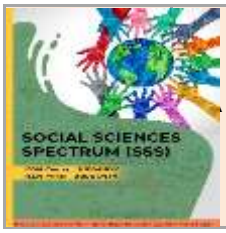

Social Sciences Spectrum

Double-Blind, Peer-Reviewed, HEC recognized Y-category Research Journal

E-ISSN: 3006-0427 **P-ISSN:** 3006-0419
Volume 04, **Issue** 01, 2025
Web link:https://sss.org.pk/index.php/sss

Check for updates

Urdu Translation and Adaptation of Beliefs about Psychological Problems Inventory (BAPPI)

Aqsa Gulzar
MS Clinical Psychology Scholar, Department of Humanities, COMSATS University, Islamabad, Lahore Campus, Pakistan

Dr. Mahira Ahmad
Assistant Professor, Department of Humanities, COMSATS University, Islamabad, Lahore Campus, Pakistan
Correspondence: mahira.ahmad@cuilahore.edu.pk

Article Information [YY-MM-DD]

Received 2024-12-20 **Accepted** 2025-02-22

Citation (APA):

Gulzar, A & Ahmad, M. (2025). Urdu Translation and Adaptation of Beliefs about Psychological Problems Inventory (BAPPI). *Social Sciences Spectrum*, *4*(1), 385-400. https://doi.org/10.71085/sss.04.01.226

Abstract

The purpose of the study was to translate and validate the Beliefs about Psychological Problems Inventory (Moraira, 2021) on a Clinical Population. Sample was comprised of 615 individuals, aged 24-40 who have been diagnosed with mild anxiety approached from outdoor psychiatric units in Lahore through convenient sampling. The results of the Confirmatory Factor Analysis (CFA) indicated a moderate-to-good fit of the model to the data, as reflected by the reported indices (GFI = .86, CFI = .90, TLI = .92, RMSEA = .08). The parameter was significant at p<.001. Hu and Bentler (1999) as well as West et al. (2012) recommend the criteria of relative indices, where $\chi 2$ /df should be in between 0 and 3, RMSEA value should be .08 or lesser and Comparative Fit Index (CFI), and Goodness of Fit Index (GFI) values of 0.9 or higher are considered as good fit whereas less than .8 is acceptable. The indices confirmed a moderate fit of the model. The translation and validation of the BAPPI ensure its relevance and applicability in addressing mental health challenges within clinical populations The current research contributes to the broader goal of promoting mental health literacy, and improving access to psychological interventions.

Keywords: Beliefs, Psychological problems, Anxiety, Psychometric validation, Urdu translation.

Introduction

Psychological problems are patterns of thought, emotion, and behavior that are deviant, distressing, and dysfunctional. They can affect an individual's daily life, relationships and overall well-being (Davison, 2017). Combination of genetic, environmental, and psychological factors can be the cause of psychological problems. Psychological problems can be manifested in many ways such as unhelpful thinking patterns, inappropriate emotional responses, manipulative or harmful behaviors and changes in bodily functions, such as sleep or appetite disturbances. Psychological problems can be classified into different categories such as anxiety disorders, personality disorders, mood disorders and others (APA, 2013).

The etiology of mental illness throughout history have been based on several perspectives which includes psychogenic, somatogenic and supernatural etc. In ancient time the supernatural perspective explained that some supernatural beliefs cause psychological problems which includes possession by evil or demonic disturbances. Following this perspective many individuals believed that psychological problems arises due to displeasure of the Gods, eclipse, curses and sins (Farreras, 2024). On the other hand, somatogenic/biomedical perspective assumed mental illness developed due to the physiological, biochemical and anatomical changes in the body (APA, 2018). The biomedical model has persisted since before 400 BC when the Hippocrates supported for physical etiologies of psychological problems. In 20th century the biomedical model created from Virchow's conclusion that all illness or diseases result from cellular abnormalities (as cited by Derick & Peter, 2004). This theoretical framework based on the idea that mental illness are the brain diseases and are the result of abnormalities in the genes.

Freud (1896) postulated psychoanalytic theory in which he highlighted the role of past experience, unconsciousness on individuals' feelings, motives, and decisions. The disturbances in the unconscious mind cause displeasing psychological problems including feelings of pain, and anxiety (Saul, 2024). The theory also claimed that individual's unhealthy behavior is linked with their unresolved conflicts. These unresolved conflicts are made from a series of stages that an individual's go through during development period which are also known as psychosexual stages (Soul, 2024). Any unresolved conflicts occur during these stages can causes psychological problems (Jessica et al., 2022). While psychoanalytical approach focused on unconscious, past experience and memories other focused on role of learning and environment on individuals' behavior (Saul,2024). According to behaviorism, mental illness is primarily a result of learned maladaptive behaviors, dysfunctional reinforcement, or negative environmental influences. Treatment involves re-learning healthier patterns of behavior and reshaping the environment to promote adaptive functioning (Malone, 2014). Both psychoanalytic and behaviorism perspective hold prominent place in understanding beliefs about mental illness and maladaptive behaviors. However, in mid-20th century, humanistic approach aroused which believed that psycho-dynamic focused only on pathology and behaviorism approach was also too mechanistic and reduced the human nature down to simple conditioned response (Schneider et al., 2015).

