way to become more active, feel better, and think more positive thoughts, all at once."

“Even if we try to increase pleasant activities and find we are unable to enjoy them, we may discover that negative, depressing thoughts are getting in the way. Then we can work on identifying and questioning those thoughts.”

Barriers in activity scheduling

1. Difficulty with initiation: Some patients may need encouragement or reinforcement to motivate them to increase enjoyable and satisfying activities. In this case, spend time with the patient to identify the one or two most powerful pleasant or satisfying activities, and work with the patient to start with these. Discuss with the patient minimum amount of activities he or she may be able to do depending on their mood and agree on a simple plan For example- ‘worst’ mood- make the bed and watch news on TV; ‘bad’ mood- sweep the room and make a telephone call to a friend; ‘ok’ mood- cook a meal; ‘good’ mood- go to the temple and visit a relative/ watch tele-dramas.

2. Feasibility or practicalities- Some patients may select activities that are too expensive, reliant on the weather (playing cricket in the afternoon in rainy season), or contingent on the cooperation of others (going to temple with the brother who is busy). Encourage patients to select activities that are inexpensive, practical, not dependent on extraneous factors such as weather or other people’s cooperation and can be done frequently. Those should be activities so patient would be active not passive such as sleeping. Finally, the activities should not be social unacceptable, or harmful to us or to others. For example it would be hard to go on family holiday with the whole extended family or play a game of cricket with a team of 11-players because that would involve a lot of people or also it would be hard to buy a big new HD TV because that is expensive or it would be hard to watch Vesak lanterns on the Vesak poya day because that happens only annually.

3. “Shoulds”: Therapist will discuss with the patient about the possibility of not having as improved mood as they “should” when doing pleasant activities. Some patients may choose activities that they think they should enjoy, even if they really do not. In such instances thoughts pertaining to lack of enjoyment and social desirability could be elicited and addressed. For example, a Sri Lankan patient may think visiting their relatives should make him feel better which in fact worsens his mood due to tensions in the relationship.

4. Social isolation- Some patients may require remedial actions to increase the opportunity for social interaction as social isolation restricts activities they can engage in. For some patients, social activities may not be enjoyable due to poor social skills. Use of problem solving skills and social skills may benefit these patients and such skills should be introduced early in the therapy for them.

Homework-

For homework, the patient is encouraged to notice and record situations that happen in the morning, afternoon, and evening each day of the week that are associated with feeling good or feeling bad.

Patient with psychomotor retardation and severe depression is asked to add one additional activity (either enjoyable or fulfilling) per day. If patients do not report significant psychomotor retardation and are still reasonably functional adding more than one enjoyable or fulfilling activities per day will be considered. Patients in latter category will be asked to maintain a daily activity schedule with prospective and retrospective ratings.

Third session

Agenda for the session is established collaboratively. It will include review, mood check, homework, items for this session and winding up and setting homework for next session.

Review mood dairy.

Reviewing of mood diary may reveal several challenges. One of the most common challenges, particularly with Sri Lankan patients is failure to identify mood states correctly. Then focusing on associated physiological sensations or behaviors thereby assisting them to identify the mood. Using variety of words to describe the mood may also be useful. Another potential problem may be that patients fail to record any variation in mood and reports mood is consistently depressed. If this occurs, empathise with the patient and then briefly review the week to capture any variations in mood the patient failed to capture.

Therapist- *It looks like that you did not have changes in mood. I wonder whether it is because you missed some fluctuations in the mood. For example, tell me whether you did anything you may have enjoyed in the last 2 weeks……. Can you remember what happened to your mood back then? ..... Did you cry or feel like crying over the last two weeks? What happened to your mood? ……. Did you have a headache or any other physical health problems or discomfort? How was your mood at the time? ……. Were there upsetting events over the last 2 weeks? How did you feel during those times?*

Persistently low mood may help the therapist to discuss doing more things that the patient enjoys. It is not uncommon for some patients forget to complete the form or finds it overwhelming. In either of these cases, look for the reason for this and assist the patient select a time to look back over the past 24 hours and record their mood, as well as a particular place where the form will be kept (e.g., on a bedside table). Specially designed computer application on the smart phone, tablet or laptop can be used for more computer savvy patients. If patient has not completed the form, it is important to attempt to reconstruct the form as completely as possible during the session

Review activity log-

Some patients have to do a lot of required activities, either related to study, work, or home chores. While some patients may get sense of fulfillment by doing these chores others may find it

overwhelming. While it is important to highlight the sense fulfilment the patient may be getting from these chores rather than trying to focus only on enjoyable activities, it may be necessary to gather support of the family and others to free up the patient's schedule to accommodate more enjoyable activities. It is equally important to explain to the family patient may find things they did without problem in the past overwhelming due to lack of energy, poor motivation, lack of self-confidence and negative evaluation.

Some patients may already be engaging in activities which theoretically could be enjoyable or satisfying but they are sabotaging these activities with negative thoughts and evaluations. In those instances, gather information on the patient's negative cognitions during homework review, making notes for the rest of this session on cognitive distortions.

If patients indicate that these activities were pleasant in the past but are not currently enjoyable, explore with the patient the associated thoughts and or any other factor that reduces enjoyment. Encourage the patient to engage in these activities even if they do not feel like doing so at this time. There are two reasons for this: positive behaviour leads to positive emotions; and, the thoughts that are getting in the way of enjoyment may become clear when the activities are tried.

At other times patients increase their activity level yet report no corresponding improvement in mood. There can be several explanations: (a) Activities that have the strongest effect on the mood are not being monitored, (b) time elapsed between activity scheduling and appreciable improvement in mood (c) no benefit from activity scheduling.

<u>Review problem list</u>

Look at problem list again – if there are pressing problems such as anxiety and sleep disturbances then address them with relaxation techniques, sleep hygiene techniques and looking at how to challenge the cognitive distortions related sleep. Consolidate on activity scheduling and if there are difficult tasks break them down to smaller manageable tasks.

