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COMPARING THE EFFECT OF DAILY INFORMATIVE AND SUPPORTIVE TEXT MESSAGES ON PEOPLE WITH MILD AND MODERATE DEPRESSION

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ÖZET

İLKAY, Özlem. ***Günlük Bilgilendirici ve Destekleyici Metin Mesajlarının Hafif ve Orta Derecede Depresyonu Olan Kişiler Üzerindeki Etkisinin Karşılaştırılması.*** **Başkent Üniversitesi, Sosyal Bilimler Enstitüsü, Klinik Psikoloji Tezli Yüksek Lisans Programı, 2023.**

Bu çalışmada BDT bileşenleri içeren bilgilendirici ve destekleyici metin mesajlarının hafif ve orta şiddette depresyon belirtileri üzerindeki etkisi deney ve kontrol grupları karşılaştırılarak incelenmiştir. Araştırma başlamadan önce kişilere gönderilmek üzere araştırmacı tarafından BDT temelli kısa mesajlar oluşturulmuştur. Araştırmanın örneklemini 96 kadın, 34 erkek ve 1 cinsiyet belirtmek istemeyen 18-68 yaş arası toplam 131 katılımcı oluşturmaktadır. Katılımcılar önce bilgilendirilmiş onam formunu onayladıktan sonra sırasıyla demografik bilgi formu, Beck Depresyon Ölçeği (BDÖ), Beck Anksiyete Ölçeği (BAÖ) ve Pozitif-Negatif Duygulanım Ölçeği'ni (PANAS) tamamlamışlardır. Çalışmaya BDÖ puanı 10 ve üzerinde olan katılımcılar çalışmaya dahil edilmiştir. Depresyon puanı 30 ve üzerinde olanlar profesyonel psikolojik desteğe yönlendirilmiştir. Katılımcılar BDÖ puanlarına göre iki gruba ayrılmıştır. Puanı 10-16 arasında olanlar hafif depresyon, 17-29 arasında olanlar orta derecede depresyon grubuna dahil edilmiştir. Daha sonra katılımcılar seçkisiz olarak deney veya kontrol grubuna atanmışlardır. Atama işlemi sonucunda 4 grup elde edilmiştir. Müdahale sonunda hafif depresyon deney grubunda 22, orta depresyon deney grubunda 48, hafif depresyon kontrol grubunda 18 ve orta depresyon kontrol grubunda 43 kişi bulunmaktadır. 30 gün boyunca her gün 9.00, 12.00, 15.00 veya 18.00 saatlerinden herhangi birinde deney grubundaki katılımcılara WhatsApp uygulaması üzerinden mesaj gönderilmiştir. 30 günlük mesaj uygulamasının sonunda BDÖ, BAÖ ve PANAS ölçekleri tüm gruplardaki katılımcılar tarafından tekrar doldurulmuştur. Mesaj müdahalesinin etkisini karşılaştırmak için karma model tekrarlanan ölçümler ANOVA analizi yapılmıştır. Yapılan analiz sonucunda mesaj müdahalesinin deney grubunda yer alan katılımcıların depresyon belirtilerini azaltıcı bir etkiye sahip olduğu bulunmuştur. Mesaj müdahalesinin hangi depresyon düzeyinde etkili olduğunu incelemek için çoklu karşılaştırma testi yapılmıştır. Bu analiz sonucunda mesaj müdahalesinin orta düzey depresyon belirtilerinde etkili olduğu, hafif düzey depresyon belirtilerinde ise etkisinin olmadığı görülmüştür.

Anahtar Kelimeler: Hafif depresyon, orta depresyon, cep telefonu tabanlı BDT, kısa mesaj müdahaleleri, mobil sağlık uygulamaları

ABSTRACT

İLKAY, Özlem. ***Comparing the Effect of Daily Informative and Supportive Text Messages on People with Mild and Moderate Depression.*** **Başkent University, Institute of Social Sciences, Master's in Clinical Psychology, 2023.**

In this study, the effect of informative and supportive text messages containing CBT components was examined on mild and moderate depressive symptoms comparing the experimental and control groups. Before the research started, short messages based on CBT were created by the researcher. The sample of the study consists of 96 women, 34 men, and 1 who did not want to specify their gender with a total of 131 participants, aged between 18 and 68 years. First, the participants approved the informed consent form, then they filled in the demographic information form, Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), and Positive-Negative Affective Schedule (PANAS), respectively. Before the intervention began participants whose BDI score was 10 and above were included in the study. Those with a depression score of 30 and above were referred to professional psychological support. Participants were divided into two groups according to their BDI scores. Those who scored between 10 and 16 were assigned to mild depression, and those who scored between 17-29 were assigned to moderate depression groups. Then they were randomly assigned to either the experimental or control group. As a result of the assignment process, 4 groups were obtained. There were 22 people in the mild depression experimental group, 48 in the moderate depression experimental group, 18 in the mild depression control group, and 43 in the moderate depression control group at the end of the intervention. Text messages were sent to the experimental group via WhatsApp at any of the hours of 9.00, 12.00, 15.00, or 18.00 every day for 30 days. At the end of the 30-day message intervention, BDI, BAI, and PANAS were filled in again by the participants in all groups. To compare the effect of the message intervention, mixed-model repeated measures ANOVA analysis was performed. As a result of the analysis, it was found that the message intervention had a reducing effect on the depression symptoms of the participants in the experimental group. A post-hoc test was performed to examine which depression level the message intervention was effective for. As a result of this analysis, it was seen that message intervention was effective on moderate depressive symptoms but had no effect on mild depressive symptoms.

Keywords: Mild depression, moderate depression, mobile-based cognitive behavioral therapy, text message interventions, mHealth applications

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LIST OF ABBREVIATIONS

APA	American Psychiatric Association
BDI	Beck Depression Inventory
BAI	Beck Anxiety Inventory
CBT	Cognitive Behavioral Therapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
PANAS	Positive-Negative Affective Schedule
SMS	Short Message Service
WHO	World Health Organization

1. INTRODUCTION

Depressive disorders are one of the most threatening disorders for psychological health. Depression is a disorder encountered in approximately 5% of the population worldwide, is currently the leading cause of disability in the world (World Health Organization [WHO], 2021), and is projected to continue to be so in 2030 (Mathers & Loncar, 2006). According to the data from the Global Burden of Disease Collaborative Network (2021), approximately 3.5 million (1.3 million are men and 2.2 million are women) of Türkiye's 83.5 million population in 2019 consists of people suffering from depressive disorders.

Depression is a common and crucial psychological disorder that negatively affects a person's way of thinking, emotions, and feelings (American Psychiatric Association [APA], 2013). It is a mood disorder with a cycle in which negative emotions and thoughts cause a depressive mood, and the depressive mood produces negative thoughts. These negative thoughts and depressive mood begin to make the person feel worthless and hopeless (APA, 2005). When a person's emotional state is constantly negative, the person cannot physically feel good, and feel restless and fatigued. Additionally, slowness in reactions occurs (Robbins, 2008). There is also a loss of concentration and loss of interest in things that used to be interesting. In addition, the person's sleep and eating patterns are disrupted. The combination of all these symptoms constitutes a depressive disorder. Long-lasting or recurring depression can significantly affect a person's capacity to perform in daily life (WHO, 2017). In fact, when depression is at a very severe level, it increases the risk of suicide. Therefore, depressive disorders are mental disorders that should be taken seriously and intervened before it gets severe.

The causes of depression have been investigated by many researchers from the past to the present (Barton & Hirsch, 2016; Hewitt et al., 2022; Kendler et al., 2002; Sullivan et al., 2000). It should not be forgotten that depression can affect everyone, regardless of age, gender, or culture, including a person who lives in ideal circumstances (APA, 2005). However, numerous variables such as genetics and environment, have been observed to increase a person's likelihood of developing a depressive disorder (Heim & Binder, 2012). In a study conducted with twins, it was reported that the risk factor for the development of depression was genetic at a rate of 38% (Kendler et al., 2006). Environmental factors that

create risk factors for depression are parenting styles, stress, trauma, and socioeconomic status (Nestler et al., 2002). Depression is also associated with other health problems such as asthma, coronary heart disease, arthritis, cancer, and diabetes (Moussavi et al., 2007), and other psychological disorders such as anxiety, personality disorders, eating disorders, and substance use disorder (Kool et al., 2000; Lamers et al., 2011; Santos et al., 2007; Swendsen & Merikangas, 2000). In other words, having another chronic health condition also increases a person's risk of having depression (Harpole et al., 2005).

Fortunately, depression is a psychological disorder that has been extensively thought about, researched, and studied for its treatment from past to present (Abbass et al., 2006; Agyapong et al., 2012; Beck, 1964; Bowlby, 1980; Driessen et al., 2010; Duffy et al., 2022; Freud, 1917; Frankl, 1985; Lazarus, 1968; May, 1953; Rogers, 1951; Ugwu et al., 2022; Vos et al., 2015). There is more than one approach such as psychodynamic therapy, person-centered therapy, existential therapy, gestalt therapy, rational emotive behavioral therapy, and cognitive behavioral therapy (CBT) to explain depression and how it can be treated. Each of these is generally used in face-to-face therapy settings. Studies are showing the effectiveness of these therapies on depression (Bahmani et al., 2016; Ciharova et al., 2021; David et al., 2008; Driessen et al., 2010; Raffagnino, 2019; van Rijn & Wild, 2013). However, one of the most researched, widely used, and highly effective methods for the treatment of depression is CBT (Pearce et al., 2015).

CBT suggests that a person's thought patterns, beliefs, emotional state, and behaviors are interrelated (Beck, 2011). According to Beck (1963, 1964), schemas and dysfunctional thought patterns shaped by experiences affect how depressed people perceive themselves and their environment. Depressed people have schemas consistent with worthlessness, unlovability, and incompetence. These schemas cause people to constantly process information negatively and have an even more negative perception of themselves, their environment, and the future (Beck et al., 1979). Therefore, CBT treatment of depression focuses on replacing dysfunctional beliefs and thoughts with more functional ones. Thus, people develop more adaptive and realistic beliefs over time, and their symptoms gradually decrease (Beck, 1989).

CBT is a therapy method in which sessions can be adapted to different types of interventions (Williams & Whitfield, 2001). Apart from traditional face-to-face therapy, with the development of technology, CBT can be delivered by adapting it to computer-based

or telephone-based applications and it is quite effective as face-to-face therapies (Agyapong et al., 2012; Agyapong et al., 2013; Donner, 2008; Ebert et al., 2015; Lim et al., 2008; Molloy & Anderson, 2021). While delivering the CBT, using the internet, phone, or computer provides advantages such as accessibility, anonymity, flexibility, and saving time and money (Cunningham et al., 2009). In light of all this information, in the current study, the depression symptoms of individuals were tried to be reduced by using message-based CBT intervention. It was aimed that anyone in need can access therapy by overcoming limitations of face-to-face therapies such as not participating in therapy sessions or quitting treatment early, poor engagement in therapy, not being able to start treatment for fear of being labeled, being under financial stress, and not finding time to go to the therapy. When the relevant literature was reviewed, it was seen that the studies using message intervention so far either added message intervention in addition to therapy or studied depression with other comorbid disorders (Agyapong et al., 2017; Aguilera & Muñoz, 2011; Hartnett et al., 2017; Richmond et al., 2015; Whittaker et al., 2012). For this reason, this study is a study that only intervenes with depressive symptoms without any other comorbid disorder using message intervention. Thus, it can form the basis of creating an additional intervention method that is easy to access and apply, apart from traditional face-to-face treatments.

1.1. Depressive Disorders

Depression is a highly serious mental disorder that is quite common and causes negative impairments in many people. The importance of studies on depression has increased due to the possibility of depression becoming chronic and the risk of leading to suicide (Bland, 1997; Waraich et al., 2004).

In the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), major depressive disorder, dysthymia, disruptive mood regulation disorder, substance/medication-induced depressive disorder, premenstrual dysphoric disorder, depressive disorder due to another medical condition, other specified depressive disorder, and unspecified depressive disorders are included under the title of depressive disorders (APA, 2015). According to APA (2013), generally, in all depressive disorders, some symptoms are in common. Such as cognitive and somatic changes occur in individuals, and the presence of a hopeless, helpless, and sad state significantly affects the individual's capacity to function. However, there are some different symptoms encountered in the clinical appearance of major depressive disorder.

1.1.1 Clinical appearance of depression

The diagnostic criteria for major depressive disorder according to DSM-5 are as follows (APA, 2013):

During the two-week period, five (or more) of the following symptoms were found, and there was a change in the previous level of functioning; at least one of these symptoms is either a depressed mood or loss of interest or pleasure.

1. Depressed mood (sadness, emptiness, or hopelessness) is present most of the day, nearly every day, and can be self-reported or observed by others.
2. Significant decrease in interest in all or nearly all activities or the state of not enjoying them, almost every day (determined by self-report or observation).
3. Losing or gaining significant weight (a change of more than 5% of body weight in a month) when not trying to lose weight (not dieting) or increase or decrease in appetite almost every day.
4. Hypersomnia or insomnia almost every day.
5. Almost every day, psychomotor agitation, or psychomotor retardation (observable by others, not as an inability to rest or feel slowed).
6. Almost every day, fatigue, or lack of inner strength (loss of energy).
7. Almost every day, inappropriate or excessive guilt (can be delusional) or feelings of worthlessness (not just self-blame or guilt about being sick).
8. Almost every day, decreased ability to concentrate or think or indecisiveness (self-report or observed by others).
9. Repetitive thoughts of death (not just fear of death), recurrent thoughts of suicide without planning a specific action, or attempting to kill oneself, or planning a specific action to kill oneself.

In addition, clinically severe discomfort, or functional impairment in social, occupational, or other areas is brought on by all these symptoms. Moreover, this period cannot be linked to the effects of a substance or other health condition (APA, 2013).