According to the Maslow (1943) who is considered as a father of humanistic approach assumed that human beings are reasonable creatures and they strive to achieve balance, personal growth and self-actualization in their lives. The main goal of humanism is to helping people to live a better life, achieve personal growth, and make the world a better place (Schneider et al, 2015). In the second half of the 20 century the focused shifted

from unconsciousness, faculty behavior, self-aware of oneself to cognitive processes for understanding the causes of mental illnesses. According to cognitive paradigm distorted or dysfunctional cognitive processes are responsible for psychological problems. By addressing and modifying maladaptive cognitive patterns, individuals can improve their emotional health and overall functioning (Beck, 1967; DiGiuseppe, et.al, 2016; Thorne & Henley, 2005).

With the passage of time other researchers addressed psychological issues by examining them within the context of complex systems and relationships (Jeanne, 1986; Salvador et al. 1980). This approach is known as systematic approach that recognizes that the individuals are the part of interconnected systems, such as families, social groups, organizations and culture and do not exist in isolation. It also emphasizes that the individuals' behaviors, thoughts and emotions are influenced by the dynamics and interactions within these systems. The disturbances occur in all these complex relationships can cause psychological problems (Braziller, 2003).

In other to assess that nature of the psychological issues/problems different researchers focused on different perspectives responsible for psychological problems. Mora et al. (2023) developed a scale named as The Treatment Expectancies questionnaire (TEQ) which focused only on two dimensions: biological and psychodynamic perspective to understand one's understanding about the nature of his/her psychological problems and treatment. In addition to this, Jorm (2000) developed The Causes of Illness Inventory (CII) which also assessed two main approaches: medical model and non-medical explanations. Similarly, Whittle (1996) designed a questionnaire named as The Causal Belief Questionnaire which assessed four main factors: psychosocial, biological, structural conditions (cultural beliefs), and stress and recent life events. However, the available assessment questionnaires on the clients' beliefs about their psychological problems present substantive limitations, including the very limited number of dimensions assessed e.g. medical VS non-medical or biological/individual VS psychodynamic/group.

In recent years Moraira (2021) developed the Beliefs About Psychological Problems Inventory (BAPPI) which examined broader beliefs about the origins and nature of psychological issues, incorporating diverse theoretical perspectives. BAPPI was developed to assess the individual's perceptions, attitudes and beliefs about psychological problems. It is based on 6 main theoretical approaches to mental health problems that includes systemic, psycho dynamic, humanistic, biomedical, cognitive behavioral and eclectic approach.

BAPPI is a crucial psychological instrument for assessing people's beliefs and attitudes toward psychological problems. This understanding is of importance to mental health research, clinical practice, and raising mental health awareness. It helps to identify the misconceptions and stigma related to psychological problems, which hinders an individual from seeking professional help. The instrument also helps clinicians to understand the belief system of a client about their psychological issues, thus guiding individualized interventions. It enhances the therapeutic relationship by addressing and challenging irrational or culturally ingrained beliefs during therapy. In culturally diversified settings, the BAPPI helps implement interventions that are sensitive to the cultural values and worldview of the clients.

In culturally diversified settings, the BAPPI helps implement interventions that are sensitive to the cultural values and worldview of the clients. It enables researchers and clinicians to understand how cultural factors influence mental health literacy and

behavior. In other words, BAPPI provides a standardized method of investigating the relationship between beliefs and psychological health outcomes, including the influence on help-seeking behavior and compliance with treatment. It enables cross-cultural studies to compare beliefs about psychological problems across populations. By understanding the beliefs that people hold about psychological problems, the BAPPI works as a bridge between individual perspectives and the goal of building a healthier and more informed society regarding mental health.

The current study aimed to translate and validate the BAPPI (Moraira, 2021) on a clinical population. Review of literature has shown that limited research has been conducted on culturally relevant measures of beliefs about psychological problems. A culturally adapted version ensures the tools applicability, reliability, and validity in capturing beliefs specific to population. The BAPPI validation will not only enhance its cross-cultural utility but also contribute to developing evidence-based practices tailored to the unique needs of Pakistani population.

Method

The present study aimed to develop the psychometric properties of the translated version of Beliefs about Psychological Problems Inventory (BAPPI) on Pakistani population to assess their beliefs about psychological problems.

Research Design

In this study correlational research design was utilized. Correlational research design is the method used for assessing the relationship between desired variables (Fitzgerald, Runrill & Schenker, 2004).

Participants and sampling strategy

In this research, convenient sampling was employed and clinical population age ranged 24-40 years (N= 230) diagnosed with anxiety issues were approached. The sample size was determined as per 10:1 criterion (Nunnally, 1978).

Measures

1- Demographic Information Sheet (DIS)

Demographic sheet was self-developed to assessed information related to participant's gender, age, education, marital status, occupation, any physical or mental disability and family structure.