Identifying negative thoughts –

Negative, distorted or maladaptive thoughts will negatively influence emotions and behaviours. In CBT, a fundamental intervention focus is teaching patients to identify and challenge errors in thinking. Therefore, it is necessary to teach the patient how to identify and then to counteract negative irrational thinking patterns.

This module builds upon the patient's understanding of the mood monitoring and launches into the next step of evaluating the role played by thoughts in mood disturbance. Having completed two weeks of a mood monitoring log and linked emotions to specific situations, the patient may have already begun to identify thoughts associated with these situations. In this session, a four-column mood-thought log will be introduced on which the patient records time and dates, upsetting events, negative thoughts associated with the situation, and resulting emotions (figure 3).

Date and time	**Event**	**Thought**	**Feeling/ emotion**
Thursday morning	Could not get up on time	"I am the laziest man on earth. I can't do a simple thing right"	Sad
Friday morning	Went to the University	"I can't understand the lectures. I must be dumb. How am I going to complete the degree if I don't understand the lectures?"	Sad and anxious
Friday midday	A friend did not return her phone calls	"Everyone ignores me"	Angry

Sri Lankan patients may have significant difficulty in identifying thoughts and differentiating feelings from thoughts and therapist should put emphasis on psychoeducation of identifying thoughts.

Therapist- *"Thoughts are ideas that we tell ourselves or images occur in mind. We have a constant internal dialogue we may or may not be aware of. Medium of this internal dialogue is thoughts and they can be conceptualized as objects that have a clear effect on our actions, feelings and bodies. It is important to understand that they are different from feelings. For example, you don't think sad, you feel sad. Likewise, you think you are a failure rather than feeling you are a failure. Different types of thoughts influence our mood differently. Some thoughts worsen the mood or increase symptoms of depression, while others help you feel better. "*

Therapist should take examples from the mood monitoring log and focus on thoughts that occurred with changes in mood.

"Let's look at your mood monitoring log and try to figure out what your thoughts have been in the past two weeks"

Once the patient is comfortable with identifying thought therapist will introduce the topic of "automatic thoughts".

"As we discussed before thoughts influence our emotions or in other words thoughts are associated with mood changes. However, it may be hard to identify the thought is that goes with an emotion. These thoughts often come so quickly and occur in the periphery of the mind and we don't even notice that they are there. A name for these thoughts is 'Automatic Thoughts' because they happen so fast. We have got used them so well we don't even notice them."

Therapist should choose an example relevant to the patient. Following example may be suitable for a patient who drives regularly.

"Try to remember how you learnt to drive. At the beginning you do everything with effort and so you notice everything such as hands on the wheel, where the different pedals are, where the

indicators are, how wide the car is, how far you are from the middle of the road. After some practice, these thoughts become automatic and you don't notice them so much or hardly at all. Automatic thoughts are like that. Maybe when we first got depressed we noticed them. Or maybe we learned them growing up before we even got depressed. But now they are so fast and automatic that we don't even notice them. So first we have to recognize them and get them down on paper."

Therapist can choose other examples such as playing a sport, playing a musical instrument, chopping mallum leaves to explain this to the patient.

Sometimes patient may find it difficult to directly link mood changes with thoughts. In that instance, the therapist can use different techniques to help patients to identify negative thinking.

<u>Identifying negative thoughts during the session-</u>

Therapist will pay attention to patient's negative thoughts or hot thoughts during sessions. Hot thoughts are automatic thoughts that occur in combination with a change in emotion or mood. Hot thoughts are particularly distressing or strong thoughts that are often associated with dysfunctional deep seated beliefs and should be targeted in therapy. To identify which automatic thoughts are "hot", the therapist observes verbal cues, such as the language used in the thought and nonverbal cues, such as change of tone or volume of speech, changes in facial expression, shifts in posture, or hand movements. When therapist notices any changes suggestive of hot thoughts, this is an opportune time to bring it to the patient's attention and assist them in identifying an automatic thought associated with the changes in emotions. In these instances, you are simply an observer of the behaviour and make a note of your observation to the patient ("Y*ou are speaking very softly; what is going through your mind right now?*").

Patient: *"My boss told me off again yesterday" (Sighs heavily; eyes down casted)*
Therapist*: "Tell me more."*
Patient: *"I made a presentation about how to increase sales of our products at the monthly office meeting. He said he had expected a better plan." (voice gets softer, begins wringing hands).*
Therapist: *"Your voice became softer when you said that; tell me what is going through your mind right now?"*

Patient: *"I just feel like a failure at everything. My work has always been the one thing I was good at, and now I am failing at that, too."*
Therapist: *"Let's take a look at that line of thinking and the feelings it creates. It seems that when that thought entered your mind, your mood changed very quickly. Did you notice that?"*
Patient: *"Yeah, I guess it did make me sad pretty fast."*

Therapist may use imagery (see pg for the example) or role play to help patient recall (see pg for the example) and identify their negative thoughts.

Introduction to cognitive errors

Therapist will just introduce the topic of cognitive distortions taking one or two examples from what patient has described already. However, if therapist feels that the patient requires more time to consolidate on identifying thoughts this could be done at the next session.

"*We are going to discuss different types of negative thoughts, or ways of looking at things that happen to us, that are harmful because they make us feel bad because they are not based on facts or they distort reality. For a description of each type of thinking error, I will give you a leaflet called Thinking Errors. We will look at whether there were thinking errors in some of the examples we discussed today"*

Read and discuss few types of thinking errors which came up during the session. Invite the patient to read each type after the sessions. Ask patient whether he can relate to these thinking errors while identifying thoughts in the next two weeks.

<u>All or nothing thinking:</u>

This is when you look at things as if they were completely good or completely bad. For example, if you make a mistake doing something, you think all your work was useless. You might think, "I'm not even going to try out for the job because I'll never get selected" Or "I can't do anything right."

