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The cultural adaptation of mindfulness-based cognitive therapy for older adults with depression in Indonesia

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ABSTRACT

Despite its global recognition, Mindfulness Based Cognitive Therapy (MBCT) remains under-explored in terms of cultural adaptation and effectiveness among older adults in non-Western contexts such as Indonesia, where depression is both prevalent and shaped by cultural perceptions. This study presents a culturally adapted MBCT approach for older Indonesians with depression to enhance its relevance, acceptability, and therapeutic efficacy. The adaptation process utilised a systematic methodology grounded in the FMAP (Formative Method of Adapting Psychotherapy) as a multistep therapeutic adaptation procedure, and the PAMF (Psychotherapy Adaptation and Modification Framework) facilitated the identification of places suitable for adaptation to enhance the legitimacy of these alterations. The modified intervention was tested with a cohort of eight older adults, and qualitative feedback was gathered to evaluate its acceptability and efficacy. Initial findings indicate that the culturally adapted MBCT programme was well received, as demonstrated by high attendance rates and low attrition, highlighting its practicality and acceptance within this community. The study emphasises the importance of cultural sensitivity in mental health interventions. It also provides recommendations for future research, advocating for larger randomised controlled trials to validate the findings and further refine the cultural adaptation and implementation of MBCT for older population.

Keywords: depression, older adults, mindfulness-based cognitive therapy, Indonesia

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1 INTRODUCTION

Depression is one of the severe health concerns that are linked to comorbidity, impaired functioning, excessive use of health care resources, and increased mortality (including suicide) in the older population. Late-life depression is a form of depression that encompasses the affective state of sadness that arises in response to a variety of human circumstances, such as the loss of a loved one, the failure to achieve goals, or disappointment in romantic relationships, in individuals who are 65 years of age or older and have no prior history of depression (Sekhon et al., 2023). The two main therapeutic approaches for depression in older adults often consist of a combination of pharmaceutical and non-pharmacological methods (Ebrahimi et al., 2021). Although pharmacological therapy can expedite symptom alleviation, clinical responses to medications used for depression are often insufficient, with approximately 40%-60% of patients demonstrating an incidence of relapse (Walaszek, 2024). Older adults have increased vulnerability to the side effects of antidepressants, such as falls, fractures, blood pressure changes, hyponatremia, weight variations, cardiac arrhythmias, and suicidal thoughts. Consequently, there is a growing demand for evidence-based, non-pharmacological therapies (Musa et al., 2020).

Psychotherapy is a therapeutic intervention for emotional issues that enhances patient care by developing therapeutic skills, fostering trust, facilitating behavioural change, strengthening interdisciplinary team dynamics, promoting cultural competence, enabling early identification of mental health issues, supporting patients with chronic illnesses, and ensuring consistency, continuity, and coping strategies (Fountoulakis, 2022; Opland & Torrico, 2024). One of the various psychotherapy approaches is MBCT, a psychosocial group-based intervention developed by (Segal et al., 2002). MBCT is a blending of aspects of cognitive behaviour therapy and mindfulness meditation and practices to enhance participants' understanding of the interconnections between their thoughts, emotions, bodily sensations, and behaviours, paying attention to present-moment experiences in a non-judgemental manner.

Psychotherapy predominantly originated in the West. Consequently, specific psychotherapy models adopt Western cultural norms and values (Rochelle & Hoyer, 2024). The existing MBCT program was primarily developed in Western nations. Given the importance of cultural elements in psychotherapy, therapists must follow specific engagement guidelines when working with Asians, especially in Indonesia. The regulations include respecting the culture, investigating the distressed experience, and adapting a good communication style to the individual's preferences (Cucchi, 2022). Cultural adaptation has been established to mitigate mental health inequities in heterogeneous settings by attuning to clients' unique experiences as cultural individuals (Chu & Leino, 2017). Cultural adaptation is a fundamental element of effective and scalable mental health intervention implementation (Sit et al., 2020). Cultural adaptation is a crucial connection between cultural competency and sensitivity (Rathod et al., 2020). Cultural adaptation is modifying an intervention to align more effectively with an individual's language, cultural values, and conventions (Praptomojati et al., 2024; Wong & Hung, 2023). Further, cultural adaptations include establishing engagement with the target group, evaluating interests and needs with community leaders, formulating and testing the adapted intervention, monitoring modifications, and gathering feedback (Llave et al., 2024). Several studies indicate that culturally adapted treatments optimise

treatment effectiveness, making them more efficacious than non-adapted ones (Anik et al., 2021; (DeLuca et al., 2018); Hwang et al., 2015). Meta-analyses stated that culturally adapted interventions are more effective than standard interventions and have the most significant effectiveness (Skewes et al., 2024).