2- Beliefs about Psychological Problems Inventory (BAPPI: Moriera, 2021)

BAPPI investigates the beliefs about psychological problems based on six dimensions (psychodynamic, humanistic, biomedical, cognitive behavioral, systemic, and eclectic approach). It comprised of is 23 items having 5-point Likert format. The systemic sub-scale is related to behavior towards family and comprised of 5 items; (1,2,3,4,5), the Eclectic/Integration subscale is related to changing behavior and comprised of 5 items (6,7,8,9,10), the Humanistic subscale is related to decision making and its impact in life and comprised of 4 items (11,12,13,14), the cognitive behavioral sub scale tend to measure items related to behavior and thoughts and their consequences on life and it comprised of 4 items (item number 15, 16, 17, 18), the psycho-dynamic subscale measures the insight about behavior and comprised of 2 items (19, 20). The biomedical subscale is related to psychological problem due brain functioning and medication and comprised of 3 items (items numbers 21, 22, 23). Th reported Cronbach alpha was greater than .70 for all subscales.

3- Opinion about Mental Illness Scale (OMI) (Cohens & Struening, 1962)

Opinion about Mental Illness Scale was used to assessed the convergent validity. OMI consists of 51 items scale which investigate the opinion about mental illness based on five dimensions (authoritarianism, benevolence, mental hygiene ideology, social restrictiveness and interpersonal relationships). The authoritarianism subscale is comprised of 11 items, the benevolence subscale comprised of 14 items. The third subscale named as mental hygiene ideology subscale is comprised of 9 items, the social restrictiveness subscale is comprised of 9 items, the Interpersonal sub scale is comprised of 9 items. It is a six-point Likert scale with values 1 to 6 and categories from strongly disagree to strongly agree in general, higher scores to a subscale reflects a more positive attitude.

4-Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) (Tennant et al., 2007)

Warwick-Edinburgh Mental Wellbeing Scale was used to assessed the discriminant validity. It comprised of 14 items using 5-point Likert format to investigate mental wellbeing. The scale is considered to valid for clinical setting (Tennant et al., 2007).

In order to carried out the current research approval was taken from the ethical review board of humanities department of COMSATS University, after which participants were asked for their voluntary participation in the study and their written consent was taken. Prior to data collection permission from original authors of the scales were taken. During the study, ethical considerations were followed.

Process of translation

Stage 1

Ethical Consideration

Permission was taken from the original author of the BAPPI scale was taken to translate and adapt it in Urdu language. After that, approval from the COMSATS advance research board committee was taken and all the ethical guidelines related to confidentiality were followed.

Forward Translation

Two bilingual translators from psychology background teachers/clinician having at least 5 years of experience were approached. Translators were requested to focus on emphasizing conceptual rather than the literal translation as well as to avoid jargon words in order to make translation easy and understand to general audience. These translators separately translated the original English version of BAPPI into targeted Urdu language.

Committee Approach

A committee was formulated by approaching 3 bilingual experts belonging to psychology field having at least 2 years of experience. They were asked to review translated item on 4-point format in terms of items clarity, accuracy and cultural equivalency.

Back Translation

In this step, two another independent bilingual translator was approached. The current researcher was request them to translate forward translated scale version into English language in order to ensure its accuracy and equivalence with original version.

Final Translated Version

The current researcher was incorporate suggestions given by the experts and was formulate a unified linguistically and culturally coherent translated version for pilot testing.

Stage 2:

Pilot Study

In order to determine any ambiguity a pilot study was conducted. Convenient sampling was employed and clinical population (N= 230) age ranged 24-40 years diagnosed with anxiety issues was approached. They were encouraged to report any discrepancy or difficulty in understanding the items. After that the suggestion was incorporated and list was formulated for further analysis.

Content Validity

After translation the scale was presented to 4 experts (psychologist having at least 2 years of experiences) to evaluate the content validity of the items. They were asked to assess the items on the accuracy, the construct and relevance.

Statistical Analysis

Confirmatory Factor Analysis (CFA)

In order to check the factor structure CFA was conducted through AMOS-27. Confirmatory Factor Analysis is a procedure researcher used to test how well the measured variables represent the number of constructs. An additional sample (N=615) of adults aged between 24-40 years suffering from anxiety issues was contacted.

Reliability Analysis

Cronbach's alpha was used to assess internal consistency. This analysis ensured that items within each scale or factor of the translated BAPPI correlate well with each other, indicating that they are measuring the same construct reliability in the new language.

Validity Assessment

Various methods were used to assessed content, criterion validity, and construct validity of translated version of BAPPI. Content validity ensured that the questionnaire items content was relevant and comprehensive. Criterion-related validity assessed how well the questionnaire predict and correlates with the established criteria. Construct validity ensured if the questionnaire measures the intended constructs in the new language context.

Convergent validity

Convergent validity measured how well the translated BAPPI correlated with related construct, ensuring it captured the similar concepts. In order to establish convergent validity, the Opinion about Mental Illness (OMI) scale was administered on sample of (N=50). It was hypothesized that there were likely to be positive correlation between both scales.