<u>Mental Filter:</u>

This is when you take a single negative event and you focus on it in such a way that you see everything as negative and think everything is going wrong. It also refers to making or seeing things as bigger than they really are. For example, a young architect had been asked to do a minor amendment to one of seven plans he drew. Six of his plans were approved without any correction, but all he thought was the about the minor revision to the seventh plan.

Therapist- *"Nimal, why do you look so upset?"*
Patient- *"My boss does not think I am a good worker. I might lose my job"*
Therapist- - *"What happened? I thought he liked you"*
Patient - *"He told me that I have change the background colour of the plan I drew"*
Therapist- - *"So, he did not like the plan at all?"*
Patient "*No he was ok with the rest, I guess. But he wanted me to change the colour"*
Therapist- - *"I am still not clear how you thought he does not like you or your work"*
Patient- *"Hmm"*
Therapist- *"What about other plans you drew?"*
Patient - *"He approved those"*
Therapist- *"How many?"*
Patient- *"He approved six"*

Discounting the positive:

This is when you do not notice positive things that happen, and you only see the negative things. Or when positive things happen they seem less important to you than they really are. For example, you might believe that nobody likes you to the extent that if someone is nice to you, you think that something must be wrong with that person. Or if someone tells you how good you look, you think he or she says it just so you would not feel bad.

Jumping to the wrong conclusions:

This is when you come to conclusions too quickly and you see the negative side of things. There are two types:

Mind reading:

This is when you assume what someone is thinking without really knowing. For example, you see that someone is angry, and you think the person doesn't like you or that the person is angry with you. It might well be that the person is having his/her own difficulties. Other examples: "Dad thinks I'm stupid" or “the coach won’t let me play anymore because I didn’t score in the game, he thinks I am a bad player.”

Fortune-telling:

This is when you feel and predict that only disasters and tragedies will happen to you in the future. For example, "I'm going to flunk out of school" or "I won't have any friends at my new school" or "No one’s going to want to dance with me at the party" or "I'm not going to the audition because I'll never be picked."

Taking your feelings too seriously:

This is when you think that your feelings are the only version of reality. For example, you think, "I feel so sad, it proves what a disaster I am" or "I’m so lonely that my life has no meaning." “I am always bored so other people probably see me as a boring person.”

Shoulds / Perfectionism:

This is when you try to motivate yourself with shoulds; that is, with what you believe people should or have to do or say. Even if there are things you need to do, it’s important to be careful not to have unrealistic, excessive or inflexible expectations for yourself. For example, you might think, "I should get all A’s in school" or "My Mom should pay attention to me all the time" or “my boyfriend/girlfriend should always go out with me whenever I want.” When you tell yourself you should, you feel guilty. It’s better to do things the best you can and because you want to, not because you feel guilty. When you think shoulds about other people, you get angry and frustrated if they don’t do things the way you expect them to.

Labeling yourself or others:

Only because you make one mistake, you start to think you're a loser. For example, you might say, "I yelled at Mom, I’m a bad daughter" or "I’m stupid because I have bad grades" or "I'm ugly."

You might also label others: "The teacher is stupid because she scolded me." “She’s a traitor because now she hangs out with other friends besides me.”

Blaming yourself:

This is when you blame yourself for the negative things that happen around you and over which you have no control. For example, if something bad happens to one of your family members or friends, you feel as if it was your fault because you couldn’t prevent it. Or if your parents get divorced, you feel it was your fault because they were always arguing in front of you.

Homework-

Therapist will encourage the patient to continue with activity scheduling, activity monitoring and adding more enjoyable and fulfilling activities to their daily routines.

Patient will be asked to add another column to their mood dairy. They will be asked to make it a three column monitoring form - situation (with time and date), emotions and accompanying thoughts.

Fourth session

Fourth session would involve cognitive restructuring. Therapist will assist patient to reevaluate distorted and negative thoughts. Thoughts can be re-evaluated on the grounds of validity and utility.

Validity of thoughts-

These instructions might be useful to help patients develop balanced thinking. Pertinent questions therapist should help patient to ask are;

- What evidence is there that this thought is true?
- What evidence is there that this thought is distorted / not true?
- What would I tell someone I loved if they were in this situation and had these thoughts?

Once evidence has been sought, look for a more balanced alternative thought. This thought will likely be much longer and more nuanced than the original hot thought.

The therapist will help patient to ask;
Taking all evidence for and against into account, what is a more balanced thought that more accurately reflects the facts or what is the alternative way of thinking about the situation?
Can someone I trust understand this situation in a different way?

The patient will re-rate the hot thought and resultant or associated mood once an alternative thought is generated and re-evaluate the conviction or believability of thought and strength or intensity of mood (0-100%). While greater reduction of believability of thought is desirable, it is not often realistic nor necessary. A small reduction of conviction (10%) often results in appreciable improvement in mood. If patient and therapist feel that a significant improvement of mood is not likely with this process, more work is needed to find evidences for and against the hot thought and to identify more believable alternative thoughts. While it is not uncommon for patients to have new emotions associated with the alternative thought, the therapist should always help the patient to re-rate the old mood before generating new emotions.

Therapist *– Dharshanie, now we will look at how we can help you to think differently. This is the stage in CBT that we refer to as 'challenging the automatic thoughts'. So, we will look back at your situation with your friend Ama the other day.*
Patient *– Ok*
Therapist *–If I remember correctly you had the thoughts that "She is too busy for me", "She doesn't really want to help me".*

Day	Situation	Mood	Thoughts
Monday a.m.	Going for lectures	Anxious	
Tuesday	Going to library	Bored	
Wednesday p.m.	Thinking about exam	Anxious	
Thursday a.m.	Talking to a friend (Ama) about an assignment	Sad	Ama is too busy for me Ama doesn't really want to help me
Friday			