To successfully implement MBCT in Indonesia, particularly in West Sumatra, where the majority of the population adheres to Islamic religious traditions and Minangkabau cultural practices, MBCT must be culturally adapted to be particularly sensitive to their needs (Blignault et al., 2023). Creating culturally tailored interventions for depression may enhance access and equity in counselling services for marginalised groups (Anik et al., 2021). A psychological counselling intervention adopted based on Indonesian culture and values is considered very useful in helping to overcome the problem of depression in older adults (Sit et al., 2020). From a cultural perspective, MBCT can be seen as deeply rooted in different religions, reflecting their beliefs, values, and practices. Cultural adaptation can help Muslim clients embrace MBCT as an intervention and practice it when it aligns with their beliefs and worldview (Thomas et al., 2016).

The Minangkabau culture is closely linked to the Islamic religion. The MBCT, tailored for Muslim individuals, may foster a belief that engenders a sense of Allah's presence and acceptance. From an Islamic viewpoint, Allah is the creator and guardian; hence, one can depend on Him; this constitutes dependence on Allah (tawwakul) (Ernawati & Wilodati, 2021). This practice cultivates patience (sabr), allowing individuals to endure undesirable feelings and thoughts without self-judgment or evaluating the emotions encountered. One can experience a decline in negative emotions over time. This may result from practising awareness of negative emotions and Allah's presence, non-reactivity to negative emotions, and acceptance and letting go (Blignault et al., 2023). Finally, forgiveness is a necessary component. It is discussed in all major religions and predicts depression with a high degree of accuracy (Ernawati & Wilodati, 2021).

This study aims to ensure engagement by systematically adapting MBCT for older adults in Indonesia, assessing its feasibility before wider clinical use. Additionally, this paper provides a brief overview of the cultural adaptation process for creating a new intervention module, detailing a structured approach to maintain the intervention's relevance. To the author's knowledge, this is the first account of adapting the MBCT intervention module for older adults with depression in the Indonesian context.

2 METHODS

This study followed the co-design, participatory, and collaborative research methods. These innovative methods ensure that the research addresses the real needs and concerns of those it aims to benefit. Research co-design involves stakeholders in the design and development of research projects. The study received ethical approval from the International Islamic University Malaysia (IIUM): IIUM/504/14/11/2/IREC 2023-136. Furthermore, the study application obtained the Description of Ethical Approval (reference: 442/UN.16.2/KEP-FK/2023) from Indonesia's Faculty of Medicine, Andalas University Research Ethics Committee. Participants were provided with clear, comprehensive information about the study's objectives, procedures, potential benefits, and

risks. To ensure understanding, researchers used culturally and linguistically appropriate materials, including translated consent forms in *Bahasa Indonesia* and verbal explanations tailored to participants' cognitive and literacy levels. Given the significance of Islamic and Minangkabau traditions, the consent process also incorporated respectful engagement strategies in discussions to align with local norms and avoid using the term "depression" and rephrasing psychological terms into common parlance, mental health prob, or psychological problem. Participants were encouraged to ask questions, and their comprehension was verified through interactive discussions before obtaining written informed consent. This approach ensured that participants made informed decisions while respecting their cultural and linguistic needs. The adaptations of the MBCT intervention have involved a staged systematic process by the framework of (Hwang et al., 2015), including the FMAP and the PAMF framework (see Figure 1).

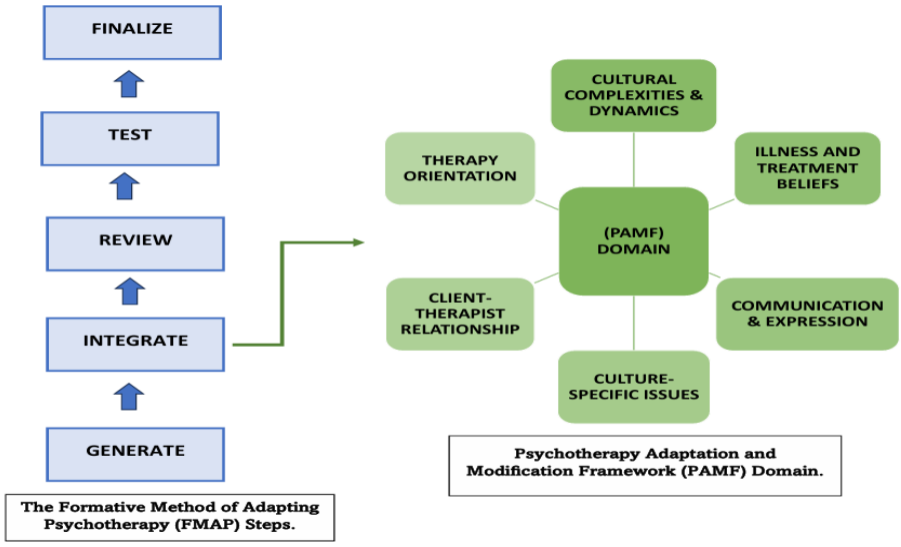

Figure 1. The FMAP and PAMF frameworks.