Discriminant validity

Discriminant validity assessed the distinctness of the translated BAPPI from unrelated constructs, demonstrating its specificity. In order to establish discriminant validity Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) was used on a sample

(N=50). The scale was considered to valid for clinical setting (Tennant et al., 2007). It was hypothesized that both scales were negatively correlated with each other.

Results

Table 1: *Descriptive analysis of demographic variables (n=615)*

Characteristic	***n***	***%***
Gender		
Male	291	47.3
Female	324	52.7
Education level		
Matric	122	19.8
Intermediate	111	18.0
Graduate	112	18.2
Undergraduate	128	20.8
Other	142	23.1
Occupation		
Unemployed	203	33.0
Employed	310	50.4
Housewife	102	16.6
Marital Status		
Married	233	37.9
Unmarried	296	48.1
Divorced	73	11.9
Widow	13	2.1
Family system		
Nuclear	419	68.1
Joint	196	31.9
Physical Illness		
Yes	195	31.7
No	420	68.3
Psychological Illness		
Yes	535	87.0
No	80	13.0

Section II: Psychometric Properties of the Scales

Reliability Analyses

Table 2: *Psychometric Properties of the Scales*

Scale	*M*	*SD*	*Range*	*Cronbach's a*
BAPPI	62.7	15.1	23-91	.92
OMI	222.7	37.43	97-292	.94
WEMWBS	46.3	12.03	21-65	.91

Note: BAPPI =Beliefs about Psychological Problems Inventory, OMI=Opinion about Mental Illness, WEMWBS= The Warwick-Edinburgh Mental Well-being Scale, α=alpha.

The table 2 shows psychometric properties for the scales used in the present study. The Cronbach's a value for Beliefs about psychological problems Inventory (BAPPI) was .92 (<.70) which indicated high internal consistency. The Cronbach's a value for Opinion about Mental Illness (OMI) Scale was 0.94 (<.70) and The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) was .91(<.70) which indicated both scales has high internal consistency.

Table 3: *Cronbach's alpha values for the subscales of the Beliefs about Psychological Problems Inventory (BAPPI) (N = 615)*

Subscales	**Total No. of Items**	***a***
Systemic	5	.81
Eclectic	5	.69
Humanistic	4	.56
Cognitive	4	.78
Psychodynamic	2	.77
Biomedical	3	.71
Tot_BAPPI	23	0.92

Table 3 shows the internal consistency of the BAPPI subscales and total score, as measured by Cronbach's alpha. The internal consistency of the subscales and the total score of BAPPI, ranges from 0.56 to 0.92. While most values are within the acceptable range ($\alpha > 0.70$), the subscale with an alpha of 0.56 indicate a lower level of internal consistency.

Confirmatory Factor Analysis (CFA)

To validate the initial factor structure of BAPPI, confirmatory factor analysis (CFA) was conducted to confirm the scale's factor structure. The scale consisted of six sub factors named systemic, eclectic, humanistic, cognitive, psycho dynamic and biomedical along with the total BAPPI score. The basic aimed of applying CFA was to empirically validate the factor structure of the adapted BAPPI on a new set of population that understands the Urdu language.

Figure 1: *Displays the Confirmatory Factor Analysis with standardized parameter estimates*