It is clinically essential to assess the severity of the disorders. The severity of depressive disorder is defined in DSM-5 as mild, moderate, and severe depending on the number of symptoms, the level of distress caused by the intensity of these symptoms, and the level of impairment in functionality (APA, 2013). In mild depression, there are few symptoms necessary to make the diagnosis, the intensity of the symptoms is distressing but manageable, and the symptoms have been described as causing mild impairment in functioning. In contrast, severe depression; is defined as when the number of symptoms is

significantly greater than necessary to make a diagnosis, when the intensity of symptoms is severely obtrusive and unmanageable, and when symptoms significantly affect the person's functioning. In people with moderate depression, the symptoms and the impairment of daily functions are between mild and severe depression. There is a difference between the benefits of treatment for people with mild and moderate depression. A meta-analysis found that psychotherapy and combined therapy (psychotherapy and medication) significantly reduced the symptoms of people with moderate depression (de Maat et al., 2007). However, no difference was found in people with mild depression. Like these findings, in another and more recent meta-analysis of the internet-based cognitive behavioral therapy method, there was a significant decrease in depression symptoms of people with moderate depression after the intervention, but no difference was found in people with mild depression (Karyotaki et al., 2021). The severity of the disorder negatively affects the person's decisions to seek treatment, whether to continue treatment, and the type and intensity of treatment (Zimmerman et al., 2018). In addition, it has been reported that as the severity of depression increases, cognitive functions such as memory and executive functions decrease (McDermott & Ebmeier, 2009). In addition, as Van et al. (2008) mentioned in their review, when working with depressed patients, severe depression patients are generally not included in studies due to the possibility of psychotic symptoms, high risk of suicide, and too intense depressiveness to comply with the guidelines in the study. All these findings suggest that working with cognitive and behavioral assignments may be easier and more productive in people with mild and moderate depression than in people with severe depression. In the current thesis, since most of the messages include cognitive and behavioral tasks, it was thought that it would be more efficient to work with people with mild and moderate depression. It is also predicted that people with moderate depression will benefit more from message intervention.

1.1.1.2. Comorbidity

Basically, untreated depression reduces the quality of life by negatively affecting people's well-being, social life, and physical health. First of all, depressed people perceive higher levels of stress due to dysfunctional coping styles, unwanted negative thoughts, and lack of social support and activities (Chao, 2014; Thimm et al., 2018). In addition, depressed people experience problems such as sleep difficulties (Zhai et al., 2015), problems with weight (Ibrahim et al., 2016), and low self-esteem (Sarubin et al., 2020). Also, the probability of suicide is remarkably high in depression (Hawton et al., 2013). According to a study, it

has been observed that 50% of people who commit suicide have a depressive disorder (Bertolote et al., 2003).

Apart from all these, depression also affects the physical health of people. There is comorbidity between depression and some physical chronic diseases such as asthma (Mancuso et al., 2000), diabetes (Anderson et al., 2001), obesity (Becker et al., 2001; Rosmond & Björntorp, 2000), cardiovascular diseases (Rugulies, 2002), arthritis (Musil et al., 2001) and cancer (Bodurka-Bevers et al., 2000). As a result of the analysis of the World Health Survey data collected from 46 different countries, it was found that between 9.3% and 23% of the participants had one or more chronic diseases comorbid with depression (Moussavi et al., 2007).

Besides physical chronic diseases, there are other psychological disorders in which depression is comorbid. Anxiety is at the forefront of other psychological disorders in which depression is comorbid. In a longitudinal study, it was found that 67% of the participants with depression had an anxiety disorder in the 12-month period, and 75% of them had a lifetime anxiety disorder comorbid with their depression (Lamers et al., 2011). In addition to anxiety, depression has also been found to be comorbid with personality disorders. In particular, there is a correlation between Cluster A personality disorders, paranoid, schizoid, schizotypal personality disorders and depression (Kool et al., 2000). Apart from these, studies examining the relationship between depression and eating disorders also reported a positive correlation between depression and eating disorders (Perez et al., 2004; Santos et al., 2007). Similarly, substance abuse is comorbid with depression (Swendsen & Merikangas, 2000). In conclusion, all this shows how important it is to treat depression.

1.2. Conceptualization and Treatment

Up to the present, depression has been studied by many scientists, and research has been carried out on topics such as what depression is, depressive symptoms, risk factors, and its treatment (Beck, 1964; Bowlby, 1980; Freud, 1917; Lazarus, 1968). Each approach such as psychoanalytic, humanistic, existential, gestalt and cognitive approaches have tried to conceptualize depression from their perspective. However, one of the leading approaches in treating depression is CBT. Since the current research was based on CBT, it was explained in great detail.

1.2.1. Cognitive behavioral therapy

From the early stages of development, people try to understand and make sense of their environment and the world (Rosen, 1988). According to Aaron Beck (1979), people tend to be more interested in certain stimuli in the face of situations they encounter and interpret the situation by combining these stimuli with a particular pattern. People's interpretation of other similar situations is in a consistent and stable cognitive pattern. The cognitive patterns of people as a result of these similar situations form what Beck calls schemas. These cognitive structures are generalized in line with a person's attitudes, beliefs, values, and goals and determine the way people perceive and organize the world and the environment (Beck, 1964).

People's interactions with the environment and other people are combined by their genetic predisposition. As a result, they develop certain meanings and understandings about the environment. These understandings are called core beliefs in CBT (Beck, 1979). Core beliefs are the most fundamental beliefs as they begin to form in the early developmental stages of the person and form the way they perceive the world (Beck, 2011). They are profound, rigid, persistent, overgeneralized, and difficult to recognize. Generally, people accept these beliefs as absolute facts and truths. Most people develop more positive core beliefs, such as “I am worthy, lovable, and successful.” However, people who experience psychological stress during their life develop negative and very unrealistic core beliefs such as “I am unlovable, worthless, or incompetent” (Beck et al., 2004). For instance, people who are highly sensitive to inherently destructive and stressful events, such as rejection or abandonment, may develop intense and fearful beliefs like "I am unlovable" about these events. This core belief that a person develops about oneself emerges again and again in a powerful way, especially when the person is more vulnerable. In that case, the belief becomes more robust and embedded.

People's core beliefs affect how they perceive events. The way people perceive and interpret an event affect people's feelings and thoughts, and reactions (Beck, 2011). When core beliefs are activated through environmental cues and people's responses to their inner state or emotions about a situation, automatic thoughts arise (Dozois & Beck, 2008). Automatic thoughts come to mind quickly without any conscious awareness and cognitive evaluation during an event. These thoughts do not arise during the events by reasoning. On the contrary, it occurs very spontaneously, briefly, and rapidly. Often, people are unaware of these automatic thoughts. However, the emotions or behaviors that follow these thoughts

are more noticeable. Even if people are aware of these thoughts, they are accepted without thinking, questioning or noticing whether they are true, and without being critically approached (Beck, 1979).

Beck (1963) observed that people with the same pathologies have similar core beliefs and automatic thoughts. He also saw that each pathology has its own cognitive content and structure. That is why CBT is a content-specific therapy (Beck et al., 2004). Considering depression, when people's beliefs about a situation are dysfunctional, people's negative automatic thoughts focus more on personal deficiencies, self-blame, and negative expectations, which is the leading cause of depressive symptoms (Beck & Alford, 2009). Dysfunctional beliefs and negative automatic thoughts do not occur actively in a person who is not depressed. However, when the person begins to show depressive symptoms, these schemas become dominant and cover all the person's cognition (Beck, 1964). He mentioned that the dysfunctional beliefs of depressed people are grouped under three basic core belief categories: worthlessness, helplessness, and unlovability. As people's depressive symptoms increase, they begin to pay attention to things that validate these core beliefs (Beck, 2011). When they experience something positive, they use different cognitive distortions to shape it to fit the pattern of their core beliefs. Beck and his colleagues (1979) have named many cognitive distortions common in depressed people, such as overgeneralizing, all-or-nothing thinking, and mind reading. Depressed people use these cognitive distortions to make depressogenic assumptions that contribute to their depressive feelings. As an example of all-or-nothing thinking, one thinks, "If I cannot read the whole book, even reading a part of it will not do me any good" (Beck, 2011). As a result, all these negative automatic thoughts and core beliefs cause changes in people's emotions, physiology, and behavior.

Beck et al. (1979) put forward three essential elements while explaining depression and named it the cognitive triad. The first element of the cognitive triad is that the depressed person has a negative self-perception. The person thinks that one's negative experiences are caused by one's own psychological, physical, or moral defects. Therefore, the person thinks one does not deserve to be loved and valued. The second element is the negative interpretation of the events. The person defines the world as something that makes impossible demands of oneself or puts obstacles in front of the person, making one unable to reach one's goal. The third element is that the depressed person approaches the future negatively. One expects constant frustration and constantly failing. The person thinks that these negativities and difficulties will continue in the same way in the future. Consequently, people show depressive symptoms such as low or sad mood, difficulties in concentration,

sleep problems, self-blame, negative attitude towards themselves, dissatisfaction, hopelessness, negative expectations for the future, and loss of interest (Beck & Alford, 2009).

CBT is based on the cognitive model that suggests that the way people perceive and interpret events affects their emotions, behavior patterns, and physiology (Beck, 2011). CBT aims to change behavior while intervening with people's negative automatic thoughts and core beliefs (Beck et al., 1979). One of the main purposes of CBT is for patients to learn the methods applied during the therapy process, to be able to apply them on their own, and to become their own therapists. Therefore, starting from the first session, the interaction of automatic thoughts, emotions, and behaviors, namely the cognitive model, is taught to patients with psychoeducation (Beck, 2011).

In therapy, first of all, the aim is to reveal and evaluate negative automatic thoughts arising from people's core beliefs and to try to replace them with more functional ones with a supportive and collaborative approach (Beck & Alford, 2009). It is tried to develop the patients' ability to find their own automatic thoughts by teaching how to elicit automatic thoughts starting from the first session. A simple question is used to elicit automatic thoughts: "What is going through your mind right now?" Then with the identification and emergence of automatic thoughts, people begin reality testing to assess the accuracy, and validity of these thoughts. (Beck, 2011). Having a thought does not mean it is entirely accurate. For this reason, changing those thoughts makes people feel better. By teaching these to the patients, therapists try to ensure that their strong, rigid and learned core beliefs can be unlearned and that patients acquire more reality-based beliefs. In the continuation of therapy, one of the main goals of therapy is to alleviate the symptoms of people, especially the intense negative emotions they experience (Beck & Alford, 2009). When excessively negative emotions prevent people from enjoying things, thinking clearly, and developing problem-solving patterns, it becomes something that contributes to their depression. That is why it's important to find and reduce the intensity of the excessive negative emotions that automatic thoughts make people feel. In the following sessions, an attempt is made to help people change their core beliefs as quickly as possible. Because when people develop more reality-based beliefs, they feel better and their perceptions of themselves, their experiences, and the future become more realistic and constructive (Beck, 2011). As in every phase of therapy, patients are taught through psychoeducation that core beliefs are learned, there are many different core beliefs, and they can develop another core belief in place of this current

dysfunctional core belief. The disadvantages of the existing core belief are highlighted, and this belief is tried to be modified with a functional one (Beck, 2011; Beck & Alford, 2009).

In CBT, homework is in the core place in order to develop more functional automatic thoughts and core beliefs and to create behavior change (Beck et al., 1979). Because the most basic feature of CBT is to become one's own therapist, homework is an especially important tool for one to engage in therapeutic techniques outside of therapy sessions (Beck & Alford, 2009). For instance, behavior activation, especially in depressive disorders, is one of the essential techniques used in CBT starting from the first sessions (Beck, 2011). One of the reasons for the continuation of depression is that people do not engage in activities that used to give them pleasure and satisfaction, causing them to continue behaviors that contribute to depression, such as doing nothing and sleeping all the time. Therefore, behavioral activation has a great importance in therapy for people to be more active and to improve their mood by helping them to appreciate themselves as a result of what they do (Beck & Alford, 2009). Apart from this, to make a person think about what one would say to a friend if the friend were in the same situation is a technique that is used to develop strategies to find solutions to one's problems. Another technique is to decide by making a pros and cons table about the things that the person has difficulty deciding. Another one is relaxation or breathing exercises or mindfulness techniques to increase people’s awareness of their emotions. In addition to these, there is the technique of breaking down the goals one wants to achieve into small steps. There is also the technique of making a list of the things one appreciates in oneself (Beck, 2011; Beck et al., 1979; Beck & Alford, 2009).

Whether CBT is effective on depressive disorders has been investigated in many studies from past to present in different groups and settings (Ciharova et al., 2021; Dobson, 1989; Rupke et al., 2006). Examples of some of these studies in the literature are as follows; a study comparing adults receiving CBT treatment to a waiting list (Embling, 2002), a meta-analysis of 18 studies comparing adults who received CBT in one group, placebo in one group, and a group who did not receive any treatment (Honyashiki et al., 2014), a study applying individual and group CBT to individuals in a rehabilitation setting (Hauksson et al., 2017), a meta-analysis of studies using CBT in a primary care setting (Twomey et al., 2014), a meta-analysis of studies comparing face-to-face and group therapies to adolescents (Oud et al., 2019), a review of studies comparing CBT and placebo in the elderly (Peng et al., 2009). All these studies show that CBT is an effective therapy method for reducing depressive symptoms. Some therapy approaches derived from the CBT approach also try to reduce the depressive symptoms of people by using similar methods. For instance, solution-

focused therapy progresses with behavioral assignments on discovering one's strengths and finding solutions to their problems (Cox et al., 2014). Mindfulness-based therapy, on the other hand, regularly uses behavioral methods such as breathing exercises and meditation to increase people's awareness of their life and responsibilities (Kabat-Zinn, 1982). Like CBT, studies are showing that both therapies are effective in the treatment of depression (Bell & D'Zurilla, 2009; Cuijpers et al., 2007; Ma & Teasdale, 2004). As mentioned before, although CBT is an approach that has traditionally been a face-to-face therapy, it has been adapted to different intervention methods such as short message service (SMS) interventions over time (Agyapong et al., 2012; Cole-Lewis & Kershaw, 2010).