The FMAP has been utilised to create a multistep therapeutic adaptation procedure and offer supplementary assistance for theoretically indicated alterations. The PAMF facilitated the identification of places suitable for adaptation and provided justifications to enhance the legitimacy of these alterations. The FMAP has been done in five stages, which consist of:

2.1 Generated Knowledge and Collaboration with Stakeholders

The initial phase of FMAP generates knowledge and concepts of adaptation for practical engagement with a diverse clientele. Customer and community partnerships generate information holders. The researcher opted to engage the following six stakeholders: an Associate Professor specialising in Minangkabau culture, an Assistant Professor with expertise in Psychogeriatric Nursing, an Assistant Professor focused on Islamic Religion, a nurse from a Mental Health Hospital, a Clinical Instructor from nursing homes, and a retired lecturer as a healthy older person. All stakeholders have been invited to conduct a Focus Group Discussion (FGD) moderated by the

researcher as a facilitator due to their knowledge, competence, and experience in treating depression.

2.2 Integrated Generated Information with Theory, Empirical, and Clinical Knowledge

Data were analysed utilising stakeholder focus groups, the PAMF framework, theoretical constructs, empirically validated therapeutic literature, previous community therapy initiatives, and practical experience (Primasari et al., 2024). During this phase, the researcher conducted a content analysis based on the Psychotherapy Adaptation and Modification Framework (PAMF) by synthesising all stakeholder input from Phase 1. The PAMF is a structured approach designed to enhance psychotherapy interventions' cultural sensitivity and effectiveness. By integrating theory, empirical evidence, and clinical knowledge, PAMF ensures that psychotherapy is tailored to meet the unique cultural needs of the Indonesian context. The PAMF domain includes cultural complexity and dynamics, illness and treatment beliefs, communication and expression, culture-specific issues, client-therapist relationships, and therapy orientation. Following approval, the researcher created a revised module. The findings section delineates cultural adaptations within the domain based on the PAMF employed to develop the revised MBCT module.

2.3 Review and Revision of the Proposed Culturally Adapted Intervention

During this third FMAP phase, stakeholders were asked to assess and evaluate the culturally adapted MBCT manual intervention, offer feedback, suggest improvements, evaluate the benefits and validity of cultural adjustments, and revise the module accordingly. The researcher conducted a content analysis to systematically analyse and interpret the content of the feedback from stakeholders and solicited initial impressions and suggestions for improving the new intervention.

2.4 Testing of the Culturally Adapted Intervention

In this stage, the researcher assessed the culturally adapted intervention not for clinical effectiveness, but rather for its feasibility, client engagement, usability, and enhanced clinical outcomes during the pilot test, prior to initiating a clinical trial. The pilot test involved eight older adults selected through convenience sampling, with inclusion criteria of 60 years or older, suggesting a high likelihood of depression based on the Geriatric Depression Scale 4 items, and excluding participants who had symptoms of cognitive impairment. The pilot participants were residents of the Lubuk Buaya Community Health Centre work area in the Koto Tengah District, which has the highest percentage of older adults in Padang City, West Sumatra, Indonesia. The potential participant who visited the Community Health Centre for routine health control was invited to join this pilot feasibility test. If they are interested in joining, researchers conduct a screening test that includes depression and cognitive levels. These eight eligible participants gave written informed consent to take part in this preliminary study. The eight-week MBCT program was conducted at the public health centre for eight consecutive days for the pilot. The pilot study used the MBCT program's content and all the triggers to ensure it was feasible and understandable

for Indonesian adults, especially in the Minangkabau culture. The responses were documented and explained in the results section.

2.5 Synthesising Stakeholder Feedback and Finalising the Culturally Adapted Intervention

The final phase of the FMAP involves consolidating all information generated during the various project phases and applying the insights and knowledge acquired to enhance and refine treatment (Arjadi et al., 2018). This phase entails consolidating all information gathered from previous project phases and using the acquired insight and knowledge to enhance and adjust treatment, mainly based on feedback from the pilot test, for a final revision of a new intervention module. Finally, the cultural adaptation process results in changes to the MBCT module in two forms: explicit changes, such as modifications to activities, and implicit changes, such as shifts in values, attitudes, and relationships. The detailed, explicit change of cultural adaptation in MBCT per session is outlined in the results.