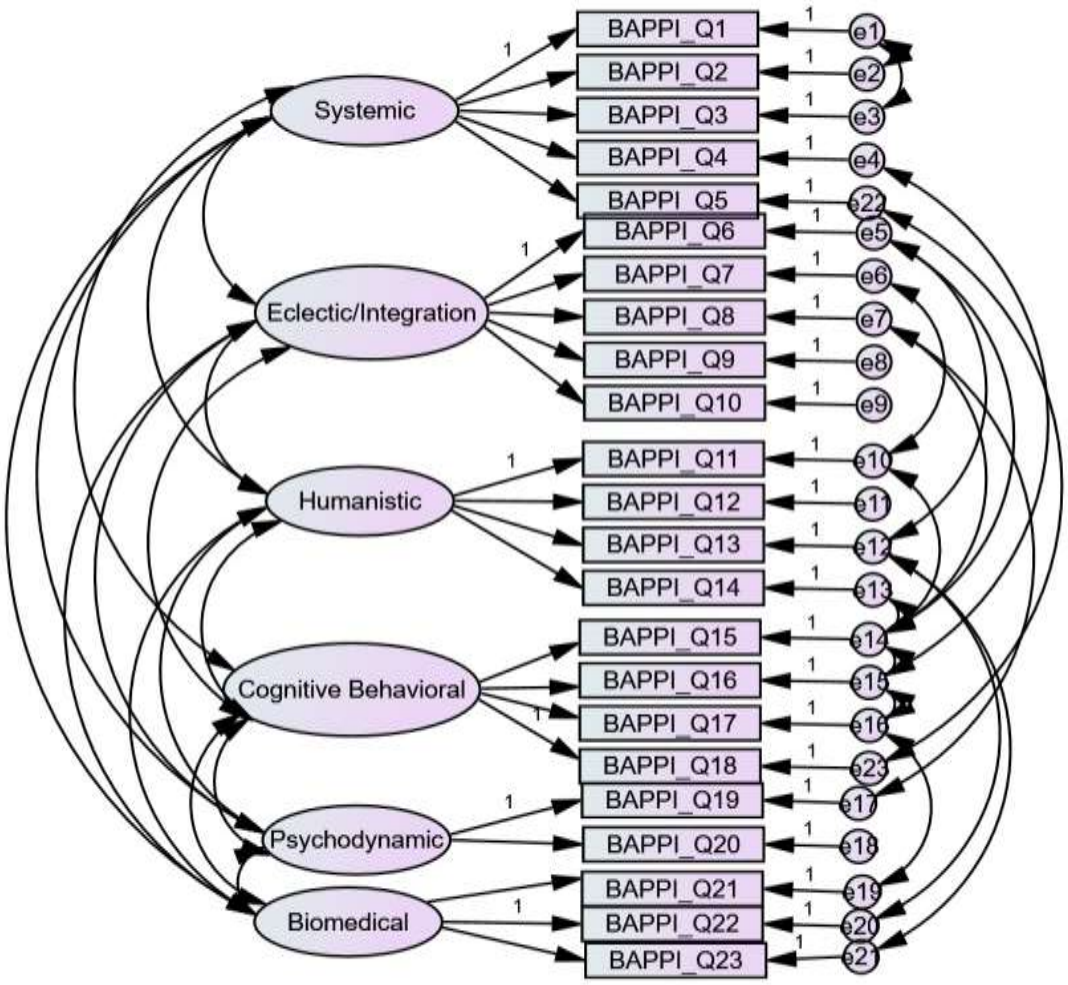

Table 4: *Fit indices of Confirmatory Factor Analysis for BAPPI (N = 615).*

Model	**X^2 /df**	**GFI**	**CFI**	**TLI**	**RMSEA**
Model Fit	2.356	.86	.90	.92	.08

The table shows that X^2 /df value is 2.356 is considered to indicate absolute model fit. Therefore, the indices of relative fits (CFI = 0.90; GFI = 0.86; TLI = 0.92; RMSEA =

0.08) were evaluated. The parameter was significant at p<.001. Hu and Bentler (1999) as well as West et al. (2012) recommend the criteria of relative indices, where χ^2 /df should be in between 1 and 3, RMSEA value should be .08 or lesser and Comparative Fit Index (CFI), and Goodness of Fit Index (GFI) values of 0.9 or higher are considered as good fit whereas less than .8 is acceptable. Since the RMSEA for the initial model was .08 whereas the .86, .90, were the values of GFI, and CFI. The indices confirm a moderate fit of the model.

Table 5: *Factor structure of BAPPI (N=615)*

	Factors					
Item	**F1**	**F2**	**F3**	**F4**	**F5**	**F6**
Item 1	.479	-	-	-	-	-
Item 2	.589	-	-	-	-	-
Item 3	.636	-	-	-	-	-
Item 4	.758	-	-	-	-	-
Item 5	.807	-	-	-	-	-
Item 6	-	.402	-	-	-	-
Item 7	-	.402	-	-	-	-
Item 8	-	.507	-	-	-	-
Item 9	-	.622	-	-	-	-
Item 10	-	.858	-	-	-	-
Item 11	-	-	.698	-	-	-
Item 12	-	-	.893	-	-	-
Item 13	-	-	.539	-	-	-
Item 14	-	-	.482	-	-	-
Item 15	-	-	-	-	-	-
Item 16	-	-	-	.458	-	-
Item 17	-	-	-	.785	-	-
Item 18	-	-	-	.826	-	-
Item 19	-	-	-	-	.673	-
Item 20	-	-	-	-	.941	-
Item 21	-	-	-	-	-	.756
Item 22	-	-	-	-	-	.89
Item 23	-	-	-	-	-	.49

Note: F1 = Systemic, F2 =Eclectic , F3= Humanistic , F4= Cognitive Behavioral, F5= Psychodynamic, F6= Biomedical

Table 6: *Correlation among the subscales of BAPPI and Opinion about Mental Illness Scale (OMI) (n = 615)*

Subscales	1	2	3	4	5	6	7	8	9	10	11
1. SA	-	.43**	.59**	.58**	.40**	.44**	.41**	.20**	.34**	.21**	.13**
2. EA		-	.63**	.48**	.50**	.68*	.41**	.40*	.43*	.36**	.33**
3. HA			-	.71**	.58**	.70**	.47**	.51**	.61**	.51**	.38**
4. CBA				-	.64**	.68*	.55**	.53*	.57*	.38**	.44**
5. PA					-	.80**	.59**	.55**	.39**	.35**	.42**
6. BA						-	.56**	.53**	.59**	.43**	.46**
7. Aut							-	.69**	.60**	.50**	.65**
8. UB								-	.78**	.68**	.79**
9. MHI									-	.76**	.70**
10. SR										-	.70**
11. IE											-

Note: **p<0.01 (2-tailed); *p< 0.05 SA= Systemic Approach, EA= Eclectic Approach, HA= Humanistic Approach, CBA= Cognitive Behavioral Approach, PA= Psychodynamic Approach, BA= Biomedical Approach, Aut= Authoritarianism, UB= Benevolence, MHI= Mental Hygiene Ideology, SR=Social Restrictiveness, IE= Interpersonal

The table 6 is showing convergent validity of subscales of BAPPI with the subscales of OMI. The subscales of BAPPI are positively correlated with the subscales of OMI scale for convergent validity. All the values are showing mild to moderate significant correlation among all the subscales of BAPPI and OMI with p=<0.01 and p=<0.05. The correlation values are showing moderate association among all the subscales.