1.3. Short Message Service in Psychological Interventions

From past to present, depression has been tried to be treated with various psychotherapy methods, and as a result of various studies, it has been found that they are effective on depression (David et al., 2008; Driessen et al., 2010; Duffy et al., 2022; Raffagnino, 2019; Rupke et al., 2006; Vos et al., 2015). However, some barriers restrict people's access to traditional psychotherapies, causing them to be unable to receive treatment when there is functional treatment (Kohn et al., 2004; Mohr et al., 2006). The first of these is that the psychotherapy fees are high, and it is not possible for people with low socioeconomic status to be able to pay the therapy fees (Delgadillo et al., 2018). The reasons for the early termination of therapy by the patient were investigated, and it was found that one of the reasons was financial distress (Khazaie et al., 2016; Roe et al., 2006). One of the barriers that prevent people from receiving and continuing traditional psychotherapy is that people do not have time to go to therapy (Collins et al., 2004). Even if there is time, it is also a reason that it is difficult to transport to the place where the session is. Another barrier is the fear that when people seek professional help, they will be stigmatized and viewed as inferior by society (Barney et al., 2009). The other is that it is difficult for people to access experts in their field, and even if they do, the availability of experts is low (Collins et al., 2004). In addition to all these, other barriers are as follows; people giving care to someone in need of care at home and not being able to go to therapy by leaving that person alone, being afraid to talk about their personal issues, being seen by others when they get emotional or crying and the fear of what their acquaintances will say (Mohr et al., 2006). For all these reasons, people cannot receive the necessary treatment for their psychological disorders. Today, however, new methods have emerged in which most of these barriers do not exist.

In addition to face-to-face psychotherapy services, thanks to the rapid advancement of technology, the use of mobile phone SMS and smartphone apps called mHealth applications in psychological interventions, and some prevention techniques are becoming widespread (Agyapong et al., 2012; Agyapong et al., 2013; Donner, 2008; Lim et al., 2008; Molloy & Anderson, 2021). When the statistics of people using smartphones in the world are examined, it has been reported that approximately 6 billion people worldwide use smartphones in 2021 (Statista Research Department, 2023). In addition, it is predicted that this number will reach 7 million in a few years. When this was the case, healthcare professionals began to adopt smartphone applications for medical interventions and treatments (Luxton et al., 2011). These applications have multiplied constantly, and in 2017, more than 10.000 applications for psychological health began to be used (Torous & Roberts, 2017). Especially since there are so many people using mobile phones, providing psychotherapy services to people via smartphones has improved the possibility of people accessing psychotherapy (Molloy & Anderson, 2021). Because SMS is accessible, low-cost, and extremely fast, it is now seen as one of the important tools for behavior change (Cole-Lewis & Kershaw, 2010).

SMS is accessible, fast, and convenient because text messages reach people's mobile phones whenever and wherever people are (Richmond et al., 2015). The reason why it is accessible is that according to data from the Turkish Statistical Institute (2020), the number of mobile phone subscribers in 2019 was reported to be about 82 million in Türkiye. Moreover, this number is increasing day by day. This means that the majority of people in Türkiye have a mobile phone and can access psychological interventions through the text message service. It is fast because The British Chamber of Commerce Türkiye (2017) indicated that people check their phones 78 times a day, which means every 13 minutes in Türkiye. It is convenient because it allows people to notice, reflect on, and work on their own symptoms outside of the session. In addition, it is low-cost and does not require advanced knowledge of technology (Hall et al., 2015; Lim et al., 2008). There are also some mobile phone-based intervention methods, and applications other than SMS, and these interventions require the internet. (Aguilera & Muñoz, 2011). According to the Digital 2022 Global Overview Report, 95.5% of Türkiye's population access the internet with their smartphones (We Are Social, 2022). In fact, the most used application by people with internet access between the ages of 16 and 64 is WhatsApp with a rate of 93.2%. This data shows that the majority of the population in Türkiye has smartphones and internet access. That is why text message interventions are more accessible to people than traditional face-

to-face therapies, even if some apps or interventions require the internet. These features of text messages appear to be quite functional as an intervention tool in psychological disorders that have a high likelihood of relapse, such as depression (Agyapong et al., 2017).

These days, studies that try to create behavior change in many ways with text message intervention using smartphones have become widespread. For instance, in a meta-analysis of studies aiming at positive behavior change, it was reported that text message intervention increased positive healthy behaviors in a short time (Armanasco et al., 2017). In another meta-analysis, studies that used message intervention to increase physical activity in people were analyzed, and as a result, it was found that message intervention moderately increased people's physical activity (Smith et al., 2020). According to two meta-analyses that analyzed message intervention studies that tried to create positive behavioral change in smokers and substance users and make them quit smoking and reduce their substance use, message intervention was effective for people to quit smoking and other substances (Mason et al., 2015; Spohr et al., 2015). There are also studies investigating whether message intervention is an effective method for people who have low-income. For example, in a study that added text messaging to the treatment of low-income people who continue to receive psychotherapy, the messages increased their participation in psychotherapy, resulting in more positive outcomes. At the same time, these people gave feedback that they liked the incoming messages and that the messages improved their mood (Aguilera & Muñoz, 2011). The increasing use of message interventions to treat symptoms of depression is the most important feature of message interventions for the current thesis.

1.3.1. Message interventions in treatment of depression

There are several studies in the literature investigating whether text message intervention is effective on depression (Agyapong et al., 2017; Aguilera & Muñoz, 2011; Hartnett et al., 2017; Richmond et al., 2015; Whittaker et al., 2012). In some of these studies, adolescents who participated in group sessions at school were studied (Whittaker et al., 2012), some of those who continued to receive any treatment such as CBT or primary care, SMS was added in addition to their treatment (Agyapong et al., 2017; Richmond et al., 2015). Moreover, in some of them, people who have depression with comorbid disorders such as substance use were studied (Hartnett et al., 2017), and in some, individuals who have low-income were studied (Aguilera & Muñoz, 2011). Although each of these studies was conducted with different samples, they have one thing in common; the content of the text messages.

Text messages are based on the theory, principles, and therapy techniques of CBT. In the treatment of depression, as mentioned before, CBT tries to reduce depression symptoms. In addition, it tries to achieve behavioral changes by giving patients psychoeducation about depression and homework such as activities that keep people physically active during the day, thought records to recognize and evaluate negative automatic thoughts, and some behavioral experiments (Beck, 2011). The basis of the messages is the principle of CBT, which tries to improve people's emotional states by encouraging people to think and work on their feelings and thoughts (Bhattacharjee et al., 2022). When people read the message they receive, they monitor themselves at least once a day. This allows people to develop more awareness of their feelings, thoughts, and later on their behavior (Bennett-Levy et al., 2010). Text messages have the characteristics of homework, behavioral activation, and psychoeducation, which are among the methods used in CBT (Martinengo et al., 2021; Wilansky et al., 2016). Supportive, informative, and stimulating text messages can be seen as a reminder of the homework given to clients in CBT contributes to behavioral change by enabling people to take action (Michelle et al., 2014). This allows people to be accessed outside of the session. Text message interventions are especially important for depressed people outside of therapy sessions. Because informative text messages help people perceive support, feel like they are being taken care of, develop skills, and increase self-awareness (Aguilera & Berridge, 2014). The contents of text messages enable people to try to apply therapeutic skills in their lives (Pfeiffer et al., 2016). It also provides them with an intrinsic motivation to achieve their goals and aspirations.

It has been previously investigated whether text message intervention has a supportive effect on therapy while people with depressive disorder continue to receive therapy and use medication (Agyapong et al., 2012; Agyapong et al., 2017; Hartnett et al., 2017). In these studies, it was observed that the text message intervention added to the treatment had a positive effect on reducing the depressive symptoms of individuals. As a result of another study that sent daily supportive messages to people who had breast cancer, to increase their support after treatment, and to reduce their depression, it was found that these messages were good for the people, reduced their loneliness, and people felt that they were taken care of (Singleton et al., 2021). In a study conducted with adolescents, messages based on CBT principles were sent to adolescents for nine weeks. It was reported that this practice could be protective and preventive for depression. When adolescents were asked, they said that the messages helped them feel more positive, cope with problems at school, get rid of negative thoughts, and relax (Whittaker et al., 2012). In summary, the effect of text messaging

interventions on depressive symptoms was investigated with different samples, in various methods, and various settings. Consequently, it was found that these interventions had a reducing effect on depression. Therefore, in this thesis, it was aimed to intervene in the symptoms of depression by using text message intervention.

1.4. The Purpose of the Thesis

This study aims to examine the effect of informative and supportive text messages containing behavioral, and cognitive activation, every day for a month (30 days) on the symptoms of depression in adults. When the literature was reviewed, it was seen that some studies are showing that supportive, reminding, reinforcing, and stimulating message contents in text message interventions give successful results in the treatment of depression (Agyapong et al., 2017; Morgan & Cotten, 2003; Richards & Richardson, 2012). However, these studies have generally examined the effects of message interventions on depression as an adjunct to an existing treatment. To the knowledge of the researcher, there are no studies investigating the effects of text messaging interventions on the symptoms of depression in people who do not receive any treatment, such as medication or psychotherapy. In addition, when the Turkish psychology literature was examined, it has been seen that there is no comprehensive study in our country that includes text message intervention to reduce depressive symptoms. There is only one pilot study conducted in Türkiye on this subject (Sakarya et al., 2013), a master's thesis examining the effect of message intervention to reduce anxiety and depression in first-time fathers (Onus, 2019). Therefore, this study will be the first of its kind in Türkiye that includes text message intervention to reduce depression symptoms only and will also contribute to the psychology literature on this subject.

1.5. Research Questions and Hypothesis

Based on the literature review and the purpose of the study, the research questions and hypotheses were suggested.

1. Does message intervention have a reducing effect on people's depression symptoms?

Hypothesis 1: It was hypothesized that the text message intervention would decrease the depressive symptoms of people in the experimental group compared to those in the control group.

2. Would message intervention be more effective on mild or moderate depression?

Hypothesis 2: It was expected that at the end of the text message intervention, the depression scores of people with moderate depression in the experimental group will decrease more than those with mild depression.

1.6. The Importance of the Thesis

In the current thesis it was already stated that there are many reasons that make it difficult, restrict, or completely prevent people's access to face-to-face therapies (Kohn et al., 2004; Mohr et al., 2006). Some examples of the reasons that prevent people from reaching face-to-face therapy are as follows; people living in countries with low socioeconomic status do not have the financial means to pay for therapy (Delgadillo et al., 2018; Khazaie et al., 2016), people cannot find time to go to therapy due to working hours or any other reason (Collins et al., 2004), or even if they find time, they have difficulty in transportation to go to the place where therapy sessions are made, they are afraid of being stigmatized and excluded by their social environment (Barney et al., 2009), it is difficult for people to find experts in the field and cannot leave the person or people they care for at home alone (Mohr et al., 2006). In addition to all these a new barrier has emerged in recent years. A COVID-19 pandemic was declared in March 2020 (WHO, 2020). Due to this very dangerous virus, which can be transmitted from person to person through the air, there was a lockdown for a while and people could not leave the house (Lotfi et al., 2020). In order to prevent the virus from spreading further, people had to stay at home and work from home. Thus, psychologists were forced to continue their face-to-face therapy in online settings (Békés & Aafjes-van Doorn, 2020). In this process, many people felt depressed due to social isolation and loss of loved ones, but they could not go out because of the lockdown and therefore could not receive face-to-face therapy (Karaşar & Canlı, 2020). Reasons like these and many more cause people to not receive these treatments at all even though there are functional treatments available that can treat their disorders (Kohn et al., 2004; Mohr et al., 2006). This study will contribute to the literature in terms of examining the effect of an intervention that can be made when people are unable to receive psychological help for any reason. In addition, this study will be a preliminary step for the development of a low-cost, easy-to-implement intervention program other than medication or therapy. Thus, an intervention method that can be applied to people who cannot reach face-to-face therapy for any reason will be developed. At the same time, a first step of an intervention will be developed that can be added to the existing therapy routine, such as medication or psychotherapy, and will support the current treatment process.

When the relevant literature was reviewed, even though there are studies in the literature that have applied text message intervention before, these studies were either applied in addition to an existing treatment or applied to depression with comorbid disorders (Agyapong et al., 2017; Aguilera & Muñoz, 2011; Hartnett et al., 2017; Richmond et al., 2015; Whittaker et al., 2012). According to the researcher's knowledge, there is no study in the literature that tries to treat only and directly depressive symptoms while there is no other treatment such as psychotherapy or medication and there is no study that tries to intervene only with text messages, especially in Türkiye. For this reason, this study will be the first study in Türkiye to include an intervention to directly reduce depressive symptoms only through text messages. In addition, in the current study, people with severe depression were not included in the study, and people with mild and moderate depression were studied. This highlights another importance of the study. People who are below the threshold and cannot be diagnosed because they do not have enough symptoms usually receive less attention and cannot access the necessary treatment for various reasons. Therefore, the present study is also of great importance in that it has been studied with individuals who have not received a clinical diagnosis and who have less than the necessary criteria for diagnosis.

2. METHOD

2.1. Participants

In this study, there is a within-between factors interaction since the same measurements were taken from people in different groups at 2 different times, as pre-test and post-test. To determine the number of participants in the study, a priori power analysis was performed using the ANOVA statistical test in the G*Power 3.1 program (Faul et al., 2009). When the effect size is medium (d = .25), the alpha value is .01, the power estimate is .99, number of groups are 4 and number of measurements are 2, the calculated total number of participants is 128. However, considering the possibility that the participants would stop participating in the study, it was aimed to reach more people than this number.

The inclusion criteria of the participants in the study were as follows; being older than 18 years old, native Turkish, using mobile phone, participating in the study voluntarily, opening the read receipt information (two blue check marks) in WhatsApp, to get between 10-29 points from the Beck Depression Inventory (Hisli, 1989). Those who get 30 or more from BDI were not included in the study and were directed to psychological support. Going to any psychiatrist or psychologist and using any medication to reduce symptoms of depression were considered as exclusion criteria for participants. Because this study is a study that measures whether the depressive symptoms of people who do not receive any psychological support can be reduced by text message intervention alone.