3 RESULTS

3.1 Generated Knowledge and Collaboration with Stakeholders

During the first phase of FMAP, the stakeholders provided insightful comments, incorporating perspectives from a cultural expert regarding the importance of Minangkabau culture to the inhabitants of West Sumatra, addressing cultural beliefs, communication, expression, and many dynamic cultural elements from the Minangkabau viewpoint. A specialist in Islamic religion offered insights on Islamic principles, practices, psychological concerns, and coping strategies from an Islamic perspective. The psychogeriatric nursing specialist advised on treatment approaches and the relationship between religiosity and an individual's psychological health.

3.2 Integrated Generated Information with Theory, Empirical, and Clinical Knowledge

In this phase, the specific domain, principle, and rationale for the cultural adaptation process of MBCT for older adults experiencing depression in Indonesia are elucidated using the PAMF framework by (Hwang et al., 2015). In this study, we modified all six domains to conform to Indonesian culture, informed by discussions within the research group and stakeholder comments to guarantee the intervention's cultural appropriateness. The PAMF Domain includes:

3.2.1 Dynamic Issues and Cultural Complexities

The PAMF's primary focus is on understanding and managing cultural complexity and emerging concerns. To ensure its relevance to the older adults in Indonesia, particularly in West Sumatra, the program must reflect Islamic religious tenets and Minangkabau cultural traditions, as most older individuals are Muslim and adhere to Minangkabau customs. It is essential to understand complex cultural issues and group affiliations, including age (where in Minangkabau culture mandates more tremendous respect for elders), developmental stages (encompassing advanced life

phases), disabilities (encompassing both physical limitations and mental health challenges such as depression), religious and spiritual affiliations (predominantly Islamic), ethnic backgrounds (primarily Minangkabau), Indigenous heritage (focused on familial and communal ties), and national origin (necessitating the translation of the original program into *Bahasa Indonesia*, the national language population).

3.2.2 Treatment Orientation and Increasing Mental Health Awareness

Cultural adaptation provides a comprehensive overview of mental health concerns and concentrating on and identifying the psychological and physical symptoms while addressing the psychiatric problems and early treatment is crucial. In general, Indonesians have minimal knowledge about mental health problems and psychotherapy. Depression is considered a sensitive issue. Giving an educational session for the client regarding the process of interventions and setting therapy goals enhances a sense of security and establishes practical expectations, ultimately reducing the chances of the client ending treatment prematurely. In addition, there is a need to evaluate the psychological and physical symptoms of depression without directly referring to psychiatric diagnoses due to the word depression being taboo and the stigma in Indonesian culture. Further, acknowledging the correlation between the mind and body, adding physical activities such as walking around and admiring scenic mountain views can promote peace, relaxation, appreciation for nature, and gratitude toward God's creation.

3.2.3 Cultural Beliefs about Mental Illness and its Treatment

In the adaptation process, it is important to realise the condition of older adults as therapy clients, including minimal prior knowledge about therapy, physical decline, and cognitive limitations. Modify worksheets to better reflect various cultures and simplify specialised therapy terminology into more understandable language. Further, adapting the original module by incorporating cultural and religious elements that align with the client's beliefs, such as using traditional musical instruments and reciting the Holy Qur'an during yoga therapy, can enhance the experience by promoting comfort and inner peace through Islamic values. Faith in Allah, acknowledging one's sins, and seeking forgiveness can enhance mindfulness. Islamic and cultural values in the MBCT program can assist older individuals in alleviating depression. For instance, Minangkabau clients may postpone seeking treatment due to stigma and may present with more severe issues when they finally seek help.

3.2.4 Client-Therapist Relationship

This domain enhances the therapist's confidence and self-efficacy in offering emotional support, encouraging words, optimism, positive feedback, and empathy to the client. A good relationship between therapist and client enhances feelings of comfort and support, a stronger focus on seeking support and cultivating positive self-affirmations. In Minangkabau cultures, individuals are more inclined to express admiration towards others than themselves. The therapist is asked to be able to apply the principles of the value of harmony, mutual respect, tolerance, respecting differences of

opinion, and accepting the results of joint decisions. In Minangkabau, we say "saiyo sakato" (unanimous/ feeling united), which refers to the values of balance and fairness in living together. Further, a sense of solidarity, togetherness, and unity is created, and the indigenous language is called "raso" (tolerance). Most of that value can be felt in the concept of social support.

3.2.5 Cultural Differences in Expression and Communication

The therapist utilises this to teach communication skills that are more effective within the client's cultural context. It enhances comprehension and minimises miscommunication between client and therapist. Use words and expressions appropriate to the target population. In Minangkabau, cultural values and Islamic views should be used in therapeutic communication; for example, older adults must be respected. The principle of intercultural communication for the Minangkabau adults is absolute politeness. It is called the principle of "Kato nan ampek-kato mandaki" (the words of four: communication with respected older adults and parents) (Ernawati & Wilodati, 2021). Pay attention to nonverbal communication in Indonesian: look into the eye, touch the shoulder if the therapist and client are the same gender, and do not touch the head area.