Validity Analysis

Table 5: *Convergent and divergent validity of Beliefs about Psychological Problems Inventory (BAPPI)*

Variables	***R***	***Significance***
Opinion about Mental Illness (OMI)	.61**	.001
The Warwick-Edinburgh Mental Well-being Scale (WEMWBS)	-.19**	.001

Note: correlation is significant at the 0.01 level (2 tailed), N=100

The table revealed that Opinion about Mental Illness (OMI) has moderately high and positive correlation with Beliefs about Psychological Problems Inventory (BAPPI) (r=.61**). whereas Warwick-Edinburgh Mental Well-being Scale (WEMWBS) has negative and low correlation (r=-.19) with BAPPI and both of the scale are inversely correlated to each other.

Conclusion

The research on the Beliefs About Psychological Problems Inventory (BAPPI) underscores its significance as a reliable and valuable tool for understanding individuals' perceptions and attitudes toward psychological problems. By capturing beliefs that influence help-seeking behavior, stigma, and treatment adherence, the BAPPI offers critical insights into the psychological and cultural barriers to mental health care. Its application in diverse populations highlights the need for culturally sensitive tools that reflect the unique sociocultural dynamics affecting mental health beliefs.

Recommendations and Implications

The current researcher recommends futures researches to conduct longitudinal studies to explores how beliefs about psychological problems evolves over time and in response to therapeutic interventions. Moreover, future researches should also consider integrating qualitative methods, such as in-depth interview or focus groups, to complements the quantitative data from the BAPPI. Thus the mixed methods approach would allow for a deeper understanding of the cultural and contextual factors influencing beliefs. Additionally, expanding the use of the BAPPI to non-clinical population such as caregiver, educators, or community leaders, could provide a broader perspective on societal beliefs about psychological problems and their role in mental health stigma.

References

Adams, K. M., Hester, P. T., & Bradley, J. M. (2013). A historical perspective of systems theory. Industrial and Systems Engineering Research Conference. Retrieved fromhttps://www.researchgate.net/publication/288782223_A_historical_perspective_of_systems_theory.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing. https://doi.org/10.1176/appi.books.9780890425596.

Asen, E. (2002). Outcome research in family therapy. *Advances in Psychiatric Treatment, 8*(3), 230–238. https://doi.org/10.1192/apt.8.3.230

Amoretti, S., Cabrera, B., Torrent, C., Bonnín, C., Mezquida, G., Garriga, M., Jiménez, E., Martínez-Àran, A., Solé, B., Reinares, M., Varo, C., Penadés, R., Grande, I., Salagre, E., Parellada, E., Bioque, M., García-Rizo, C., Meseguer, A., Anmella, G., Rosa, A., Contreras, F., Safont, G., Vieta, E., & Bernardo, M. (2019). Cognitive Reserve Assessment Scale in Health (CRASH): Its validity and reliability. *Journal of Clinical Medicine, 8*. https://doi.org/10.3390/jcm8050586

Anderson, S. A. (1984). The Family Environment Scales (FES): A review and critique. *American Journal of Family Therapy*, *12*(4), 59–62. https://doi.org/10.1080/01926188408250199

Beck, A. T., Baruch, E., Balter, J. M., Steer, R. A., & Warman, D. M. (2004). A new instrument for measuring insight: The Beck Cognitive Insight Scale. *Schizophrenia Research*, *68*(2–3), 319–329. https://doi.org/10.1016/S0920- 9964(03)00189-0

Brown, G., Hawkes, N., Cooper, A., Jónsdóttir, S., & Tata, P. (2015). The Anxiety Attitude and Belief Scale-2: Development, measurement model, and initial validity. *Clinical Psychology & Psychotherapy, 22*(6), 687-697. https://doi.org/10.1002/cpp.1928

Baugh, L. S., & Antony, M. M. (2023, December 5). Cognitive behaviour therapy. *Encyclopedia Britannica*. Retrieved from https://www.britannica.com/science/cognitive-behaviour-therapy

Cavelti, M., Contin, G., Beck, E., Kvrgic, S., Kossowsky, J., Stieglitz, R., & Vauth, R. (2012). Validation of the Illness Perception Questionnaire for Schizophrenia in a German-speaking sample of outpatients with chronic schizophrenia. *Psychopathology, 45,* 259-269. https://doi.org/10.1159/000330262

Cann, A., Calhoun, L. G., Tedeschi, R. G., Kilmer, R. P., Gil-Rivas, V., Vishnevsky, T., & Danhauer, S. C. (2010). The Core Beliefs Inventory: A brief measure of disruption in the assumptive world. *Anxiety, Stress, & Coping, 23*(1), 19-34. https://doi.org/10.1080/10615800802573013

Camposano, L. (2011). The Professional Counselor: Silent Suffering - Children with Selective Mutism.