A total of 452 people were reached during the data collection phase. The questionnaire of 106 of them were terminated because they left the questionnaire after accepting informed consent. In line with the exclusion criteria, the questionnaires of these people were terminated before going on to other questions, since 28 people are receiving psychiatrist support, 18 people are receiving psychologist support, 7 people are using a psychiatric drug, and 33 people did not accept to open the read receipt of messages (two blue check marks) in the WhatsApp application. In addition, when the BDI scores of the remaining 260 people were examined, 79 people with a BDI score below 10, and 31 people with a BDI score above 30 were excluded from the data. As a result of the pre-intervention measurement, 150 participants remained who met all the criteria before the study began. At the beginning of the study, 76 (50.7%) people were randomly assigned to the experimental group and 74 (49.3%) to the control group. The experimental group of 76 people consisted of 26 (17.3%) participants with mild depression and 50 (33.3%) participants with moderate depression. The

control group of 74 people consists of participants with 25 (16.7%) mild depression and 49 (32.7%) with moderate depression. When the message intervention started, it was observed that 1 person did not have a WhatsApp account and therefore this participant was excluded from the study. In addition, one participant dropped out of the study because she said that she started receiving psychological support and therefore wanted to withdraw from the study. For this reason, a total of 148 participants remained in the message intervention phase. In post-intervention measurement phase, a total of 17 people, 6 from the experimental group and 11 from the control group, did not fill in the BDI, BAI and PANAS scales, which had to be filled in after the 30-day message intervention, and withdrew from the study. Thus, 131 people who constituted the main sample of the research remained. The flowchart related to the whole process was given in the Figure 1.

The sample of the study consists of a total of 131 participants who meet all the criteria and fulfill all the requirements. 96 (73.3%) of these participants were female, 34 (26%) of them were male and 1 (.8%) of them did not want to specify their gender. The age of the participants ranged from 18 to 68 (M = 29.59, SD = 10.84) years old. 40 (30.5%) of these participants have mild depression (M = 12.40, SD = 1.97) and 91 (%69.5) of them have moderate depression (M = 23.16, SD = 3.32). The details of the other demographic information of the participants according to their groups can be found in Table 1.

Figure 1. *Flowchart of the whole process*

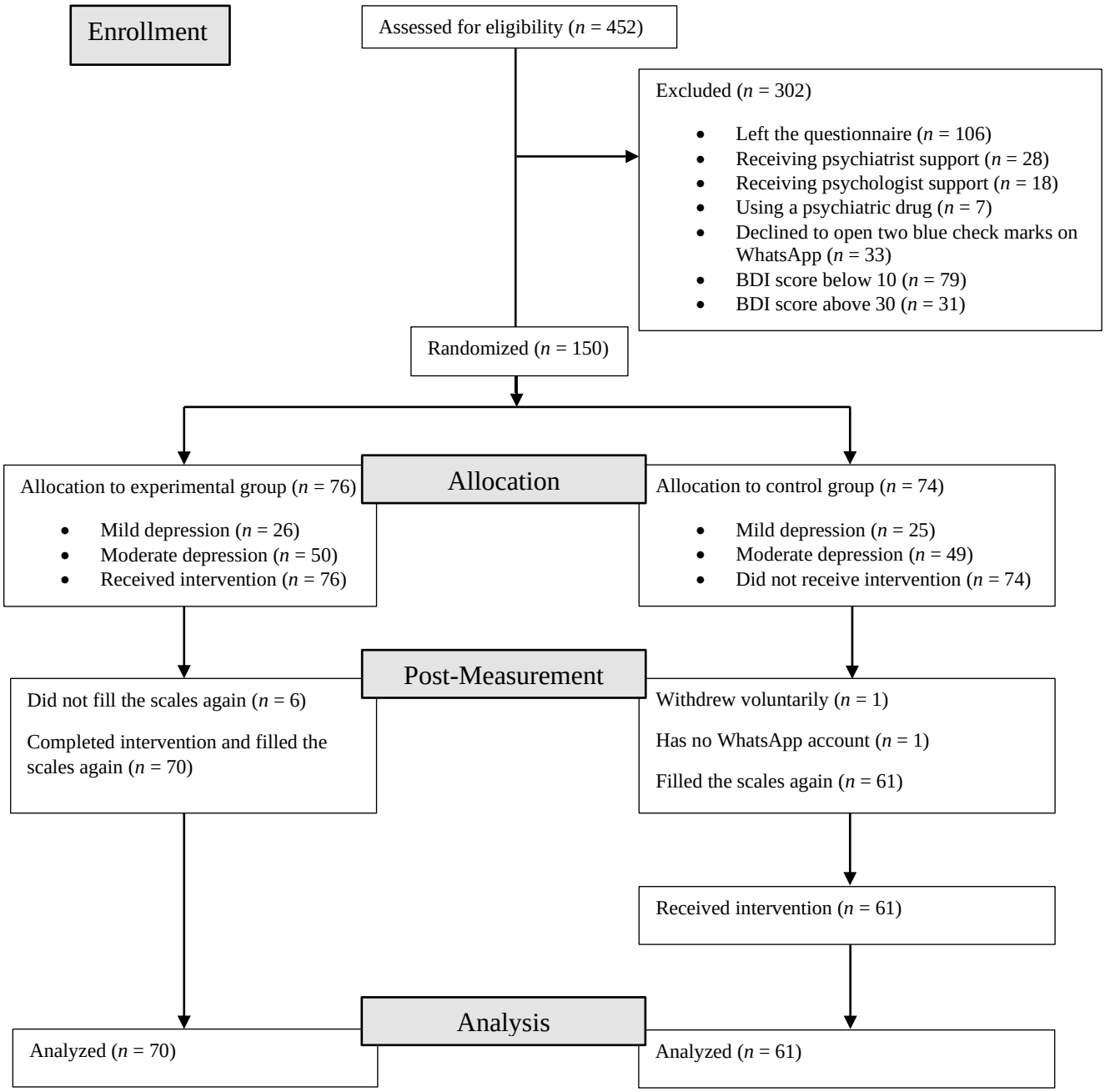


Table 1. *Demographic Characteristics of Participants*

Demographic characteristics	Mild experimental		Mild control		Moderate experimental		Moderate control		Full Sample	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Gender										
Female	18	81.8	10	55.6	36	75	32	74.4	96	73.3
Male	3	13.6	8	44.4	12	25	11	25.6	34	26.0
Not identified	1	4.5	0	0	0	0	0	0	1	.8
Marital status										
Married	5	22.7	4	22.2	13	27.1	9	20.9	31	23.7
Single	16	72.7	14	77.8	31	64.6	31	72.1	92	70.2
Divorced	1	4.5	0	0	4	8.3	3	7.0	8	6.1
Average cell usage time										
Less than 1 hour	1	4.5	0	0	1	2.1	0	0	2	1.5
1-3 hours	5	22.7	4	22.2	13	27.1	10	23.3	32	24.4
3-6 hours	8	36.4	13	72.2	18	37.5	16	37.2	55	42.0
More than 6 hours	8	36.4	1	5.6	16	33.3	17	39.5	42	32.1
Previous psychiatric support										
Yes	6	27.3	6	33.3	15	31.3	9	20.9	36	27.5
No	16	72.7	12	66.7	33	68.8	34	79.1	95	72.5
Previous psychologist support										
Yes	10	45.5	6	33.3	15	31.3	18	41.9	49	37.4
No	12	54.5	12	66.7	33	68.8	25	58.1	82	62.6
Previous diagnosis of psychological disorder										
Yes	5	22.7	2	11.1	8	16.7	8	18.6	23	17.6
No	17	77.3	16	88.9	40	83.8	35	81.4	108	82.4
Student										
Yes	10	45.5	9	50	20	41.7	18	41.9	57	43.5
No	12	54.5	9	50	28	58.3	25	58.1	74	56.5
Employment										
Yes	10	45.5	11	61.1	25	52.1	21	48.8	67	51.1
No	12	54.5	7	38.9	23	47.9	22	51.2	64	48.9
Educational status										
High school	2	9.1	1	5.6	8	16.7	1	2.3	12	9.2
Vocational school	0	0	1	5.6	2	4.2	1	2.3	4	3.1
University	15	68.2	12	66.7	22	45.8	26	60.5	75	57.3
Master's degree	3	13.6	3	16.7	13	27.1	15	34.9	34	26.0
Doctoral degree	2	9.1	1	5.6	3	6.3	0	0	6	4.6
Residence type										
With my family	19	86.4	12	66.7	34	70.8	29	67.4	94	71.8
With my friends	0	0	2	11.1	3	6.3	3	7.0	8	6.1
Solitary	1	4.5	1	5.6	10	20.8	9	20.9	21	16.0
Stay at dorm	2	9.1	3	16.7	1	2.1	2	4.7	8	6.1
Emotional support										
Yes	21	95.5	16	88.9	41	85.4	40	93.0	118	90.1
No	1	4.5	2	11.1	7	14.6	3	7.0	13	9.9
Emotionally affecting event in 1-2 weeks										
Yes	15	68.2	10	55.6	34	70.8	29	67.4	88	67.2
No	7	31.8	8	44.4	14	29.2	14	32.6	43	32.8

2.2. Materials

Data were collected via Qualtrics throughout the research. The Qualtrics link, where participants can access the scales, was shared via social media (see Appendix 1).

2.2.1. Informed consent form

Participants were required to approve the informed consent form stating that they voluntarily participated in the study and accepting that they shared their personal information such as mobile phone number (see Appendix 2).

2.2.2. Demographic information form

Demographic information form was used to obtain the socio-demographic information of the participants (see Appendix 3). In the demographic information form, the participants were asked questions such as whether they use mobile phones, how long they use mobile phones on average, whether they receive support from a psychologist or psychiatrist, and whether they use a psychiatric drug. The questions were asked to the participants in this form were prepared on the basis of a previous study on depression in the literature (Özçırak, 2015).

2.2.3. Beck Depression Inventory

The Beck Depression Inventory (BDI) was developed by Beck et al. (1961) to determine the depressive symptoms and the severity of these symptoms. BDI was translated into Turkish by Hisli (1984). In order to identify depression-specific behaviors, individuals evaluate how they have felt in the past week on a 21-item scale ranging from 0 to 3. The scores that can be obtained from the scale range from a minimum of 0 to a maximum of 63. Depression levels indicated by the scores obtained from the scale are as follows; a score of 0 to 9 is defined as normal or minimal depression, 10 to 16 mild depression, 17 to 29 moderate depression, 30 to 63 severe depression. Examples of depression-specific behaviors measured by scale items are as follows; depressed mood, pessimism, sense of failure, dissatisfaction, self-hatred, self-blame, cravings for punishment, crying spells, irritability, social withdrawal. An example item of the scale is as follows: (0) I do not feel sad, (1) I feel blue or sad, (2) I am blue or sad all the time and I can't snap out of it, (3) I am so sad or unhappy that I can't stand it. There is no reverse item in the scale (see Appendix 4). Permission was obtained from Prof. Dr. Nesrin Hisli Şahin to use the scale.

The validity and reliability studies of the scale were performed by Hisli (1989), and the split-half reliability was found to be .74, and the Cronbach's Alpha coefficient was found to be .80. In this study, individuals were asked to respond by thinking about how they felt

during the 1-month period while filling out the BDI, since an intervention was made for 1 month. In the current study, the internal consistency was .63 for BDI.

2.2.4. Beck Anxiety Inventory

Beck Anxiety Inventory (BAI) is a 21-item scale developed by Beck et al. (1988) to measure the anxiety symptoms of individuals and to determine the severity of these symptoms. The scale was first translated into Turkish by three different psychologists and then back translated by three independent instructors from Bilkent University English Department (Ulusoy et al., 1998). The items of the scale evaluate how much the symptoms bothered the people when they feel anxious and worried. Scale items are scored as *0 = not at all, 1 = mildly, 2 = moderately, and 3 = severely.* The lowest score that can be obtained from the scale is 0, and the highest score is 63. Anxiety levels indicated by the scores obtained from the scale are as follows; a score of 0 to 7 is defined as normal or minimal anxiety, 8 to 15 mild anxiety, 16 to 25 moderate anxiety, 26 to 63 severe anxiety. Some examples of scale items are as follows; numbness or tingling, fear of dying, hot sweats, heart pounding, and fear of losing control. There is no reverse item in the scale (see Appendix 5). Permission was obtained from Prof. Dr. Nesrin Hisli Şahin to use the scale.

Ulusoy et al. (1998) conducted the validity and reliability studies of the scale. The internal consistency coefficient of the scale was found to be .93. The correlation of the scale with BDI was found to be .46. In this study, individuals were asked to evaluate how much the symptoms bothered them in the last 1 month while completing the BAI, since a 1-month intervention was made. In the current study, the internal consistency was .90 for BAI.

2.2.5. The Positive-Negative Affective Schedule

The Positive-Negative Affect Schedule (PANAS), developed by Watson et al. (1988), evaluates 10 positive and 10 negative affect items on a scale of 1 (very slightly or not at all) to 5 (extremely). Items 1, 3, 5, 9, 10, 12, 14, 16, 17 and 19 of the scale express positive affect, while items 2, 4, 6, 7, 8, 11, 13, 15, 18 and 20 express negative affect. The lowest score that can be obtained from the scale each for positive and negative affect is 10, and the highest score is 50. There is no reverse item in the scale. Positive affect items measure how interested, excited and strong the person feels, while negative affect items measure how distressed, unhappy and guilty the person feels (see Appendix 6).

The validity and reliability study for the Turkish adaptation of the scale was carried out by Gençöz (2000). The internal consistency of the scale was .83 and .86 for positive and

negative affect, respectively. While the correlations between positive and negative affect and BDI were found as -.48 and .51, respectively, with BAI it was found as -.22 and .47, respectively. In the current study, the internal consistency was .82 and .84 for positive and negative affect, respectively. Permission was obtained from Prof. Dr. Tülin Gençöz to use the scale.

2.2.6. Text messages

For the current study, the messages used in the study were created by the researcher. While preparing the messages, each of the BDI items were taken as the basis. Except that, in a similar study conducted to reduce the depression symptoms, messages containing CBT components were created and used by Agyapong et al. (2012). These messages used in Agyapong's study also formed a basis for preparation process of the messages to be used in the current study in addition to the BDI items. Before starting to create the messages in this study, Dr. Vincent Agyapong was contacted, and necessary permission was obtained to use the messages he created as a guide.