Patient *– Yes*
Therapist *– Darshanie, how much did you actually believe that thought at the time on a scale of 0-100%?*
Patient *– I guess I believed it very much – about 90%*
Therapist *– Ok we'll put 90% in your thought column... and how sad did you feel, again on a scale of 0-100%*
Patient *– May be 80%*
Therapist *– Do you remember what we discussed before – sometimes automatic thoughts may be distorted that they do not reflect the truth although they may have a grain of truth. So, can we look at these thoughts about Ama now and see how accurate they seem? First, we will look at what evidence was there that the thought "She doesn't really want to help me" was true?*
Patient *– Well when she was walking away she did seem really rushed. She quickly said "Hi Darshanie, I will meet with you later and kept going fast" She did not even pause to look at me.*
Therapist *– Anything else?*
Patient *– This is not the first time. There had been at times in the past she was very busy and doesn't have much time for me.*
Therapist *– Anything else?*
Patient *– No I can't think of anything else.*
Therapist *– Ok. Now is there any evidence on the other side that she does want to help you?*
Patient *– Well she is a good person; we have been friends since the first day of University.*
Therapist *– What makes you think she likes you?*
Patient *–Well, let me think. We study together and sometimes we chat about various things for a long time.*
Therapist *– Good. So, to summarise Ama went away in a hurry without talking to you much and it has happened before. But on the other hand, she studies with you and spends time talking about things. Have I got it right?*

Thought : Ama does not really want to help me

Evidence for	Evidence against
Hardly looked at me; kept going	Usually have meals together
Sometimes very busy and doesn't have much time for me	Spends time talking about things

Patient *– Yes*
Therapist *– Ok, can we have another look at the scenario? Can there be another explanation for the situation apart from "Ama doesn't want to help you"*
Patient *– I don't understand.*
Therapist *– What other reason may have been there for Ama to leave you in a hurry?*
Patient *– Well, it is possible that she was in fact late for a lecture.*
Therapist *– Good; now can you re-rate the believability of the thought "Ama does not want to help you"*
Patient *– A little less; perhaps around 70%.*
Therapist *– Let me put it there. Now how sad do you feel?*
Patient *– It is little less too. May be 60 %*

Day	Situation	Mood	Thoughts
Thursday	Talking to Ama about an assignment	Sad 80% ⟷ 90% ***60%*** ⟷ ***70%***	Ama is too busy for me She doesn't really want to help me

Therapist *– Excellent; what did today seem to helpful. What if we could do this with all the negative automatic thoughts?*
Patient *– I may not be as depressed as before.*

Utility of thoughts-
At times, hot thoughts associated with negative mood are not inaccurate – based on realistic facts yet has little or no utility value. In other words, those are counterproductive or harmful thoughts. An example of such a thought is given below.
Patient- *I don't want to go to the job interview*
Therapist- *I thought you are going to the interview. That's what you told me yesterday.*
Patient- *Things have changed since then, there were only 2 other applicants till last week, but today I got to know there are 7 other applicants*
Therapist- *So, why don't you want to go to the interview?*
Patient- *I thought it is obvious, now my chances of getting the job are much less, so might as well not bother*

Therapist- *Do you still want the job?*
Patient- *Of course*
Therapist- *I understand your chances of getting the job, mathematically speaking, is now lesser than before. But if you do not go because of that your chances are zero, whereas if you go you still have a chance.*

- What are the advantages of this thought?
- What are the disadvantages of this thought?
- What would I tell someone I loved if they were in this situation and had these thoughts?
- Is there an alternative thought?

If the thought has more disadvantages than advantages and leads to unhelpful behaviour and is associated with negative emotions, a more helpful thought should be looked for.
The patient will re-evaluate the hot thought with less utility value and resultant or associated mood once an alternative thought is generated and re-rate the conviction or believability of thought and strength or intensity of mood (0-100%).

Homework-

Therapist will encourage the patient to continue with activity scheduling, activity monitoring and adding more enjoyable and fulfilling activities to their daily routines.

Patient will be asked to adopt a 7 column thought record.

7 Column thought record

Situation/ Trigger	Feelings, emotions and body sensation (Rate 0-100%)	Thoughts/Images (Rate 0-100%)	Facts that support the thought	Facts that against the thought	Alternative/ more realistic thought	Outcome: rerate the thought and emotions

Considering the relative complexity of the 7-column thought record, therapist should do at least one example with the patient at the session.

Fifth session

Agenda for the session will be established collaboratively. It will include review of the last two weeks, mood check, review of homework, items for this session and winding up and setting homework for next session.

Fifth session is dedicated to problems often associated with depression in Sri Lankan patients. These are optional modules. Therapist and patient will identify the problems that require interventions. If there is more than one problem the therapist should decide which intervention may be most beneficial.

- Relaxation techniques
- Problem solving techniques
- Assertiveness training and social skills training

Review of

Relaxation techniques

Depression is often associated with considerable anxiety or agitation. Inability to relax has been identified as a significant problem by many with depression.

Therapist could use three specific techniques: mindfulness for anxiety, progressive muscle relaxation, deep breathing, and imagery. Therapist will largely determine selection of a specific technique, based on patient's expressed interests and preferences/abilities in mind. For example, patients who are largely somatically focused may prefer muscle relaxation or deep breathing. People with religious inclinations may find mindfulness and breathing techniques more useful and acceptable due to Buddhist / Hindu traditions. Patients who appreciate the association between thoughts and mood, may prefer guided imagery. However, the ultimate decision of which technique to use may relate to exposure to all three techniques and a trial-and-error approach.

Mindfulness-

"You can't stop the waves, but you can learn to surf." - John Kabat-Zinn

Instead of challenging and modifying thoughts, mindfulness seeks to change the relationship between the patients with anxiety and their thoughts. In mindfulness, the person focuses on the bodily sensations and emotions which occur when someone is anxious. Rather than avoiding or withdrawing from these feelings or sensations they remain present and fully experience those without reacting to same. Instead of struggling with distressing thoughts associated with anxiety, they acknowledge the thoughts without trying to evaluate those. This will enable patients with anxiety reduce their over identification with negative thoughts. He/she practices responding to disruptive thoughts, and letting these thoughts go. By remaining present and mindful, they learn that the anxiety they experience is merely a reaction to perceived threats. By merely acknowledging threatening events instead of being reactive they can overcome an erroneous fight-or-flight response.