Davison, G. C., & Neale, J. M. (2017). *Abnormal psychology* (13th ed.). Hoboken, NJ: John Wiley & Sons.

Decker, H. S. (2007). "How Kraepelinian was Kraepelin? How Kraepelin are the neo-Kraepelinians?—from Emil Kraepelin to DSM-III." *History of Psychiatry, 18*(3), 337–360. https://doi.org/10.1177/0957154X07078976

Ellis, A. (2019). *How to stubbornly refuse to make yourself miserable about anything - yes, anything!* (Revised ed.). New York, NY: Citadel Press.

Ghapanchi, A., Abasi, I., Rimes, K., Bitarafan, M., Zarabi, H., Derakhshan, F., Derakhshan, M., Ghanadanzadeh, S., Whitley, H., & Shamsi, A. (2023). Psychometric evaluation of a Persian version of the Beliefs about Emotions Scale in community and clinical samples. *Iranian Journal of Psychiatry.* https://doi.org/10.18502/ijps.v19i1.14343

Griffiths, L., & Griffiths, C. (2013). Unconditional positive self-regard (UPSR) and self-compassion: The internal consistency and convergent/divergent validity of Patterson & Joseph's UPSR scale. *Open Journal of Medical Psychology, 2,* 168–174. https://doi.org/10.4236/OJMP.2013.24026

Gersons, B. P., & Schnyder, U. (2013). Learning from traumatic experiences with brief eclectic psychotherapy for PTSD. *European Journal of Psychotraumatology, 4*(1), 21369. https://doi.org/10.3402/ejpt.v4i0.21369

Hirai, M., & Clum, G. A. (2000). Development, reliability, and validity of the Beliefs Toward Mental Illness Scale. *Journal of Psychopathology and Behavioral Assessment, 22*, 221–236. https://doi.org/10.1023/A:1007548432472

Högberg, T., Magnusson, A., Ewertzon, M., & Lützén, K. (2008). Attitudes towards mental illness in Sweden: Adaptation and development of the Community Attitudes towards Mental Illness questionnaire. *International Journal of Mental Health Nursing, 17*(5), 302–310. https://doi.org/10.1111/j.1447-0349.2008.00552.x

Lewis, C. A. (2021). Assessment of mental health, religion, and culture: The development and examination of psychometric measures (Part IX). *Mental Health, Religion & Culture, 24*(3), 227–230.

Jiménez, L., Hidalgo, V., Baena, S., León, A., & Lorence, B. (2019). Effectiveness of structural–strategic family therapy in the treatment of adolescents with mental health problems and their families. *International Journal of Environmental Research and Public Health, 16*(7), 1255. https://doi.org/10.3390/ijerph16071255

Kaufman, S. B. (2023). Self-actualizing people in the 21st century: Integration with contemporary theory and research on personality and well-being. *Journal of Humanistic Psychology, 63*(1), 51-83. https://doi.org/10.1177/0022167818809187

Kotsou, I., & Leys, C. (2016). Self-Compassion Scale (SCS): Psychometric properties of the French translation and its relations with psychological well-being, affect, and depression. *PLoS ONE, 11*. https://doi.org/10.1371/journal.pone.0152880

Koutra, K., Mavroeides, G., Basta, M., & Vgontzas, A. N. (2023, November 10). Family functioning, illness-related self-regulation processes, and clinical outcomes in major depression: A prospective study in Greece. *Healthcare (Basel), 11*(22), 2938. https://doi.org/10.3390/healthcare11222938

Kensit, D. A. (2000). Rogerian theory: A critique of the effectiveness of pure client-centred therapy. *Counselling Psychology Quarterly, 13*(4), 345–351. https://doi.org/10.1080/713658499

Lewis, S., Lacasse, J., & Spaulding-Givens, J. (2010). Mental Illness Beliefs Inventory: A preliminary validation of a measure of the level of belief in the medical model of mental

illness. *Ethical Human Psychology and Psychiatry*, *12*, 30–43. https://doi.org/10.1891/1559-4343.12.1.30

Main, P. (2023, November 21). Psychodynamic theory. Retrieved from https://www.structural-learning.com/post/psychodynamic-theory

Mele, C., Pels, J., & Polese, F. (2010). A brief review of systems theories and their managerial applications. *Service Science, 2*(1-2), 126-135. https://doi.org/10.1287/serv.2.1_2.126

Nunnally, J. C. (1978). *Psychometric theory*. New York, NY: McGraw-Hill.