While creating the messages, the order and course of the topics to be discussed in the CBT sessions were taken as a basis. For example, very simply, from the first session, automatic thoughts are explained, in the following sessions, the client tries to find one's own automatic thoughts, then the reality of these automatic thoughts is tested, then the emotions created by the automatic thoughts are tried to be found, and then the behaviors that these feelings cause are discussed. This trajectory of CBT was taken into account when creating and queuing messages. In addition, information such as cognitive distortions presented to the client during CBT sessions and messages about methods such as behavioral activations, goal setting or miracle questions were added. Some messages, on the other hand, are informative about depression. In addition, some of them are more about the way people think and their content. An example text message is: "*During the day, many thoughts automatically come to our minds. Many of these automatic thoughts tend to be negative. When we pretend that these negative automatic thoughts are real, we may act based on faulty assumptions. When you experience sudden mood changes, when you are happy and suddenly feel restless, anxious, or bad, stop first. Try to find out what negative automatic thoughts are running through your mind*." (*Gün içerisinde aklımıza otomatik olarak bir sürü düşünce gelip gitmektedir. Bu otomatik düşüncelerin çoğu olumsuz olma eğilimindedir. Bu olumsuz otomatik düşünceler gerçekmiş gibi davrandığımızda hatalı varsayımlara dayalı bir şekilde hareket edebiliriz. Ani duygu değişimleri yaşadığınız, mutluyken bir anda huzursuz, kaygılı*

ya da kötü hissettiğiniz anlarda önce bir durun. Aklınızdan hangi olumsuz otomatik düşüncelerin geçtiğini bulmaya çalışın.)

In the process of creating the messages, feedback on the content, structure and layout of each message was received from four different clinical psychologists with PhD and two different psychologists working in the field with CBT training. Messages were arranged in line with these feedbacks and presented to them again. After each one approved the edited version, the final version of the messages was created (see Appendix 7).

2.3. Procedure

2.3.1. Baseline

After obtaining the necessary permission from Başkent University Ethics Committee, the data collection process started. First, the Qualtrics link was shared with the participants on social media. Participants were told that if they followed all the guidelines of the study, at the end of the study, 5 people to be determined by random drawing would be given a 50 TL Migros gift voucher incentive. Participants who approved the informed consent form completed the demographic information form, BDI, BAI, and PANAS scales. In line with the inclusion and exclusion criteria of the current research, the questionnaire of the participants who answered 'no' to the question of 'Do you use a mobile phone', 'yes' to the question of 'Are you currently receiving support from a psychiatrist? or 'Are you currently receiving support from a psychologist?', and 'yes' to the question of 'Are you currently using a psychiatric medication?' were end directly without going over to other questions. BAI and PANAS were also applied because depression and anxiety were known to have high comorbidity and to see if the message intervention had an effect also on the participants' anxiety symptoms or their affect. After filling the survey, the BDI scores of the participants were evaluated by the researcher and those whose BDI score is between 10-29 were included in the study.

First of all, the people participating in the research were divided into two groups according to their BDI scores. Whose score is between 10 and 16 were assigned to mild depression, and those who score between 17-29 were assigned to moderate depression groups. Then they were randomly assigned to either experimental or control group. As a result of the assignment process, 4 groups were obtained: mild depression experimental group, moderate depression experimental group, mild depression control group and moderate depression control group.

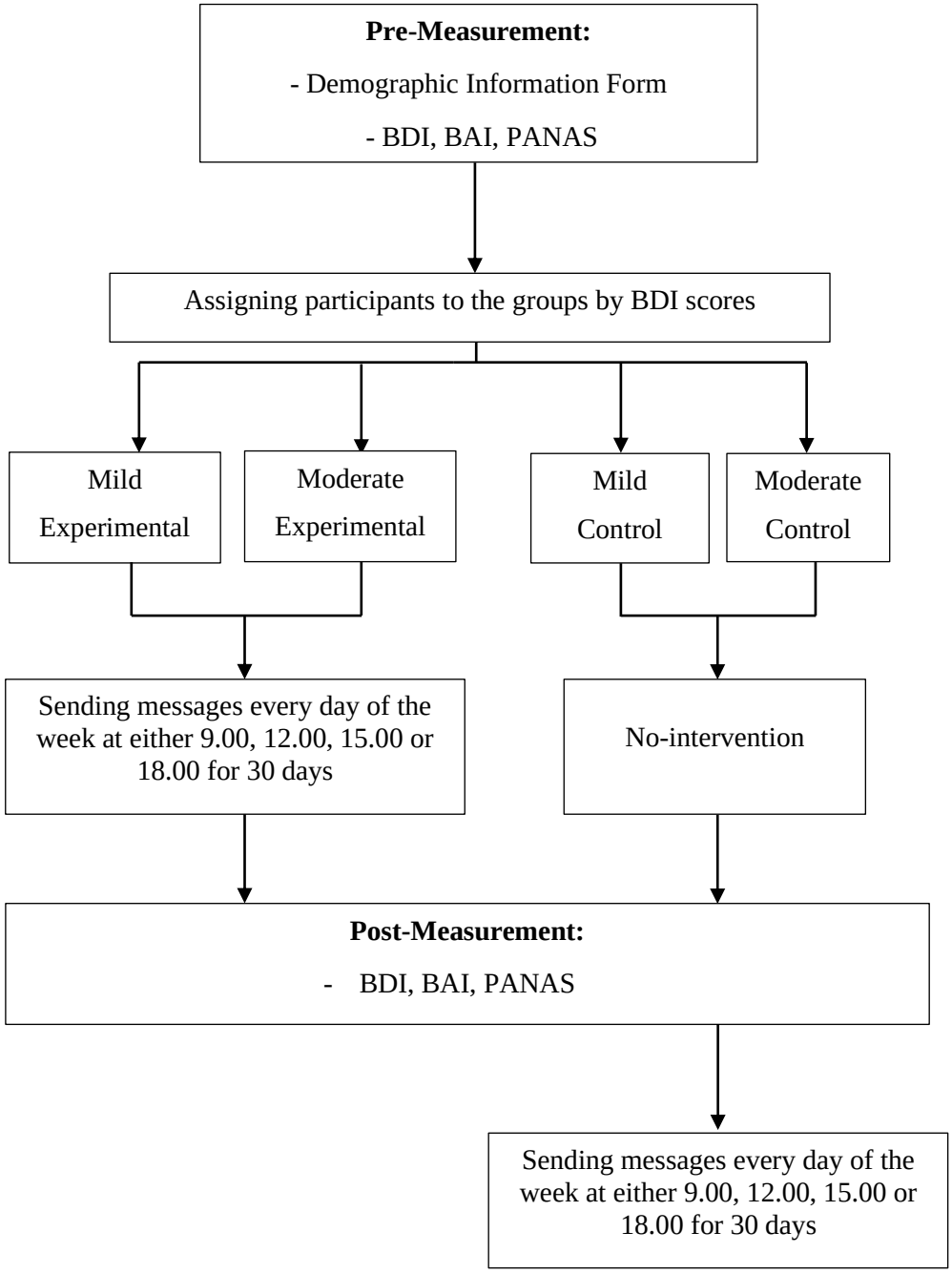
2.3.2. Intervention

Before the assignment process, the time (either 9.00, 12.00, 15.00 and 18.00) at which the messages would be sent was randomly determined by a random drawing application. The times at which messages were sent have been determined by considering previous studies on this subject in the literature (Singleton et al., 2021). Immediately after the assignment process, an informative message was sent to the participants about when the message intervention would start, depending on which group (experimental or control) they were in (see Appendix 8). Participants who get 30 or more from BDI were directed to psychological support. Because it has been reported that as the severity of depression increases, cognitive functions such as memory and executive functions decrease (McDermott & Ebmeier, 2009). This suggests that working with cognitive and behavioral assignments may be easier and more productive in people with mild and moderate depression than in people with severe depression.

For this research, a separate line was purchased, and a WhatsApp account was opened with this line. To send messages, a software in Python language was developed for WhatsApp application by using the PyCharm community edition 2022.2.3 program by a mechanical engineer. This developed software has enabled messages to be sent automatically to specified people at specified times. Thus, the messages reached all participants in about 1 minute. In a nutshell, text messages were sent by the researcher using the software over the WhatsApp application to the participants assigned to the experimental groups for 30 days at randomly determined hours.

The day after the last message was sent to the experimental group, all participants, including the participants in the control group, filled in the BDI, BAI, and PANAS scales again. To ensure that the conditions are equal in each group, and since the participants in the control group were informed that the intervention would be made at the beginning of the study, the participants in the control group were also be given a text message intervention for 30 days. After the message intervention was completed in all groups, participants were asked to give feedback on the messages received throughout the research and the effects of these messages on themselves. Participants were given a debrief form at the end of the feedback process (see Appendix 9). In addition, feedback from the participants can be seen in Appendix 10. A flow was given in Figure 2 below in which the stages are explained visually for a better understanding of the procedure process.

Figure 2. *Flow of the intervention process*



3. RESULTS

The data of 131 people who met all the criteria were downloaded from Qualtrics and transferred to the IBM SPSS Statistics 24.0 for statistical analysis. First, it was checked whether there was any missing value in the hole data, and it was determined that there was not any missing value. To determine outliers in the data univariate and multivariate outlier analyses were performed, and box plot analyses were also examined. As a result of all these analyses, no outliers were found in the data. The skewness and kurtosis values were calculated to check the normality of the data. According to Tabachnik and Fidell (2013), when the skewness and kurtosis values are between -1.5 and +1.5, the data is considered to provide normality. In the current study, it was determined that the skewness and kurtosis values of each scale filled by the participants were between -1.5 and +1.5, thus the data provided normality. In addition, homogeneity between variances was checked. The result of Levene's test is not significant, therefore homogeneity between variances was assumed.

3.1 Descriptive Statistics

Out of a total of 131 participants, 40 (30.5%) of these participants have mild depression (M = 12.40, SD = 1.97) and 91 (%69.5) of them have moderate depression (M = 23.16, SD = 3.32). There were 70 (53.4%) people in the experimental group and 61 (46.6%) in the control group. As a result of the assignment to groups, 4 groups were obtained. There were 22 (16.8%) people in the mild depression experimental group, 48 (36.6%) in the moderate depression experimental group, 18 (13.7%) in the mild depression control group, and 43 (32.8%) in the moderate depression control group. The mean and standard deviation values of the pre-intervention BDI, BAI and PANAS scales of the groups can be found in Table 2 and the post-intervention values can be seen in Table 3.

Table 2. *Means and Standard Deviations of Scores at Pre-Intervention Measurement*

Scale	Mild experimental		Mild control		Moderate experimental		Moderate control	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
BDI	12.36	2.01	12.44	1.98	23	3.61	23.34	3
BAI	14.95	11.42	11.67	8.67	21.52	10.08	21.66	10.44
PANAS								
Positive affect	27.27	8.05	24.83	5.02	21.13	4.72	21.63	5.70
Negative affect	6.91	5.34	5.17	4.60	10.06	5.09	10.07	4.97

Note. BDI = Beck Depression Inventory; BAI = Beck Anxiety Inventory; PANAS = Positive Negative Affect Schedule.

Table 3. *Means and Standard Deviations of Scores at Post-Intervention Measurement*

Scale	Mild experimental		Mild control		Moderate experimental		Moderate control	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
BDI	8.95	6.32	14.44	8.07	14.96	8.60	22.58	6.40
BAI	7.68	7.68	12.83	11.89	14.54	9.88	21.93	10.33
PANAS								
Positive affect	30.55	8.90	24.33	7.23	25.35	8.26	21.58	7.11
Negative affect	18.86	7.67	23.72	8.24	20.35	6.95	25.67	7.34

Note. BDI = Beck Depression Inventory; BAI = Beck Anxiety Inventory; PANAS = Positive Negative Affect Schedule.

Chi-square test and t-test were performed to examine whether the groups differed in terms of sociodemographic variables and pre-test BDI, BAI and PANAS scores. According to the Chi-square test results the mild experimental and mild control groups were not significantly different in terms of gender [$\chi^2(2, N = 40) = 5.21, p = .07$], marital status [$\chi^2(2, N = 40) = .85, p = .65$], previous diagnosis of psychiatric disorder [$\chi^2(1, N = 40) = .93, p = .34$], being a student [$\chi^2(1, N = 40) = .08, p = .78$], employment [$\chi^2(1, N = 40) = .97, p = .32$], educational status [$\chi^2(4, N = 40) = 1.62, p = .81$], residence type [$\chi^2(3, N = 40) = 3.42, p = .33$], and social support [$\chi^2(1, N = 40) = .62, p = .43$]. According to t-test results the mild experimental and mild control groups were not significantly different in terms of age [$t(38) = .52, p = .19$], BDI [$t(38) = -.13, p = .88$], BAI [$t(38) = 1.01, p = .20$], PANAS positive affect [$t(38) = 1.12, p = .05$], and PANAS negative affect [$t(38) = 1.09, p = .78$]. Same tests

were performed for the moderate experimental and moderate control groups. According to the Chi-square test results the moderate experimental and moderate control groups were not significantly different in terms of gender [$\chi^2(1, N = 91) = .00, p = .95$], marital status [$\chi^2(2, N = 91) = .60, p = .74$], previous diagnosis of psychiatric disorder [$\chi^2(1, N = 91) = .06, p = .81$], being a student [$\chi^2(1, N = 91) = .00, p = .99$], employment [$\chi^2(1, N = 91) = .10, p = .76$], educational status [$\chi^2(4, N = 91) = 9.01, p = .06$], residence type [$\chi^2(3, N = 91) = .51, p = .92$], and social support [$\chi^2(1, N = 91) = 1.34, p = .25$]. According to t-test results the moderate experimental and moderate control groups were not significantly different in terms of age [$t(89) = .23, p = .59$], BDI [$t(89) = -.50, p = .25$], BAI [$t(89) = -.06, p = .98$], PANAS positive affect [$t(89) = -.46, p = .21$], and PANAS negative affect [$t(89) = -.01, p = .68$].

3.2. Correlations Among Measurements

To examine the correlation of the BDI, BAI and PANAS scales used in the study, a bivariate Pearson's correlation coefficient was calculated for the groups and was presented in Table 4.