Therapist- *We discussed about your anxiety problems and you wanted to discuss about what counselling for this.*
Patient- *Yes. However much I try to avoid or change anxiety feelings and thoughts, I have not been able to get any relief.*
Therapist- *That's is not unusual with anxiety. In contrast, instead of changing or avoiding the thoughts or feelings, you can just acknowledge them without reacting to them. I will give an example, if you live in a house by a busy road, you are aware vehicles are going but you are not going to check what vehicle is going every time. Instead you acknowledge vehicles are going without reacting to that. If you can do the same with feelings and thoughts of anxiety you may get a relief. This is based on the Buddhist principle of Samma Sathi- being present in the moment. Considering your inclinations towards Buddhism, I thought you may like this.*
Patient- *Yes, I can relate to this better.*
Therapist- *Just notice the busyness of your mind and just observe your own thoughts. Stand back and watch them floating past, like leaves on a stream. Like in samma sathi, no need to try to change the thoughts, or argue with them, or judge them: just observe. This takes practice. It's about putting the mind in a different mode, in which we see each thought as simply another mental event and not an objective reality that has control over us.*

Therapist can help patients to practice this anywhere, but it can be especially helpful to take a mindful approach if patient realises that, for several minutes, they have been struggling with reliving past problems or worrying about future. To develop an awareness of thoughts and feelings, some people find it helpful to silently name them: "Here is the thought that I might meet with an accident". Or, "Here is anxiety".

Formal mindfulness practices

As well as practising mindfulness in daily life, it can be helpful to set aside time for a more formal mindfulness practice.

Few practices can help create a new awareness of body sensations, thoughts and feelings. The ones that are particularly helpful to Sri Lanka, considering cultural relevance, are:

• Meditation –sit silently and focus attention on the sensations of breathing or other regions of the body, bringing the attention back whenever the mind wanders

• Yoga – participants often move through a series of postures that stretch and flex the body, with emphasis on awareness of the breath

Breathing Technique

Another effective relaxation technique is regulated breathing which focuses on reducing rapid and shallow breathing that often occurs during periods of stress, worry, or anxiety. Rapid and shallow breaths can lead the patient to have deranged acid-base balance in the system, which can cause paradoxical-hyperventilation, dizziness, lightheadedness, or decreased ability to concentrate. Alternatively, taking a deep, full breath can produce a feeling of calmness or slowing by correcting acid-base balance.

Steps to breathing exercises

Therapist will introduce the patient to breathing techniques by explaining why breathing exercises were chosen and provide an overview of the procedures and potential benefits. This may be particularly useful for those who are familiar with the breathing meditations such as “Anapanasati”. This can be in cooperated to mindfulness techniques.

Therapist will demonstrate how to do breathing techniques by placing one hand on the abdomen, with the little finger about 1 inch above the umbilicus and putting one hand on the chest. Once the patient has placed his hands accordingly request them to pay attention to their breathing and ask them to tell you which hand is doing more of the moving? Ideally, the hand on the abdomen should be moving, while the hand over the chest remains still indicting that the breaths are deep. Encourage the patient to take deeper breaths by getting the hand over the stomach to move while having little movement of the hand over the chest. Explain to the patient that the hand on their abdomen should move out as they inhale and in as they exhale. Therapist will encourage the patients to practice slow, even, deep breaths. To pace the patient, you might suggest that he/she says the words "in and out" slowly, while taking breaths. Inhalations and exhalations should build to approximately 3 seconds in duration.

Therapist will inquire whether the patient feels relaxed with breathing techniques and make necessary changes in the technique till patient feels relaxed. Therapist will discuss with the patient about the situations when breathing techniques might be appropriate.

Encourage the patients to practice breathing techniques in between sessions. Patients could practice it for 5 min twice daily. Work with the patient to set a homework assignment that encourages application of deep breathing to situations when the patient feels stress.

Progressive Muscle Relaxation (PMR)

Therapist will teach the patient how to tense and then relax various groups of muscles all through the body in a sequential fashion, while focusing on the feelings associated with both tension and relaxation. The patient is expected to learn to identify tension and reduce its impact through willful deliberate relaxation. Therapist will explain the rationale for using muscle relaxation and how it will benefit the patient. Therapist will demonstrate how it is done.

Therapist will help patient to identify and discriminate between sensations of tension and relaxation. Inform the patient that sensations of tension and relaxation cannot co-exist. No muscles

in the body can be tensed and relaxed at the same time. Explain to the patient that tension often builds gradually without patient noticing it. Learning to identify early signs of tension will help to avoid full blown occurrence of tension. Once patient has recognized the tension they can reverse it irrespective of stage of tension.

Therapist will ask the patient to tense and release different muscle groups in sequence, moving from the arms to the face, neck, chest and shoulders, torso, and legs. It's important to try to tense only that muscle group in focus during the tensing part of the exercise.

It is important to really feel the tension in the muscles, which may even cause a bit of discomfort or shaking. Once the discomfort is considerable, let all the tightness flow out of the tensed muscles. Patient could exhale as they do this step to improve the relaxation. One should feel the muscles become loose and limp, as the tension flows out.

Patient will be asked to focus on the sensations produced by tensing and releasing the muscles. This could be reinforced by asking explicit questions during PMR - "What are you noticing about your body right now?" It is important that the patient very deliberately focuses on and notices the difference between the tension and relaxation. This is perhaps the most important part of the whole exercise.

Therapist will demonstrate how to tense and relax muscles. Following 7 large muscle groups are a good guide. But therapist may choose even smaller muscle groups such as making a fist.

Dominant arm. Make a fist and tense biceps; pull wrist upward, while pushing elbow down against the arm of a chair or bed.
Non-dominant arm. Same as above.
Forehead, lower cheeks and jaw. Lift eyebrows as high as possible, bite teeth together, and pull corners of mouth tightly.
Neck and throat. Pull chin down toward chest; at the same time, try to prevent it from actually touching the chest. Counter pose muscles in front part of the neck against those in the back part of the neck.