Oltmanns, T. F., & Turkheimer, E. (2009). Person perception and personality pathology. *Current Directions in Psychological Science, 18*(1), 32-36. https://doi.org/10.1111/j.1467-8721.2009.01601.x

Özdel, K., Taymur, I., Guriz, S. O., Tulaci, R. G., Kuru, E., & Turkcapar, M. H. (2014). Measuring cognitive errors using the Cognitive Distortions Scale (CDS): Psychometric properties in clinical and non-clinical samples. *PLoS ONE, 9*(8), e105956. https://doi.org/10.1371/journal.pone.0105956

Pingani, L., Giberti, S., Coriani, S., Ferrari, S., Fierro, L., Mattei, G., Nasi, A. M., Pinelli, G., Wesselmann, E. D., & Galeazzi, G. M. (2021). Translation and validation of an Italian language version of the Religious Beliefs and Mental Illness Stigma Scale (I-RBMIS). *Journal of Religion and Health, 60*(5), 3530–3544. https://doi.org/10.1007/s10943-021-01195-9

Pacciolla, A. (2019). Humanistic and existential psychology in the practice of psychotherapy. *19*, 1–19. https://doi.org/10.35312/spet.v19i1.84

Pollard, R. (2023, November 21). What is family systems theory? *Study.com.* Retrieved from https://study.com/learn/lesson/family-systems-theory.html

Retzlaff, R., von Sydow, K., Beher, S., Haun, M. W., Schweitzer, J. (2013). The efficacy of systemic therapy for internalizing and other disorders of childhood and adolescence: A systematic review of 38 randomized trials. *Family Process, 52*(4), 619–652. https://doi.org/10.1111/famp.12041

Rocca, E., & Anjum, R. L. (2020). Complexity, reductionism, and the biomedical model. In R. L. Anjum, S. Copeland, & E. Rocca (Eds.), *Rethinking causality, complexity, and evidence for the unique patient* (pp. 55–72). Springer. https://doi.org/10.1007/978-3-030-41239-5_5

Rivera, A. (2023, November 11). Systems theory therapy. *ThriveTalk.* Retrieved from https://www.thrivetalk.com/systems-theory-therapy/#:~:text=Systems%20theory%20can%20be%20an,reactions%20influence%20everyone%20around%20them.

Roudinesco, E. (2003). *Why psychoanalysis?* Columbia University Press.

Samouilhan, T., & Seabi, J. (2010). University students' beliefs about the causes and treatments of mental illness. *South African Journal of Psychology, 40*(1), 74-89. https://doi.org/10.1177/008124631004000108

Stratton, P. (2011). The evidence base of systemic family and couple's therapies. *Association for Family Therapy & Systemic Practice*. Retrieved from

http://www.aft.org.uk/SpringboardWebApp/userfiles/aft/file/Training/EvidenceBaseofSystemicFamilyandCouplesTherapies(Jan2011).pdf

Systemic psychotherapy/Family therapy. (n.d.). Retrieved from http://www.svhf.ie/systemic-family-therapy.html

Systemic therapy. (n.d.). *Clinical Partners*. Retrieved from https://www.clinical-partners.co.uk/counselling-and-psychotherapy/different-types-of-treatment/systemic

Shedden-Mora, M. C., Alberts, J., Petrie, K. J., Laferton, J. A. C., von Blanckenburg, P., Kohlmann, S., et al. (2023). The Treatment Expectation Questionnaire (TEX-Q): Validation of a generic multidimensional scale measuring patients' treatment expectations. *PLoS ONE, 18*(1), e0280472. https://doi.org/10.1371/journal.pone.0280472

Small, G. W. (2000). Positron emission tomography imaging of dementia. *Dialogues in Clinical Neuroscience, 2*(2), 168–169. https://doi.org/10.31887/DCNS.2000.2.2/gsmall

Stolzenburg, S., Freitag, S., Evans-Lacko, S., Speerforck, S., Schmidt, S., & Schomerus, G. (2018). Individuals with currently untreated mental illness: Causal beliefs and readiness to seek help. *Epidemiology and Psychiatric Sciences, 28*, 446–457. https://doi.org/10.1017/S2045796017000828

Tasca, G. A., Sylvestre, J., Balfour, L., et al. (2015). What clinicians want: Findings from a psychotherapy practice research network survey. *Psychotherapy (Chic), 52*(1), 1-11. https://doi.org/10.1037/a0038252

Tompkins, K., Swift, J., Rousmaniere, T., & Whipple, J. (2017). The relationship between clients' depression etiological beliefs and psychotherapy orientation preferences, expectations, and credibility beliefs. *Psychotherapy, 54*, 201–206. https://doi.org/10.1037/pst0000070

Usó-Doménech, J. L., & Nescolarde-Selva, J. (2016). What are belief systems? *Foundations of Science, 21*, 147–152. https://doi.org/10.1007/s10699-015-9409-z

Vîslă, A., Flückiger, C., Grosse Holtforth, M., & David, D. (2016). Irrational beliefs and psychological distress: A meta-analysis. *Psychotherapy and Psychosomatics, 85*(1), 8–15. https://doi.org/10.1159/000441231

Wilson, G. T. (2008). Behavior therapy. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (8th ed., pp. xx-xx). Belmont, CA: Thomson Brooks/Cole.

World Health Organization. (2018). *International classification of diseases* (ICD-11). Retrieved from https://icd.who.int/en/.