Table 4. *Correlation Among Variables for Groups*

Variables	1	2	3	4	5	6	7	8
1. Pre-BDI	-							
2. Pre-BAI	.44**	-						
3. Pre-PANAS-pstv	-.31**	.01	-					
4. Pre-PANAS-ngtv	.44**	.95**	-.01	-				
5. Post-BDI	.40**	.23**	-.00	.21*	-			
6. Post-BAI	.31**	.45**	.03	.44**	.70**	-		
7. Post-PANAS-pstv	-.19*	.02	.35**	.01	-.54**	-.33**	-	
8. Post-PANAS-ngtv	.13	.29**	.13	.26**	.72**	.69**	-.32**	-

Note. Pre and Post = measurement before intervention and measurement after intervention respectively; BDI = Beck Depression Inventory; BAI = Beck Anxiety Inventory; PANAS-pstv = Positive Negative Affect Schedule positive affect; PANAS-ngtv = Positive Negative Affect Schedule negative affect.

*$p < .05$. **$p < .01$.

According to the results from the correlation analysis for groups there was a positive correlation between pre-BDI and pre-BAI (r = .44, p < .01). Which means that in measurement before intervention when depression increases, anxiety also increases. Also, there was a negative correlation between pre-BDI and pre-PANAS-positive affect (r = -.31, p < .01) and a positive correlation between pre-BDI and pre-PANAS-negative affect (r = .44, p < .01). This result indicates that in measurement before intervention when depression increases, positive affect decreases and negative affect increases. The results of pre-BAI showed that, there was a positive correlation between pre-PANAS-negative affect (r = .95, p < .01). Which means that in measurement before intervention when anxiety increases, negative affect also increases.

When the correlation of measurement after intervention for the groups was examined, it was seen that the post-BDI scores are positively correlated with the post-BAI scores (r = .70, p < .01). In addition, post-BDI scores negatively correlated with post-PANAS-positive affect (r = -.54, p < .01) and positively correlated with post-PANAS-negative affect (r = .72, p < .01). Post-BAI scores appear to be negatively correlated with post-PANAS-positive affect (r = -.33, p < .01) and positively correlated with post-PANAS-negative affect (r = .69, p < .01). These results indicate that in measurement after intervention, when anxiety scores increase positive affect scores decrease and negative affect scores increase.

3.3. Repeated Measures ANOVA for BDI

To test the first hypothesis repeated measures ANOVA was conducted to compare the effect of (IV) text message intervention on (DV) BDI score of experimental and control groups, before and after the intervention. The main effect of time [F (1,129) = 22.72, p = .00; *Wilk's* λ = .85, η_p^2 = .15] and the main effect of intervention [F (1,129) = 13.54, p = .00; η_p^2 = .10] on the BDI scores of the experimental and control groups are statistically significant. There was a significant time*intervention interaction effect on BDI scores among groups, [F (1,129) = 23.41, p = .00; *Wilk's* λ = .85, η_p^2 = .15]. The findings showed that compared to pre-BDI scores (M = 19.66, SD = 5.90) of the experimental group, the post-BDI scores (M = 13.07, SD = 8.39) were decreased. Compared to the pre-BDI scores (M = 20.12, SD = 5.71) of the control group, the post-BDI scores (M = 20.18, SD = 7.81) remained almost the same and even increased really slightly. Detailed information about the mentioned variables was given in Table 5.

Table 5. *Repeated Measures ANOVA for BDI*

Measure	Experimental		Control		$F(1,129)$	η_p^2
	M	*SD*	*M*	*SD*		
Pre-BDI	19.66	5.90	20.12	5.71	23.41***	.15
Post-BDI	13.07	8.39	20.18	7.81	23.41***	.15

Note. Pre and Post = measurement before intervention and measurement after intervention respectively; BDI = Beck Depression Inventory; η_p^2 = partial eta squared.
***$p < .001$.

To test the second hypothesis a repeated measures ANOVA was conducted to compare the effect of text message intervention on BDI scores, before and after the intervention in mild experimental, moderate experimental, mild control and moderate control conditions. For the analysis, 4 (group) X 2 (time) mixed-model repeated measures analysis of variance was applied; groups (mild experimental, moderate experimental, mild control and moderate control) were considered as the between-group factor, and time (pre-test and post-test) as the within-group factor. When the effect of the text message intervention on the BDI scores of the groups was examined, the main effect of group [F (3,127) = 49.68, p = .00; η_p^2 = .54], the main effect of time [F (1,127) = 12.21, p = .00; *Wilk's* λ = .91, η_p^2 = .09] and the effect of the time*group interaction on the post-test BDI scores of the individuals was found to be statistically significant [F (3,127) = 10.50, p = .00; *Wilk's* λ = .80, η_p^2 = .20]. The results of the mixed-model repeated measures ANOVA were shown in Table 6 in detail.

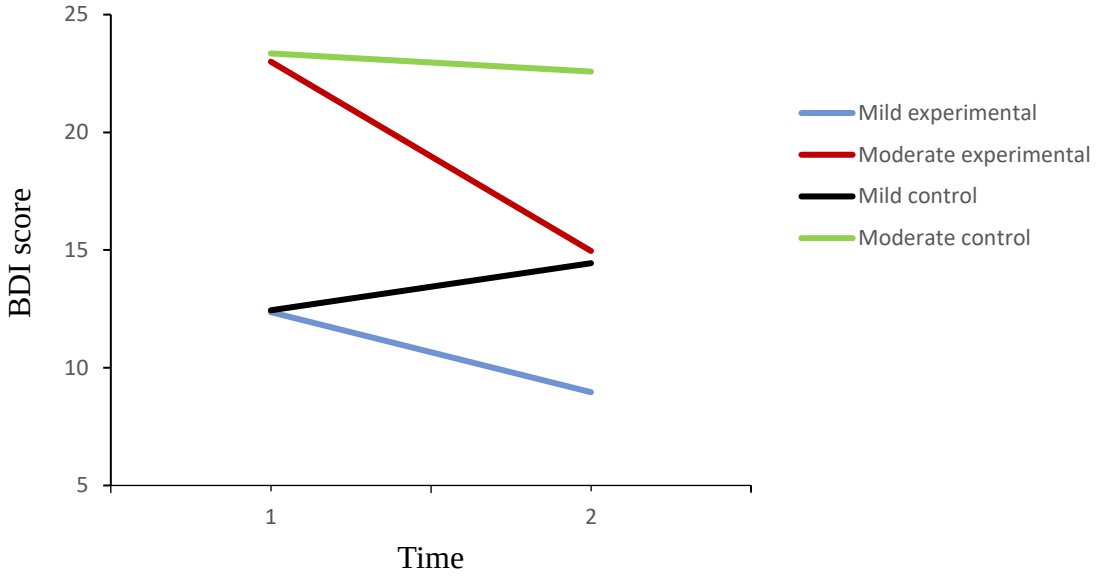
Table 6. *Mixed-Model Repeated Measures ANOVA for BDI*

BDI	*df*	*F*	*p*	η_p^2	Power
Between-subjects effect					
Group	3	49.68	.000	.54	1.00
Within-subjects effect					
Time	1	12.21	.001	.09	.93
Time X Group	3	10.50	.000	.20	.99

Note. η_p^2 = partial eta squared; Power = observed power computed using α = .05.

The mixed-model repeated measures ANOVA for BDI results indicates that the average BDI score of the mild experimental group in the post-test (M = 8.96) is lower than the pre-test (M = 12.36), and the post-test score (M = 14.96) of the moderate experimental group is lower than the pre-test (M = 23.00). There was no significant difference between the pre-test (M =12.44) and post-test (M = 14.44) BDI scores of the mild control group and the pre-test (M = 23.35) and post-test (M = 22.58) scores of the moderate control group. The graph of these results was presented in Figure 3.

Figure 3. *BDI score graph of the groups*



In Table 7, the differences in the mean BDI scores of the groups before and after the intervention were given. According to the results of the pairwise comparison of the pre-test and post-test scores of the groups obtained from the mixed-model repeated measures ANOVA analysis, the difference between the mean pre-test and post-test scores (MD = 8.04, $p < .05$) of the moderate experimental group is greater than the difference between the mean pre-test and post-test scores (MD = 3.45, $p < .05$) of the mild experimental group. There was no statistically significant difference in the mean BDI scores of the mild control and moderate control groups before and after the intervention.

Table 7. *Pairwise Comparisons of Pre-test and Post-test BDI Scores Between Groups*

Group	Mean Difference (pre-test–post-test)	Std. Error	*p*
Mild experimental	3.45*	1.64	.04
Mild control	-2.00	1.81	.27
Moderate experimental	8.04*	1.11	.00
Moderate control	.77	1.17	.51

*p < .05.

Since the message intervention was statistically significant on BDI scores between groups, a post hoc test was performed to find out in which group the intervention was more effective. According to the multiple comparisons of the Tukey post hoc test, there is a statistically significant difference between the moderate experimental group and the moderate control group (p = .00). On the other hand, in the mild experimental group, there is not a statistically significant difference with the mild control group (p = .17). Details of post hoc analysis can be found in Table 8.

Table 8. *Post Hoc Tukey Test Multiple Comparisons for BDI*

Group (I)	Group (J)	Mean Difference (I-J)	Std. Error	*p*
Mild experimental	Moderate experimental	-8.32*	1.09	.00
	Mild control	-2.79	1.34	.17
	Moderate control	-12.31*	1.11	.00
Moderate experimental	Mild experimental	8.32*	1.09	.00
	Mild control	5.53*	1.17	.00
	Moderate control	-3.99*	.89	.00
Mild control	Mild experimental	2.79	1.34	.17
	Moderate experimental	-5.53*	1.17	.00
	Moderate control	-9.52*	1.19	.00
Moderate control	Mild experimental	12.31*	1.11	.00
	Moderate experimental	3.99*	.89	.00
	Mild control	9.52*	1.19	.00

*p < .05.

3.4. Additional Analyses

Although the main purpose of this study was not included to intervene in the anxiety symptoms and affects of individuals, analyzes were also conducted to see whether the intervention had any effect on anxiety symptoms and affect.

3.4.1. Repeated Measures ANOVA for BAI

A mixed model repeated measures ANOVA was conducted to see if text messages had any effect on the BAI scores of the individuals in experimental and control groups. The time*intervention interaction on the BAI scores of the individuals was found to be statistically significant [F (1,129) = 15.88, p = .00; *Wilk's* λ = .89, η_p^2 = .11]. This result indicates that the average BAI score of the mild experimental group in the post-test (M = 7.68) is lower than the pre-test (M = 14.96), and the post-test score (M = 14.54) of the moderate experimental group is lower than the pre-test (M = 21.52). There was no significant difference between the pre-test (M =11.67) and post-test (M = 12.83) BAI scores of the mild control group and the pre-test (M = 21.65) and post-test (M = 21.93) scores of the moderate control group. This shows that BAI scores in the experimental groups decreased due to the message intervention, while there was no change in the control groups. The differences between the pre-test and post-test BAI scores of the groups were given in Table 9. The results of the mixed-model repeated measures ANOVA were shown in Table 10 in detail.

Table 9. *Pairwise Comparisons of Pre-test and Post-test BAI Scores Between Groups*

Group	Mean difference (pre-test–post-test)	Std. Error	*p*
Mild experimental	7.27*	2.34	.00
Mild control	-1.17	2.59	.65
Moderate experimental	6.98*	1.59	.00
Moderate control	-.28	1.68	.88

*p < .05.

Table 10. *Mixed-Model Repeated Measures ANOVA for BAI*

BDI	*df*	*F*	*p*	η_p^2	Power
Between-subjects effect					
Group	3	9.84	.00	.75	1.00
Within-subjects effect					
Time	1	9.36	.00	.07	.86
Time X Group	3	5.25	.00	.11	.92

Note. η_p^2 = partial eta squared; Power = observed power computed using $\alpha = .05$.

Since the message intervention was statistically significant on BAI scores between groups, a post hoc test was performed to find out in which group the intervention was more effective. According to the multiple comparisons of the Tukey post hoc test, there is no significant difference between neither mild experimental and mild control ($p = .99$) groups, nor moderate experimental and moderate control ($p = .16$) groups. Details of post hoc analysis can be found in Table 11.

Table 11. *Post Hoc Tukey Test Multiple Comparisons for BAI*

Group (I)	Group (J)	Mean Difference (I-J)	Std. Error	*p*
Mild experimental	Moderate experimental	-6.71*	2.19	.01
	Mild control	-.93	2.71	.99
	Moderate control	-10.47*	2.23	.00
Moderate experimental	Mild experimental	6.71*	2.19	.01
	Mild control	5.78	2.35	.07
	Moderate control	-3.76	1.79	.16
Mild control	Mild experimental	.93	2.71	.99
	Moderate experimental	-5.78	2.35	.07
	Moderate control	-9.54*	2.39.	.00
Moderate control	Mild experimental	10.47*	2.23	.00
	Moderate experimental	3.76	1.79	.16
	Mild control	9.54*	2.39	.00

*p < .05.

3.4.2. Repeated Measures ANOVA for PANAS

A mixed model repeated measures ANOVA was conducted to see if text messages had any effect on the PANAS scores of the individuals in experimental and control groups. The time*intervention interaction on the PANAS-positive affect scores of the individuals was found to be statistically significant [F (1,129) = 8.13, p = .01; *Wilk's* λ = .94, η_p^2 = .06]. The score of PANAS-positive affect of the experimental group increased after the intervention (M = 26.99) compared to before the intervention (M = 23.06). The score of PANAS-positive affect of the control group slightly decreased after the intervention (M = 22.39) compared to before the intervention (M = 22.57). The time*intervention interaction on the PANAS-negative affect scores of the individuals was found to be statistically significant [F (1,129) = 17.42, p = .00; *Wilk's* λ = .88, η_p^2 = .12]. The score of PANAS-negative affect of both the experimental group and control group increased after the intervention (M = 19.89, M = 25.10) compared to before the intervention (M = 9.07, M = 8.62) respectively. The results showed that the positive and negative affect of the people were changed according to the text message intervention.

Since the message intervention was statistically significant on PANAS scores between groups, a post hoc test was performed to find out in which group the intervention was more effective. According to the multiple comparisons of the Tukey post hoc test, there is no significant difference between neither mild experimental and mild control groups, nor moderate experimental and moderate control groups.