3.2.6 Culture-Specific Issues

This PAMF domain focuses on essential issues in the client's life and enhances the chances of feeling understood of life stress and content with the treatment. The methods to reduce stress within the Islamic faith include zikr therapy (religious chanting), istighfar, and increased devotion to Allah through Dua' and reading the Holy Al-Quran. Indonesians can reduce stress by listening to traditional classical music, Minangkabau instruments, or religious songs, which serve as cultural tools for mindfulness techniques to alleviate stress in older adults. In addition, information on perceived stress can be incorporated into the Thoughts and Feelings Training activity, which serves as a foundation for discussing emotional responses. Further, this domain embraces traditional or indigenous healing practices, medicine, religions, or philosophies and incorporates existing cultural strengths into the client's treatment. Furthermore, defining the concept, the aspect, and the activity of religiosity can help older adults suffering from depression. The program was adjusted to meet the needs of older participants by shortening the duration to suit their physical condition better and enhance their comfort. The results of cultural adaptation based on PAMF frameworks are presented in Table 1.

Table 1. The results of adaptation based on the domain of PAMF.

Domain	Resulting Adaptation
Dynamic issues and cultural complexities	Interact with the older adults based on Minangkabau cultural and moral values, encompassing religious values, harmony, adaptability, sharp thinking, sincerity, togetherness, tolerance, cooperation, unity, democracy, social manners, wisdom, responsiveness, and patience.

Treatment orientation and increasing mental health awareness	• Add psychoeducation about depression and the outline of the program in the first MBCT session. • Introduce the theme's substance at the beginning of each session and outline the theme for the following session. • Evaluate the physical and psychological symptoms of depression among older adults during the initial MBCT session. • Engage in physical activity like walking around to appreciate the natural scenery, incorporating Mindful walking and reflection.
Cultural beliefs about mental illness and its treatment	• Shorten the time allocated for activities in each session. • Translate the original MBCT program to *Bahasa Indonesia*. • Use metaphors and local images by adding a picture of the "Rumah Gadang" and a picture of the Al-Qur'an representing Muslims on the cover of the MBCT module. • Change contents in session five from reading Roemi's Poem from Western Country to reading the translation of Al-Qur'an. • Modify the contents in Session Seven from the Listening song "The Summer Day" by Mary Oliver to listening to the Minangkabau song "Sanang-sanangkan badan" / Rilex Your Body. • Add Minangkabau musical instruments or the Holy Qur'an during meditation therapy sessions. • Avoiding jargon and psychiatric labels, as in the Minangkabau language, we know the term "urang gilo" or adults with mental health problems that have a negative stigma, and rephrasing psychological terms into common parlance, maybe we do not call depression "gangguan jiwa" or mental health problem, but we use "masalah psikologis" or psychological problem.
Client-therapist relationship	• Include a Dua' at the beginning and end of each session. • Join the MBCT training from Oxford Mindfulness and discuss cultural adaptation with stakeholders. • Explain the concept of social support, how to provide it, the advantages of offering it within the Islamic faith and the Minangkabau cultural perspective and how social support can aid older adults in coping with depression. • Encourage the therapist and client to enhance a sense of community, unity, and solidarity.
Cultural differences in expression & communication	• Use the value of respect when communicating with older adults. Older men are called "kakek"; older women are called "nenek″ and pay attention with nonverbal communication. • Provide psychoeducation on perceived stress.

Culture-specific issues	• As part of a healing regimen with mindfulness therapy, include religious practices such as zikr, istighfar, reading the Holy Al-Quran, and traditional activities like classical music and Minangkabau instruments. • Provide psychoeducation about the concept of religiosity, the profit, and how to increase religiosity. • The 8-week program's sessions are reduced from 2.5 to 1.5 hours per session, resulting in a decrease in physical activity time. • The module should be shorter, not contain too much text, use more everyday language that is not too formal, and be more interactive.

3.3 Reviewed and Revised the Proposed Culturally Adapted Intervention

The content analysis of stakeholder comments informed the creation of the new intervention module, facilitated Indonesian translations during treatment development, and culminated in the finalisation of the manuals based on focus group insights. Following the recommendations and insights from the prior phase, all experts offered feedback regarding vocabulary selection, ambiguous instructions, values, and cultural viewpoints for enhancement.