Shoulders, chest, and upper back/abdomen. Take a deep breath and hold it. At the same time, pull the shoulder blades back and together, trying to make them touch. Try to keep your arms as relaxed as possible while tensing this muscle group. At the same time make the stomach hard by pressing it out, as if someone was going to hit you in the stomach.
Dominant leg. Lift foot off the floor and push down on the chair with thigh.
Non-dominant leg. Same as above.

Once instructed and demonstrated therapist will ask the patient to practice one muscle group at a time. Therapist will ensure that the patient can identify tension and relaxation in each group before moving on to the next.

After PMR, therapist should discuss with the patient about their reaction to the PMR. It is important to make any adjustments needed to the training. If at any point during the process patients experience pain, it is necessary to alter the technique. If the patient experiences chronic pain in any part of the body, it is best to avoid the tensing component for muscles in that area; just do the relaxing component when the patient gets to those muscle groups.

Therapist should encourage the patient to practice PMR daily over to master the technique. Patient will be asked to practice this in a quiet environment where distractions are minimal. As patients becomes increasingly skilled at PMR, they find it possible to relax without having to actively tense the muscles. Patients will be able relax muscles whenever they notice tension.

Guided imagery

Guided imagery is a cognitive relaxation technique, unlike breathing technique or PMR which are physiological techniques. Guided imagery focuses on increasing cognitive, emotional, and physical control by changing the focus of an individual's thoughts. Daydreaming about pleasant things distract people from stress and make them feel better. Guided imagery uses largely similar process which encourages individuals to adapt "dreaming" which distracts and relaxes them.

Guided imagery highlights the CBT principle of connection between thoughts, mood and physiological reaction. It appears the body may not know the difference between an actual event and a thought. Guided imagery uses the images and the perception to mimic the person is either somewhere else or in a different state of mind to reduce stress tension and anxiety by changing thoughts and emotions or through distraction.

Therapist will introduce guided imagery to the patient, pointing out the power of the thoughts and how images, when accessed correctly, can actually change physical and emotional states such as decreased outcomes.

Therapist will discuss with the patient to identify a place, real or imaginary, they would feel relaxed and calm in, that both you and the patient feel might benefit or produce the desired outcome. If patient has difficulty in selecting a place prompt them with list of places depending on the patient, i.e. village temple/church, paddy field, beach, etc. Sample imagery scripts appropriate for Sri Lankan patients are provided below and can be used if the patient has difficulty creating a personal situation. It should be noted that selection of a powerful image is critical to the success of this technique. While choosing a place / image that the patient is able to fully embrace increases the treatment success, selection of a "weak" image that is not considered as important by the patient or unable to be fully immerse in, will reduces it.

To ensure that patients find a "strong" image, ask them to explore as many senses as possible to increase vividness of the image. For example, when imagining being in village temple patient will visualize the details of temple, imagine hearing sounds in the temple, sensing smells of the temple, feeling sensations such as breeze in the temple and finally think of how he feels overall in the temple. This is an example of guided imagery that uses multiple senses and increases vividness of the image. Increasing vividness is largely a matter of increasing the details the patient experiences. The more details described by the patient, the more powerful the technique.

Therapist will discuss with the patient of their experience after the guided imagery. If they have not felt calm and relaxed, then attention should be given to appropriateness and vividness of the imagery.

Therapist will discuss with the patient about the situations when breathing techniques might be appropriate. Encourage the patients to practice breathing techniques in between sessions.

Script-

Imagine yourself in a quiet village temple around 6pm. You can see the Bo tree – its leaves are gently swaying in the breeze. There are a few coconut oil lamps around the Bo tree and their flames are also flickering with the gentle wind. White and clean sand in temple premise. There aren't many people in the temple. You can see a calm elderly female in white sitting in the far corner and chanting pirith. You can also see serene looking white coloured dagoba. You can get the smell of incense sticks, flowers and oil lamps. You hear leaves of Bo tree swaying in breeze and someone chanting pirith from far corner. You feel sand between toes and cool breeze on your skin. You are completely relaxed, clam and serene… there are no worries in this temple. There is nothing to distract you from feeling tranquil. Worries drift away. Notice the sights, smells, sounds and how it feels to be in this special place. Listen the "sili-sili" sound produced by gentle swaying of the Bo leaves which is very calming, look at the lamps flickering. You are feeling fully relaxed and completely at peace.

Therapist will explain to the patient that they can visit this place mentally, as often as they want. They need to tell themselves, "I am relaxed here… this place is special and makes me feel peaceful and content." Patient may feel at ease knowing the special place is always available to them, and they find that they feel relaxed even after they leave.

Problem solving techniques, interpersonal techniques

Those who have significant difficulties in facing problems and solving problems may find problem solving techniques useful as deficits in problem solving skills function as a vulnerability for depression. This should be discussed with the patient and therapist should collaboratively decide whether patient may find it beneficial.

Therapist - *"All of us encounter problems in our lives. Some are good at dealing with problems than others. As in your case not being able to face or solve problems can lead people to feel frustrated, discouraged or even depressed. Therefore, we will look at how you can learn a general way of solving problems. The new skill for this session is called Problem-Solving."*

The therapist should take an example from the patient and show how problem solving can be used in one or more issues that the patient has brought up so far. Therapist has to demonstrate how effective problem solving through problem solving skills will lead to improvement in mood and symptoms. For example, if patient got depressed in the context of inability to resolve financial/ family/ job related problems explain how better problem solving skills will help them with depression. If the patient is impulsive, demonstrate how problem solving techniques will assist them to think through the problem to arrive at the optimum solution without jumping to decisions which they will regret later. If the patient has been suicidal, explain how this technique can facilitate them to consider various solutions to problems without feeling so discouraged or hopeless.

Therapist will make the distinction between worrying and problem solving.