4. DISCUSSION

In this section, evaluations, and discussions about the results of the analyses to test the hypotheses mentioned in the introduction section were given. In light of the relevant literature, the results were interpreted. The evaluations of the results were made according to the ranking given in the results section. In other words, firstly the correlations among variables, and secondly the mixed-model repeated measures ANOVA results were discussed. Finally, the clinical inferences, strengths, and limitations of the research have been discussed and suggestions for future studies were given.

4.1. Correlations Among Variables

Pearson correlation analysis was performed to examine the relationships between variables. Results showed that both for experimental and control groups, both pre and post-BDI and BAI have a significant positive correlation indicating that as people's depression increases, their anxiety also increases. Similar results were found in previous studies examining the correlation between BDI and BAI (Beck et al., 1988; Fydrich et al., 1992; Ulusoy et al., 1998). Thus, this finding is consistent with the literature and quite common. As stated before, there are studies in different countries and with different samples indicating that depression is highly comorbid with anxiety. For example, according to the Netherlands Study of Depression and Anxiety, it was reported that 67% of people diagnosed with depression already had an anxiety disorder, and 75% had a lifetime anxiety disorder (Lamers et al., 2011). Moreover, in the US National Comorbidity Survey Replication, it has been reported that 57.5% of people diagnosed with major depression have at least one anxiety disorder (Kessler et al., 2007). In another study conducted with a Swedish sample, it was stated that 8.3% of 1201 people had comorbid depression and anxiety (Johansson et al., 2013). Therefore, the positive correlation between depression and anxiety was expected, and this is how it was found in this study.

When the correlation between PANAS and BDI was examined, it was found that PANAS positive affect was negatively correlated with BDI, and PANAS negative affect was positively correlated with BDI in both before and after the intervention in all groups. However, there was no correlation between PANAS positive affect with BAI in pre-intervention. This result is also consistent with the literature. Other studies in the literature analyzing the correlation of these three scales with each other found similar results (Beck et al., 1979; Gençöz, 2000). The correlation of PANAS with BDI for positive and negative

affect, and correlation with BAI only with negative affect can be explained as follows; Clark and Watson (1991) explain the similarities and differences of depression and anxiety. The similar feature is that negative affect is seen as common in both depression and anxiety. However, the distinctive aspect is that the decrease in positive affect is seen only in depression. Unlike what is stated here, a statistically significant negative correlation was found between the post-PANAS-positive affect score and the post-BAI score of the experimental group in this study. However, there was no such result for the control group. This result can be explained as follows; the aim of this study is to reduce depressive symptoms by increasing the positive affect of people. For this purpose, a text message intervention with content that helps to increase their positive affect was applied to the people in the experimental group. Therefore, it is quite normal for people in the experimental group to increase their positive affect while their anxiety decreases because they receive the intervention.

4.2. Repeated Measures ANOVA for BDI

To test the first hypothesis a one-way repeated measures ANOVA was conducted to compare the effect of text message intervention on BDI score of experimental and control groups, before and after the intervention. The results of the analysis show that the main effect of time, intervention and the interaction effect of time and intervention were statistically significant. Accordingly, it can be said that the message intervention makes a difference in the BDI scores in terms of groups (experimental and control) in which the participants were randomly assigned. There was a statistically significant decrease in the BDI scores of the experimental, compared to the BDI scores of the control group after the intervention. Therefore, the first hypothesis was confirmed.

As stated before, the messages used in this study include the components of CBT and the methods used in CBT sessions because CBT is one of the most investigated and empirically supported therapy approach to reduce the symptoms of depression (Ciharova et al., 2021; Dobson, 1989; Fenn & Byrne, 2013). Thus, CBT is effective in depression (Embling, 2002; Hauksson et al., 2017; Honyashiki et al., 2014; Oud et al., 2019; Rupke et al., 2006; Twomey et al., 2014) and CBT-containing text messages is also effective in reducing symptoms of depression (Aguilera & Berridge, 2014; Aguilera et al., 2017; Aguilera & Muench, 2012; Aguilera & Muñoz, 2011; Agyapong et al., 2017; Hartnett et al., 2017; Richmond et al., 2015; Whittaker et al., 2012). For this reason, it was thought that the text messages used in the study would have a reducing effect on the depressive symptoms

of the individuals, and as expected, there was a statistically significant reducing effect as a result.

The reducing effect of the text messages may be related to the fact that CBT is a problem-focused and structural therapy approach, and naturally, the structure of text messages was in this manner. Each session and the whole process is structured in CBT so that the treatment can be more beneficial (Fenn & Byrne, 2013). It is also easy to learn and apply because it has a systematic structure. While determining the order of the messages, the session structure of CBT, and the order of the discussed subjects in each session, were taken as a basis. The progression of the messages according to this system and structure may have been useful in terms of teaching people a certain mindset and enabling them to think in this way day by day. One participant mentioned about this subject as follows; "*The suggestions you have written are topics that we can easily apply in our daily life and that will make our life easier. I will try to apply them as much as I can*". In short, it was tried to teach people what is taught in CBT sessions. The structural model that CBT establishes between emotion, thought, and behavior may naturally affect people's minds to start thinking in this structure. For example, in the current study one participant mentioned that, "*The fact that our negative or positive thoughts on that day affect whether our decisions are wrong or right*.". This may indicate that this person understands the mentality of the cognitive model. In short, the systematic cognitive behavioral thinking mindset of CBT may have had an influence on the decrease in the symptoms of depression.

In CBT people take an active role in their own treatment and try to become their own therapists over time (Leahy, 2017). This could be another reason for the effectiveness of the intervention in the current thesis. Therapists try to teach people how to find their automatic thoughts and test their reality and educate them to replace their core beliefs and automatic thoughts with more functional ones (Flynn & Warren, 2014). This feature of CBT was at the core of the text messages used in this study to reduce the symptoms of depression. In short, people were encouraged to become their own therapists. The fact that people try to realize their automatic thoughts, emotions, and beliefs through their own efforts and try to change them may have made people feel better. For instance, one participant said, "*Sometimes I calmed myself by reading these messages and they made me realize some things*." Another participant said, "*I did some of the suggested techniques and it made me feel better*." In addition, they may have realized that they are trying to cope with their problems and that they have achieved it. For instance, one participant said, "*It helped me figure out how to deal*

with negative situations and thoughts." Thus, they may have felt that they had become their own therapists. As a result, there may be a decrease in their symptoms of depression.

Maybe the intervention was effective because of another feature of CBT including the emphasis on the here and now and monitoring oneself (Fenn & Byrne, 2013; Kobak et al., 2015). For people to acquire skills they have learned during the session such as emotion regulation and being here and now, they must be able to practice these skills between sessions and adapt them to their daily lives (Aguilera & Muñoz, 2011). This is the biggest reason why messages were sent regularly every day at specific times for thirty days. No matter what time the messages are read, as soon as people read the message, they may have moved away from the chaos of that day and focused on that message. Some messages may have brought them here and now. For example, one participant gave feedback about being here and now as " *Incoming messages made me think and feel comfortable at that moment*". When people try to practice what is written in the messages, they may try to integrate it into their daily life. Even if the person does not do what is written in the message, at least a certain time in a part of the day, the person may have taken time for oneself. More than one participant gave feedback on this subject as "*It made me stop and think for a moment*", "*It made me evaluate my feelings at that moment*", "*It created an instant awareness*" and "*It helped me regulate my emotions at that moment*". Trusting, accepting, taking care of, and taking responsibility for oneself are important in the treatment of depression. In fact, Dorothy Rowe (1996) described depression as a prison and said that one way to get rid of this prison is to take one's own responsibility. Even said that the person should only "be oneself". This is exactly what messages tried to do. To encourage people to think about themselves during the day. In fact, one participant said, "*I remember talking to a few of my friends about the messages and exchanging ideas. As a result of some of the information you provided, I researched things. It prompted me to research*." This may show that this person has started to think about one's own needs. In fact, this person does research about them, and has taken a responsibility about it. Sometimes people cannot find a single moment to think about their own needs during the day. However, when they read the message, they may stop to think about themselves and take time for themselves. Thus, there may have a decrease in their depressive symptoms.

Another important factor for self-monitoring in the treatment of depression is homework. Studies showed that self-monitoring has a huge impact on behavioral change (Cohen et al., 2013; Michie et al., 2009). The ability of people to monitor themselves is

provided by homework. According to a meta-analysis, people who do their homework regularly are associated with more significant results from CBT than those who do not (Kazantzis et al., 2000, 2016). Because homework provides a bridge between the therapy session and the time outside of therapy. In addition it is also a reminder. It allows people to practice what they have learned in the time between therapy sessions, think about their thoughts and feelings by self-monitoring, and test how they can cope with difficulties without therapy (Garland & Scott, 2002). One participant gave feedback as "*I already knew the techniques written in the messages. However, learning alone is not enough. It was very good for me to practice that the messages reminded me of the techniques and asked small facilitating questions*". This feedback indicates that even though therapy techniques have been learned, the messages are a reminder to practice them outside of therapy.

The messages used in this study can be thought of as the same as homework. Because the content of the messages includes behavioral activation, behavior experiments, or goal setting which were given as homework in CBT sessions. In addition, the messages are a reminder for people to take a break from what they are doing, to think about themselves, to monitor their feelings and thoughts, and to make the instructions written in the messages. Some participants mentioned that "*The messages were a good reminder for me to apply the techniques I know*" and "*The messages were a good reminder for me to catch and notice the negative automatic thoughts and thought errors that crossed my mind during the day*". In the literature, it shows that daily text messages added to psychotherapy are especially useful in reminding the homework given in therapy, enabling people to monitor themselves, build skills and develop self-awareness (Aguilera & Berridge, 2014; Aguilera & Muench, 2012). It was reported that for people who received text messages in additionally their CBT treatments, their participation in the sessions increased. In addition, they practiced skills that have learned in the session throughout the week and felt more supported and motivated when compared to those who did not receive text messages (Aguilera et al., 2017). Since messages are sent regularly every day, even if people forget what they wrote in the previous message, the new message may have been a reminder of the previous messages. Moreover, the fact that messages were sent in an environment that will never be lost or deleted and where people can go and read the messages again and again whenever they want. More than one participant stated, "*Since the messages were sent via the WhatsApp application, I did not miss any of them. I could read the message whenever I wanted*", "*I went back and looked again the messages*", and "*I still open and read it when I need it*". This may have enabled people to

have constant access to what is written in the messages and accordingly, to gain psychological thinking skills and develop self-awareness in time.

Messages may have an impact on symptoms of depression, as people may feel like someone was taking care of them. As Rogers (1957) stated, three elements are necessary and sufficient for behavior change in therapy. These are empathy, genuineness, and unconditional positive regard. These elements are common features required for all psychotherapy approaches. In a study, participants who received messages regularly for a week reported feeling cared for and supported (Aguilera & Berridge, 2014). The following feedback was received from the participants; "*I can also say it was nice to have someone feel interested in me and my thinking process every day*", "*Getting messages was like an invisible support for me*", "*It made me feel happy and safe to know that someone is trying to encourage me*", "*It was very good for me to have someone who reminds me to check myself, motivate me and normalize things for me*". The content of the messages used in the current study was designed to not judge people, to make them feel understood, and to accept them unconditionally. An example message would be: "*Anyone can make mistakes in life. What matters is your reaction to the mistake. That thing happened and it's over. Be kind to yourself, you may not always be able to act in the right way. Remember, you've made mistakes so far.*" Therefore, people may have thought that they were empathized with, felt supported, and accepted. Even if the messages were sent automatically, people may have felt that these messages were sent by their therapist and that there was someone taking care of them. For these reasons, there may have a decrease in the symptoms of depression.

The effect of messages on depression symptoms may be related to the expectation that people will be treated by an expert. According to Ilardi & Craighead (1994), when a depressed person hears about the treatment process from a therapist who is seen as an 'expert', may develop positive expectations for recovery. The expectation can create hope in that person and lead to improvements in the emotional state and naturally in the symptoms of depression. Lambert (1992) has studied the therapeutic factors that enable people to improve in psychotherapy. As a result, he attributed 15% of the improvement to the expectation effect, which means the knowledge that the person is being treated. Other studies have also found that clients' expectations from the therapist (for example, knowing that the therapist will help them solve their problems) are effective on therapy outcomes (Greenberg et al., 2006; Patterson et al., 2014). For instance, in a study, a client said, "*I had an expectation that my therapist would help me dig into my problems. When s/he did this, I felt*

satisfied" (Westra et al., 2010). In the invitation message in the current study, the participants were informed that the researcher is a clinical psychology graduate student, the study aimed to reduce the symptoms of depression and some messages will be sent at specific times for thirty days. This information may have created an expectation that the researcher will make them feel better through the messages. In the current study, the following feedback was received from the participants that they had expectations; "*Because I'm used to receiving messages, I have waited every day for the message to come. I was a little relieved when I saw it*", "*The messages made me wonder every day what kind of message will come today*", "*Sometimes I wait for the message to come*", "*For about one month, I sometimes waited for the messages. It was an enjoyable period*", "*I looked forward to receiving messages every day.*" These feedbacks show that the expectations of the participants were formed. They both expect to receive a message from their therapist (the researcher), and they also have an expectation about the content of the message. As mentioned earlier, these expectations of the participants may have contributed to the reduction of their depressive symptoms.

Lewinsohn's theory (1985) has another perspective on the treatment of depression. According to this theory, one of the factors that cause people to continue their depressive states is a lack of positive social reinforcement and social interaction. As the positive reinforcements from the people's environment decrease, people become more depressed. Depression is a vicious cycle in which people cannot receive positive reinforcements from the environment because they give up doing positive activities and they do not want to do these activities because they cannot receive positive reinforcements. For this reason, depressed people should be directed to positive activities that will keep them active, and as a result, they should be provided with positive reinforcements by engaging in social interactions. In this study, the content of the messages was also intended to activate people, encourage positive activities, and give positive reinforcements. For example, one of the messages sent to reactivate people is as follows; "*Set small and step-by-step goals for your future self. That goal might be to drink a glass of water as soon as you wake up tomorrow morning. The other day's goal may be to wash your face after drinking water. You will feel good when you see that you can achieve these goals*". The following message can be an example of encouraging people to do positive activities; "*You may feel that activities you used to enjoy are not giving you pleasure now. Write down three of the activities that are good for you on a piece of paper. Choose one of them. Make a plan for your chosen activity. For example, you may like to listen to music. You can open and listen to your favorite song*

or start making a new list of different songs". An example of messages that aim to give positive reinforcement to people can be: "*Stand up and look in the mirror. Find three parts of your body that you like the most. Check out these three parts. Why did you choose these parts? Try to discover what you like the most. Then make the most ridiculous face against the mirror! Laugh at yourself. Everything is fine*". These features of the messages may have activated the people in the experimental group and enabled them to do positive activities and thus to engage in social interaction. As a result, they may have received positive reinforcement from their environment. Therefore, there may have been a decrease in depressive symptoms.