3.4 Testing of the Culturally Adapted Intervention

The results of feasibility studies conducted during the fourth step of the FMAP framework among the eight participants showed an equal number of males and females, with four of each gender. The average age of participants was 66.7 years. All pilot participants belonged to the Minangkabau ethnic group and self-identified as Muslim. Six participants were married, and two were divorced. Four participants were inexperienced in employment, three had been self-employed before, and one had a background in government service. Of the eight participants, four had senior high school education, two had bachelor's degrees, and two had completed elementary school. There has been no drop-out of treatment. All the pilot participants attended the eight sessions of the adapted MBCT. The pilot test participants gave feedback after the session, as presented in Table 2.

3.5 Synthesising Stakeholder Feedback and Finalising the Culturally Adapted Intervention

By providing specific and constructive feedback, pilot participants can help researchers identify areas that need improvement and ensure that the adapted intervention is effective, more accessible, culturally appropriate, and user-friendly. Further, the detailed explicit change of cultural adaptation based on the FMAP and the PAMF framework in MBCT per session is outlined in Table 3.

Table 2. The result of the pilot feasibility test.

Questions	Feedback from the study participants
What do you like about the program?	The participants appreciated that the programs incorporate cultural practices and traditions. It makes the content feel more relatable and meaningful, and the examples are clear, which they found relatable. Further, it would be helpful because it reflects the local customs and traditions, for example, traditional musical instruments during sitting meditation and listening to Minangkabau songs to motivate. In addition, the participants said that the activities tailored to the local religious context, like Dua', "zikr istighfar," the translation of the Holy Qur'an, reduce depression symptoms, which helps participants connect better with the material.
Can you comprehend the topic and content of this phase?	The participants demonstrated a thorough understanding of the topics, were able to recall and discuss related memories, and acknowledged that the module content offered new and in-depth information. Further, the participant stated that the program was easy to understand, had interactive elements, and engaged throughout the sessions. Using illustrations and videos makes the content more interesting and easier to understand. Furthermore, the participant appreciated the comprehensive explanations and sequential directives provided by the therapist, which were straightforward to follow.
What makes it difficult to participate in?	The participants expressed that the content of the psychoeducation about depression, social support, and psychological stress is a bit too text-heavy, too complex, and uses technical terms.
What is the duration of each phase?	The participants felt that sitting for long periods to complete the modules was uncomfortable.
What could be improved about the program?	The participant recommended simplifying the language and giving more visuals or videos in the psychoeducation program, shortening sessions of the program, especially the seated meditations from 40 to 20-30 minutes, and frequent breaks during sessions. Additionally, the participant proposed an introductory explanation at the beginning and a concluding summary of each module, which would be beneficial, considering that older adults may have difficulty retaining the material.

Table 3. The cultural adaptation of MBCT per session.

Session	Curriculum	Cultural adaptation
Session 1: Awareness and automatic pilot	• Orientation and ground rules setting • Raisin Exercise • Body Scan practice	• Beginning with a Dua'. • Provide a detailed description of the theme discussed in this session. • Explanation of depression and psychotherapy. • Assess the psychological and physical symptoms of depression in older adults. • Explanation regarding MBCT and the adaptation. • Incorporate dhikr therapy into body scan practice. • Ended by addressing concerns and introducing the topic for the upcoming session. • Concluding with a Dua'.
Session 2: Living in our head	• Body Scan practice and review • Thoughts and Feelings Exercise • Pleasant Events Calendar • Sitting meditation	• Beginning with a Dua'. • Provide a detailed description of the theme discussed in this session. • Add the soft tones of Minangkabau musical instruments during sitting meditation therapy. • Incorporate education about perceived stress into the Thoughts and Feelings Training activity. • Ended by addressing concerns and introducing the topic for the upcoming session. • Concluding with a Dua'.
Session 3: Gathering the scattered mind	• Sitting meditation and review • Seeing or hearing exercises • 3-minute Breathing Space and review • Mindful walking and review • Unpleasant Events Calendar	• Beginning with a Dua'. • Provide a detailed description of the theme discussed in this session. • Walk around to appreciate the natural scenery, incorporating the activity of Mindful walking and review. • Add the soft tones of Murottal Al-Qur'an during sitting meditation therapy. • Incorporate education about meaningful existence into the Unpleasant Events Calendar activity. • Ended by addressing concerns and introducing the topic for the upcoming session. • Concluding with a Dua'.