Therapist- *When we worry, we repeatedly have thoughts about worst case scenarios and all the potential and hypothetical problems that might happen in the future and often ask ourselves 'what if'- we would do if this terrible thing ever happened. At times there is no real problem to solve. Even when the worry is based on an actual problem, we are so anxious that we can't think clearly, to find practical solutions. Instead, we just think and think about our worst fear. In summary, worrying makes us anticipate and fear something that is usually unlikely to happen in the future, yet leaves us unprepared for real problems as we have not considered them and poorly prepared for them. Unlikely occurrences even if they happen are difficult to deal with as we don't have a prepared plan of action. Problem-solving is different. It is a constructive process geared to effectively solve a real problem at hand.*

Therapist will explain to the patient principles of problem solving skills.

It involves identifying what the problem is and thinking of possible ways of dealing with the problem. We then choose which of these suggestions seem the best solutions and examine the pros and cons for each. Based on our evaluation of the solutions, we can then develop a plan of how best to deal with the situation by using one or more of the strategies we have thought of. The next step is to put this plan into place. At the end of this process, we step back and evaluate how well we have done in dealing with the problem.

Though this is not an essential component, depending on the patient, therapist may have to stress on relaxation and / or anger management technique if their problem solving ability is impeded due to emotional arousal.

Identify or define the Problem:

The first phase of problem solving may sound obvious but often requires more thought and analysis. Identifying or defining a problem is a vital yet potentially difficult task in the process. Patient needs to evaluate whether the problem real or whether they are worrying unnecessarily? What is the nature of the problem? Are there more than one problem?

By defining the problem not only is the patient able to understand it more clearly but he/she will be able to communicate its nature to others more coherently; this leads to the second phase.

Once the problem has been defined, patient may require to gain more information about the problem to increase understanding. This may involve fact finding and analysis, building a more comprehensive picture of both the goals and the barriers. This stage may not be necessary for very simple problems but is essential for problems of a more complex nature

Some patients may take excessive personal responsibility for problems or tend to attribute more control to themselves than is realistic or tend too readily to blame others for it. The pie chart method can be used with these problems.

Brainstorm-

From the information gathered in the first step of the problem solving technique it is now time to start thinking about possible solutions to the identified problem. This stage is often carried out as a brain-storming session, considering all the possible solutions (or part solutions).

Following defining the problem, patient will brainstorm to think about solutions. They are encouraged to think of all the ways in which they might solve the problem. At this stage patient should not evaluate whether one solution is better than others. They should think about all the possible solution irrespective of how improbable or silly they may appear - the sky is the limit. Patient could think what solutions they used to solve past problems. Patient may find it difficult to find a solution if the problem is too complicated, in that case they should break the problem into smaller parts they can more easily tackle.

Finding solution

Having brainstormed all the creative solutions, from seemingly improbable to serious solutions, the patient has to decide which has the most potential? The patient is encouraged to consider several aspects including the following.

- Advantages and disadvantages of the solution
- Is the solution practical?
- How would the solution make patient feel at the end?

After selecting the best solution, the patient has to consider several issues that may arise in implementation such as required resources and potential barriers / problems. Yet, a perfect and fool proof plan is not necessary.

Don't be discouraged if your plan isn't perfect. A good long-term solution may temporarily generate new problems. That does not mean you should give up the plan, just that you need to be prepared to make course corrections or even switch to a plan B.

Implement the plan

Implementation of the solution is as important as defining, brainstorming and selecting the solution. This step may be impeded by cognitive distortions such as “I can’t do this” “This is not going to work” and “I will fail”. It is not unusual for the patients to postpone it. Therapist should discuss about these problems with the patient and ensure its implementation. It is important to write down the details of the plan. The patient should not give up implementation easily without persevering with it for an adequate period. Patient should obtain support from other sources in implementing the solution.

Evaluation and reflection

Therapist should emphasise the importance of evaluation and reflection. After implementation of the selected solution the patient needs to look at whether the original problem has been solved. If not, then they should select a different solution from the list and implement it. Problem solving techniques may teach many things to the patient irrespective of whether it was a successful attempt or not. Therefore, therapist will invite the patient to reflect on experience, lessons learnt and suggestions for next time.

Sixth session

This is the last session of modified cognitive behavioural therapy. It is natural for many patients to feel anxious about losing the progress they have made, start wondering whether they are ready to face their problems without the help of the therapist, and worry whether their symptoms will come back. It is important to address these issues even when patients have not overtly mentioned these concerns. Therapist should discuss what they found beneficial during the therapy and how they would be able to maintain those benefits after therapy.

Patients cannot unlearn what they learned during CBT-

One of the concerns patients may have is whether they 'will go back to square one' once they stop therapy. Therapist should give them confidence that what they learnt will be useful in the future.

Therapist- *You said that you are worried about going back to square one from tomorrow. I guess you are worried about going back to where you were prior to the therapy?*

Patient- *Yes.*

Therapist- *Yet, it is not possible to go back to square one: you cannot unlearn all the skills and techniques that CBT teaches you. Being back at square one means having depression and not knowing how to deal with negative thoughts, unhelpful behaviours. But now you have learnt what to do with those using CBT, you do know how to manage your anxieties.*

Let patients know what to expect

Therapist will discuss with the patient that lapses and relapses are not unusual, particularly lapses. A lapse is a brief return to distorted and unhelpful thinking patterns and behviours. It is a common phenomenon. Lapses can be triggered by adverse events or even daily stress.

A relapse is a complete return to most or all of their previous distorted thinking and behavour as when they are depressed.

Therapist will discuss the importance of how patients perceive a lapse which can decide whether it will lead on to becoming a full blown relapse. If the patient views a lapse as a sign of failure and start blaming themselves, they are likely to feel frustrated and just "give up" and have a relapse. If the patient views the lapse as a slip-up, but one that they can recover from, then they less likely to have a relapse.

Awareness of early warning signs-

While acknowledging lapses and relapses can occur, therapist should discuss about ways to remain well. It is vital that the therapist discusses with the patient about the trigger factors for lapses / relapses. For example, most lapses occur during times of stress or change. While it may not be feasible to avoid or modify trigger factors all of the time, patients can be prepared to deal with them better if they know when they are more vulnerable to having a lapse/relapse. Patients will be encouraged to modify the trigger factors when they can. Therapist should discuss about practicing equanimity for perceived adverse and favorable events alike in order to increase their resilience.

Patients should be aware and mindful of tell-telling signs of lapse / relapse. Therapist should encourage the client to make a list of warning signs that tell the patient the lapse or relapse is eminent. If they are struggling to make list help them with some of the early symptoms they had such as poor sleep, easily getting tired, avoiding more activities and being pessimistic about things.

It is of no use identifying early warning signs unless patient has a plan of action when early warning signs are there. Therapist will identify coping strategies and make a list. Therapist may prompt the patient with their usual coping mechanisms. This may involve practising CBT skills more often, taking some time for yourself, relaxing and talking to someone about it.

Perfecting the art of CBT

Therapist should build the patient's confidence that they are ready to be their own therapist and thereby increase wellness and reduce lapses/ relapses. The best way to become the best therapist is to keep practicing CBT skills. Therapist will discuss that CBT skills can be perfected further with regular practice which will improve the skills of coping with and avoiding lapses /relapses.

Get the patient to make a weekly schedule for themselves to practice CBT skills. This should be practicable yet regular enough. Therapist could source help of family to ensure that practice will occur on regular basis. This should include both behavioural and cognitive skills that have helped them most.

Learning from lapses/ relapses

Therapist should emphasize the benefit of lapses/ relapses and benefits of failure in general. Lapses and relapses will teach patients things about themselves that they will never learn in another way. Patients should take lapses and relapse as challenges to face and opportunities to learn. Patients should try to figure out why they lapsed or relapsed and thereby try to determine what they could do differently next time. Therapist will discuss about the other lessons it might teach them about the impermanence of bad time - even with their worst fears realizing they will get better. By being their own therapist patient should look at scientist and in cooperate lessons learnt in to their armamentarium, so chances of further lapses and relapses are lower

Be compassionate

Therapist should emphasize on the importance of patients being compassionate to themselves. It is normal to have negative thoughts or not feel like doing things and having lapses. Patients should not beat themselves up or denigrate themselves. Therapist will reiterate the fact that all the people make mistakes and putting themselves down is only going to be counter-productive for the patient. Therapist may make reference to concept of loving-kindness for those who are used to the concept. Loving kindness starts with self-compassion - acceptance of thoughts without judgement and softening of self-criticism.

When the patients feel discouraged about the progress they have made they should think about small changes they can make that add up to big changes they may still want to achieve. For example, when someone sets off to a far-off destination the initial few steps or turns will take him nearer the destination although it may feel that he is far off from the destination. It is important to reflect on how far they have come rather than just the things they may still want to do or improve.

Avoid over-indulgence

While it is important to monitor emotions, thoughts and behaviours, focusing too much on it is not advisable. They should be advised not to get too over focused on reviewing the mood. They should be reminded that the mood will fluctuate up and down at times and that it is normal, and patient should not be alarmed about it. If family members notice the patients are having negative thoughts, or that they are ruminating over things the patient should be guided to focus on the present moment or do an activity which requires full attention. Patients should be advised to be gentler on themselves and not be too self-critical. They should be able to accept some of the negative thoughts that come into their mind without becoming judgmental about themselves.

Depression-

What is Low Mood?

Low mood is another emotion which can cause emotional distress. People can often experience a number of different symptoms that can affect the way that we think, the things that we do, as well as the physical symptoms that we can experience. This can then impact people further by causing their mood to deteriorate even more. Research has shown that the main causes for low mood can be linked to genetics, biology, early experiences in life, a combination of stressful events or even major life events such as a relationship breakdown, loss of a loved one or any traumatic event.

When feeling low, people may find themselves thinking negatively about themselves and thinking that other people do not like them. A common symptom of low mood is that people tend to withdraw from activities or social interaction, as well as having difficulties staying or trying to sleep, as well as eating. People experiencing low mood can also think that life is not worth living or may even think about harming or killing themselves. This can be quite common for people who are experiencing these difficulties.

Mood diary

Event/ Situation Date and Time	How you felt / Emotion (Strength of the emotion – 0-100%)

Daily activity schedule

PROSPECTIVE:	**RETROSPECTIVE:**
PLAN WHAT YOU ARE GOING TO DO TODAY ON AN HOURLY BASIS	**WHAT DID YOU ACTUALLY DO TODAY? RATE EACH ACTIVITY FOR PLEASURE OR ACHIEVEMENT FROM 0- 5.** The higher the number the greater the satisfaction
DATE:	
8-9 a.m	
9-10 a.m.	
10-11 a.m.	
11-12 a.m.	
12-1p.m.	
1-2 p.m.	
2-3 p.m.	
3-4 p.m.	
4-5 p.m.	
5-6 p.m.	
6-7 p.m.	
7-8 p.m.	
8-9 p.m.	
9-12 p.m.	

Activity scheduling

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

3 Column thought record

Situation/ Trigger	Feelings- Emotions	Thoughts/Images

3 Column thought record (Bodily sensations)

Situation/ Trigger	Bodily sensations	Thoughts/Images

Combined emotion and bodily sensation record

Date and time	Event	Physical sensation	Feeling/ emotion

4 Column thought record

Date and time	Event	Thought	Feeling/ emotion

7 Column thought record

Situation/ Trigger	**Feelings Emotions and body sensation (Rate 0-100%)**	**Thoughts/Images (Rate 0-100%)**	**Facts that support the thought**	**Facts that against the thought**	**Alternative/ more realistic thought**	**Outcome- rerate the though (Rate 0-100%)**

Problem solving skills worksheet

Definition of Problem				
Solution	**Advantages**	**Disadvantages**	**Practicability**	**How would that make you feel**