Session 4: Recognising aversion	• Sitting meditation and review • 3-minute Breathing Space and review • Defining the "territory" of depression: Automatic Thoughts Questionnaire and Diagnostic Criteria for Depression	• Beginning with a Dua'. • Provide a detailed description of the theme discussed in this session. • Add the soft tones of Minangkabau musical instruments during sitting meditation therapy. • Ended by addressing concerns and introducing the topic for the upcoming session. • Concluding with a Dua'.
Session 5: Allowing – letting be	• Sitting meditation and review • 3-minute Breathing Space (regular and coping) and review • Read Rumi's poem "The Guest House"	• Beginning with a Dua'. • Provide a detailed description of the theme discussed in this session. • Add the soft tones of Murottal Al-Qur'an during sitting meditation therapy. • Change Rumi's poem to read the translation of Al-Qur'an verses about 7 Al-Quran therapies for overcoming depression. • Ended by addressing concerns and introducing the topic for the upcoming session. • Concluding with a Dua'.
Session 6: Thoughts are not facts	• Sitting meditation and review • 3-minute Breathing Space and review • Mood, thoughts, and alternative viewpoints exercise • Identifying relapse signatures	• Beginning with a Dua'. • Provide a detailed description of the theme discussed in this session. • Add the soft tones of Minangkabau musical instruments during sitting meditation therapy. • Teach religious practices such as the dhikr of istighfar to manage mood, thoughts, and stress, and alternative viewpoints. • Ended by addressing concerns and introducing the topic for the upcoming session. • Concluding with a Dua'.
Session 7: How best to take care of myself	• Sitting meditation and review • 3-minute Breathing Space or mindful walking • Exercise to explore links between activity, mood, and stress level • Identifying depression signatures and actions to deal with depression • Listening to the song of Mary Oliver: The Summer Day	• Beginning with a Dua'. • Provide a detailed description of the theme discussed in this session. • Add the soft tones of Murottal Al-Qur'an during sitting meditation therapy. • Change the song of Mary Oliver to the Minangkabau song "Sanang-sanangkan Badan" / Relax your Body. • Ended by addressing concerns and introducing the topic for the upcoming session. • Concluding with a Dua'.

Session 8: Maintaining and extending new learning	• Body Scan practice and review • Explain how to sustain the momentum and discipline established over the preceding seven weeks and provide positive reasons • Whole course review • Response plan • End class with a concluding meditation	• Beginning with a Dua'. • Provide a detailed description of the theme discussed in this session. • Provide education about the concept of religiosity as the highest correlation with depression among older adults in the Whole course review. • Concluding with a Dua'.

4 DISCUSSION

This will be the first cultural adaptation study of MBCT in Indonesia. Applying MBCT intervention in Indonesia is challenging because MBCT was predominantly designed and applied in Western nations, so Western values impact the therapy (Williams et al., 2022). New populations may have different characteristics from the original intervention population, or their response to the intervention may differ. Therefore, to deal with the different cultural gaps, the MBCT needs to be adjusted to the ideals of the Indonesian culture. Cultural adaptation of MBCT is essential for improving treatment engagement and effectiveness in bridging gaps (Anik et al., 2021). Further, cultural adaptations of empirically based psychological interventions are necessary to increase dissemination and promote worldwide mental health care (Pinho et al., 2024). Adapting to the cultural context is crucial to addressing the unique requirements of older adults and successfully implementing MBCT to reduce depression. The MBCT practice with cultural adaptations to Muslim adults in Indonesia could be such that the belief creates a sense of Allah's presence and acceptance. This may result from practising awareness of negative emotions and Allah's presence, non-reactivity to negative emotions, and acceptance and letting go. Finally, forgiveness is a necessary component. It is discussed in all major religions and predicts depression with a high degree of accuracy. However, once attained, forgiveness is associated with improved mental health.

The adaptation process was executed painstakingly, following the FMAP technique, encompassing knowledge formation and stakeholder engagement, information generation through theoretical and clinical insights, stakeholder review, pilot testing, and finalisation. We focused on PAMF to pinpoint locations conducive to adaptation while providing rationales. The cultural adaptation examined superficial and profound cultural structures, a strategy often neglected in adaptation research. Conversely, deep structure adaptation entails incorporating social, environmental, cultural, historical, and psychological factors that influence the health behaviours of the target population, including their views of health behaviour determinants (Primasari et al., 2024). It is essential to acknowledge that we initially developed a top-down, theoretically informed methodology for culturally adapting therapy before formulating the community-participatory and bottom-up FMAP (Werheid et al., 2021). The PAMF was the inaugural framework established to understand and conceptualise cultural adaptation (Hwang et al., 2015). Subsequently, the FMAP

was developed, and the acronym PAMF was designated in reverse to highlight the integration of top-down and bottom-up methodologies. The PAMF was one of the initial practical and thorough frameworks for the cultural adaptation of treatment. Modifications were implemented to enhance the information's accessibility, readability, and attractiveness for the intended audience.

Numerous studies indicate that interventions that have undergone cultural adaptation demonstrate superior efficacy compared to those that remain unadopted, specifically when applied to socio-culturally diverse populations, with particular emphasis on Muslim patients. Incorporating faith-based strategies, such as prayer, into mental health care enables clients to feel understood. Islamic viewpoints strengthen connections with clients, promoting trust and more profound therapeutic relationships. By addressing mental, emotional, and spiritual health collectively, culturally adapted care provides a holistic approach that resonates with the experiences of Muslim individuals, improving mental health outcomes (Adebayo et al., 2024). These manuals are crucial resources that ensure evidence-based therapeutic methods align closely with the lived experiences of Muslims facing depression or other mental health issues.

Furthermore, initiatives aimed at enhancing the cultural competence of mental health services in multicultural nations have created a demand for cross-cultural psychotherapy research (Koç & Kafa, 2019). Stakeholders in the focus group talks contribute to the possible benefits of these discoveries. In addition, collaboration with an expert in Minangkabau culture facilitated the incorporation of existing cultural beliefs and strengths based on client belief systems. In addition to a nurse from a Mental Health Hospital and Clinical Instructors from Nursing Homes as treatment providers, healthy older adults, as the clients, are the principal consumers and key stakeholders. Their participation in the process is crucial as they are the direct recipients of the intervention and can provide experiential feedback and suggestions for enhancement (Khan et al., 2019).

Furthermore, we delineated a pilot investigation using the newly modified MBCT procedure, which was not designed to identify an effect. This study aims not to analyse the intervention's effectiveness; instead, it intends to succinctly summarise the cultural adaptation process and assess the feasibility and acceptability of the MBCT intervention. Moreover, given that the intervention is deemed acceptable, safe, and practicable, subsequent trials with enhanced statistical power should primarily evaluate the intervention's efficacy. The results of this study can be employed to determine power and indicate the intervention's effect, demonstrating efficacy in future Randomised Controlled Trials. As a result, this intervention serves as the inaugural evidence-based cultural adaptation of MBCT designed to reduce depressive symptoms among Indonesia's elderly population. Future randomised controlled trials (RCTs) should include long-term follow-up assessments to assess whether the benefits of the intervention persist. Offering a cost-effective and scalable solution could significantly improve mental healthcare in Indonesia.

In conclusion, this study offers a concise overview of the steps, domains, and outcomes involved in developing a new adapted intervention module, which will be evaluated in the subsequent study. The cultural adaptation of MBCT for older adults with depression, utilising the FMAP and PAMF frameworks, has yielded encouraging outcomes. The pilot study outcomes indicate that culturally adapted MBCT was well-received, evidenced by high attendance rates and low attrition levels,

suggesting the program's feasibility and acceptability for this community. The study holds significant implications for clinical practice, ageing policy, and older adults' mental health programming in Indonesia; it could even spread to Muslim-majority countries in Southeast Asia. Clinically, the findings emphasise the importance of culturally adapted interventions like MBCT for older adults, reducing depression levels and increasing quality-of-life scores. It underscores the potential for integrating MBCT into nursing care to boost residents' mental health. Nurses can incorporate MBCT approaches into holistic patient care, combining psychological support with mindfulness activities tailored to the unique needs of older adults. In terms of policy development, policymakers should focus on integrating culturally adapted mental health interventions into national healthcare frameworks by incorporating MBCT into routine care protocols for addressing depression and improving quality of life.

Additionally, community-based mental health programs should adopt culturally adapted MBCT to address depression among older adults, with an emphasis on early intervention and education to promote mental well-being. Nevertheless, additional study is required to corroborate these findings in larger, more heterogeneous groups. Subsequent research should investigate the long-term impacts of the modified MBCT program and its feasibility for incorporation into current mental health treatment frameworks. Future randomised controlled trials should strive to enrol a larger and more varied cohort to enhance the generalizability of the results and validate the efficacy of the customised MBCT curriculum across various cultures. Given the shared cultural and religious underpinnings across Southeast Asian and Muslim-majority countries, this adapted model holds considerable promise for regional scalability and contextual adaptation, offering a culturally congruent pathway to expanding equitable mental health care. As the first culturally tailored MBCT program for older adults in Indonesia, this study not only addresses a critical gap in geriatric mental health care but also lays a transformative foundation for culturally grounded, scalable psychological interventions across Southeast Asia.

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AUTHOR CONTRIBUTIONS

The first author conceived and designed the study and conducted the cultural adaptation process. The second author provided academic supervision and methodological guidance throughout all phases of the study. The third author reviewed and approved the adapted Mindfulness Based Cognitive Therapy module and pilot protocol. The fourth author offered critical feedback on manuscript structure, clarity, and scholarly rigor, and ensured ethical compliance and alignment with research standards.

CONFLICT OF INTEREST

The authors confirm that there are no conflicts of interest related to this publication.

DATA AVAILABILITY STATEMENT

The data underpinning the results of this research are not publicly accessible owing to ethical constraints and the necessity to safeguard participant confidentiality. De-identified data may be provided upon reasonable request to the corresponding author, contingent upon approval by the institutional ethics committee.

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