In the second hypothesis it was expected that at the end of the text message intervention, the depression scores of people with moderate depression in the experimental group will decrease more than those with mild depression. To test the second hypothesis the mixed-model repeated measures ANOVA for BDI was conducted. When the effect of the text message intervention on the BDI scores of the groups was examined, the main effect of group, the main effect of time, and the effect of the time*group interaction on the post-test BDI scores of the individuals were statistically significant. These results show that message intervention is also effective between groups (mild experimental, moderate experimental, mild control, and moderate control). Considering the main effect of time, pairwise comparisons of the analysis showed that there is a statistically significant decrease in post-BDI scores compared to the pre-BDI scores of the mild experimental and moderate experimental groups. However, the mean difference between the pre-BDI and post-BDI scores of the moderate experimental group was greater than that of the mild experimental group. There is no statistically significant difference was found in the mild control and moderate control groups. Since the message intervention was statistically significant on BDI scores between groups, a post hoc test was performed to find out in which group the intervention was more effective. According to the multiple comparisons of the Tukey post hoc test, considering the interaction effect of time*group, there is a statistically significant difference between the moderate experimental group and the moderate control group. However, there is no significant difference between the mild experimental group and the mild control group. This shows that receiving messages helped people with moderate depression to reduce their depressive symptoms. However, messages did not have a statistically significant effect on the reduction of depression symptoms in people with mild depression. Therefore, based on this result, although no effect was found in mild depression,

the second hypothesis was confirmed since the intervention had a reducing effect on depression symptoms in moderate depression.

As mentioned before, there are studies in the literature stating that as the level of depression increases, the efficiency of therapy increases (Bower et al., 2013; de Maat et al., 2007; Karyotaki et al., 2021). However, some outdated studies are showing that psychotherapy, especially CBT, is better for people with less severe depression, but these studies generally compared psychotherapy and medication treatment (Elkin et al., 1995; Thase et al., 1991). Even these studies' findings about which level of depression patients benefit more from a single treatment method are not very clear. Similar to the findings of the current study, a meta-analysis reported that people with moderate depression had a significant decrease in their depressive symptoms when they received only psychotherapy or both psychotherapy and medication, but no difference was found in people with mild depression (de Maat et al., 2007). Otherwise, a concept that can be considered as "low-intensity treatment" has been introduced recently in the literature (Bower & Gilbody, 2005). The term low-intensity treatment includes less usage of the specialist therapist's time in a more cost-effective way. It is generally based on CBT and delivered through health technologies with the limited guidance of therapists (Bower et al., 2013). That is, low-intensity treatment includes internet-based CBT, self-help books, group therapies, informative videos, interactive interventions, and advice clinics (Bennett-Levy et al., 2010; Bower et al., 2013). As stated before, there are many studies show that internet-based interventions are effective in reducing symptoms of depression (Agyapong et al., 2017; Aguilera & Muñoz, 2011; Hartnett et al., 2017; Richmond et al., 2015; Whittaker et al., 2012). When low-intensity treatments were investigated, it was found that people with high levels of depression in the baseline benefited more from the treatment than those with lower levels of depression (Bower et al., 2013). In a more recent meta-analysis with similar findings, it was stated that receiving internet-based CBT, which can be considered low-intensity treatment, provided a significant reduction in depressive symptoms in people with moderate depression, and there was no difference in people with mild depression (Karyotaki et al., 2021). The intervention in this study can also be considered a low-intensity treatment, as it is a written, mobile phone, and internet-based intervention with limited therapist support. Thus, in the current study, similar results were found in the other studies in the literature.

Considering the possible reasons why the message intervention in the present study was effective in moderate depression but not effective in mild depression, more than one factor comes to mind. As mentioned before, the intensity of depressive symptoms of people with mild depression according to DSM-5 is distressing but manageable, and these people have few symptoms (APA, 2013). At the same time, it affects the functionality of people in daily life at a quite low level. Therefore, people with mild depression can continue to do the things they do on a daily basis, as their functionality is not impaired. They can continue to do most of the activities they enjoy. They may already have people who provide social support to them and continue to meet with these people and share personal and emotional problems with them. When asked, they may say that they are just in a low mood and sometimes feel down, or reluctant. The person may not even be aware that they are depressed. Since the research was conducted with people living in Türkiye, the economic crisis, the increase in the rate of violence against women, the inability to find a job, and the devastating natural disasters should also be taken into consideration. Before the intervention began, the participants were asked whether they had experienced any emotionally challenging event in the last 1-2 weeks, and most of the participants mentioned the terrorist incidents in the country, economic difficulties, and terrifying events in the media. That is why it is very unlikely that a person living in Türkiye will not have at least a few of the symptoms of depression. For a person living in Türkiye, some depressive symptoms such as feeling sad or hopeless, no longer enjoying the activities that were enjoyable before, fatigue, and difficulties in concentration have become normal. In summary, mild depression is now normalized in Türkiye. However, despite all this, most people living in Türkiye continue to maintain their lives as before. For this reason, it is not an unexpected result that the message intervention did not have any effect on the symptoms of mildly depressed people living in Türkiye and are now accustomed to living with these symptoms.

Moreover, we cannot expect anyone to have a zero depression score. Everyone has a certain amount of depression. People with mild depression already had a low depression score from the very beginning and their functioning was not as impaired as those with moderate depression. For this reason, even though people with mild depression voluntarily participated in the research, they may have never applied or even read the messages, because they thought that they did not need to do the things written in the messages, or thought that they were already doing what is written there. In short, they may not even feel depressed enough to need the message intervention. In this situation, it would not be logical to expect

a significant decrease in mild depression, even if the message intervention has been applied. However, it is more possible to expect the intervention to be effective in moderate depression because more depressive symptoms are seen in moderate depression. Although not as significant as in severe depression, the functionality of these people is severely impaired and people have difficulty in managing these symptoms. People with moderate depression may need a push to get back to functioning in their life, need normalization of their feelings and thoughts to feel better, and want to know that someone is taking care of them and understanding them. They may be waiting for someone to show a way to find solutions to their problems and a shred of hope from someone that everything will get better. The fact that the nature of the messages is informative about depression and depression symptoms, supportive of the problems people experience, offering some ways to find solutions, and enabling people to take action may have been effective on the depressive symptoms of people with moderate depression.

4.3. Additional Analyses

4.3.1. Repeated Measures ANOVA for BAI and PANAS

A mixed model repeated measures ANOVA was conducted to see if text messages had any effect on the BAI and PANAS scores of the individuals in different groups. The time*group interaction on the post-test BAI and PANAS scores of the individuals was found to be statistically significant. However, when groups were compared, no difference was found between the experimental and control groups for BAI and PANAS scores. This can be explained as follows, as mentioned before, depression and anxiety are disorders with high comorbidity (Lamers et al., 2011). Although the main purpose of the study is to reduce the depressive symptoms of people, there are also purposes such as improving the well-being of people, supporting them, and gaining new and functional cognitive skills. For this reason, the anxiety symptoms of people who receive messages may also naturally decrease after the intervention. In addition, there was an increase in the PANAS-positive affect of each experimental group after the intervention. This is an expected result, just like the decrease in anxiety, because the positive affect of the people was tried to be increased via messages in the study. However, no difference was found between the experimental and control groups for PANAS-negative affect scores. The reason for the increase in PANAS negative affect scores in each group after the intervention may be due to the economic problems experienced in our country or other stress factors such as exams or work that individuals have difficulty with individually.

4.4. Clinical Implications

The greatest importance of the current study in terms of clinical implications is that it shows that there can be an alternative intervention method other than traditional face-to-face therapies or medication in the treatment of depression. As mentioned before, traditional face-to-face therapies have limitations that prevent people from reaching these therapies, although there is an existing therapy that can treat them (Kohn et al., 2004; Mohr et al., 2006). These limitations are summarized as follows; not being able to find time to go to therapy, not being able to afford the therapy fees, it takes too much time to go to the therapy session, fear of being stigmatized, being afraid of the reactions from the social environment, having a relative to take care of at home, and so on (Barney et al., 2009; Collins et al., 2004; Delgadillo et al., 2018; Khazaie et al., 2016; Roe et al., 2006). On the other hand, the message-based intervention method used in this study is capable of preventing these barriers in terms of many features. The method used in this study is easy and fast to apply, people do not have to go from place to place to receive this intervention, it reaches people as long as they have a phone and internet access, it is low-cost compared to face-to-face therapies, it takes less time of both the person receiving the therapy and the specialist, it is a more confidential method, people do not need to be afraid of going to therapy and being excluded by their environment. In summary, an intervention has been developed that will constitute the first step of a treatment method that can be applied to people who cannot reach psychological help for any reason.

Another clinical outcome is that by using this method, people can be intervened before their depression worsens. As with any physical health problem, it is important to intervene with depression in the early stages and before it becomes chronic. Because as the level of depression becomes more severe, seeking and continuing treatment decreases, and it takes much longer for the person to benefit from treatment (Zimmerman et al., 2018). The message intervention used in this study can be considered as first aid. When people seek treatment while their depression is still mild, this method can be intervened directly and their psychological health can be stabilized. Since this method requires a short amount of time, it is also faster and easier to apply, it is possible to prevent depression become more severe by intervening at the beginning of depression.

In the literature, there are studies in which text message intervention was added in addition to an existing treatment method such as psychotherapy or medication, and this intervention supports the existing treatment, increases the participation of people in

treatment and their willingness in therapy (Aguilera et al., 2017; Aguilera & Berridge, 2014; Aguilera & Muñoz, 2011). Since the message intervention used in this study was effective in reducing the symptoms of depression, it can be used in addition to psychotherapy or medication to support the treatment processes of people who are already in for depression.

Although there are controversial findings in the literature about which level of depression benefits more from therapy, it was found that people with moderate depression benefit more from low-intensity treatment such as internet or mobile phone-based CBT (Bower et al., 2013; Karyotaki et al., 2021). In the current study, mobile phone-based message intervention, which can be considered a low-intensity treatment, was performed and it was found that people with moderate depression benefited more from this intervention. In short, it supports the findings in the literature. Therefore, when this intervention method is going to be used, it may be preferable to use it primarily for people with moderate depression compared to people with mild depression. Apart from these, in order to be diagnosed with major depressive disorder, the person must meet 5 of 9 DSM-5 diagnostic criteria. People with less than 5 symptoms cannot be diagnosed. However, having fewer than 5 symptoms does not mean that they do not have depression. These people can be overlooked because they are diagnosed with depression according to the DSM-5. Because people cannot get the diagnosis of depression, they may not receive the necessary medication or psychotherapy treatment. People with moderate depression stay below the threshold because they do not meet the necessary 5 criteria and therefore may not be diagnosed. Therefore, it is an important finding that this intervention is effective in moderate depression.

In addition to all these, although the main purpose of the study did not include reducing anxiety symptoms, it was observed that the intervention had a reducing effect on anxiety symptoms as well as depression symptoms. Since depression and anxiety were highly comorbid, it was an expected result that while the symptoms of depression decreased, the symptoms of anxiety also decreased. When viewed from a perspective above the diagnoses, instead of developing a separate intervention method for each diagnosis, this intervention can be used to reduce both depression and anxiety symptoms of people.

4.5. Strengths and Limitations of the Current Study, and Suggestions for Future Studies

It is thought that the current study contributes to the literature in several ways. First, the a priori power analysis determined the number of required participants as 128 for the current study. However, 131 people were reached. This number is even higher than the

number of people determined by the power analysis. Secondly, the messages in the message intervention were sent from an environment that will never be deleted or lost. This feature gave people the opportunity to open and read the message at any time and even go back and read old messages. Third, as mentioned before, according to Digital 2022 Global Overview Report, 95.5% of people in Türkiye have access to the internet from their mobile phones (We Are Social, 2022). WhatsApp application was chosen for sending messages because WhatsApp application was the most used application with a rate of 93.2% in recent years. Before this application was chosen, it was observed that people did not check their text message boxes or even did not open them at all. However, they open the WhatsApp application to communicate with their relatives at any time of the day, even for a short time. Even, according to The British Chamber of Commerce Türkiye (2017) people check their phones 78 times a day, which means every 13 minutes in Türkiye. Moreover, due to the nature of the WhatsApp application, people do not have a chance to pass without seeing a message coming to them. In fact, when the application is opened, some of the message content appears on the phone screen, even with a small number of words. This prevents people from not seeing the messages at all. In addition, the participants were asked to turn on the read receipt of messages (two blue check marks) on the WhatsApp application before the study started and people who did not agree to turn on this feature were not included in the study. At the end of the intervention process, there was no participant who did not turn on the blue check marks feature. Thus, the possibility of people not reading the messages is prevented.

One of the strengths of the study is that there is only a pilot study (Sakarya et al., 2013) and a master's thesis (Onus, 2019) conducted in Türkiye on this subject. In the pilot study, message intervention was examined in addition to the treatment of people using a medication, but statistical analyses could not be made due to the small number of participants. In addition, in the master's thesis, anxiety, and depression symptoms of first-time fathers were studied. In this respect, the present study is the first study that aims to reduce depression symptoms by using message intervention in Turkish participants with depression symptoms. In other studies, in the literature on message interventions, generally, the effect of message intervention has been examined in addition to the existing therapy processes of individuals (Aguilera et al., 2017; Jurinec & Schienle, 2022; Richmond et al., 2015). Other studies have looked at the effect of the intervention on depression with comorbid psychological disorders such as anxiety, substance use disorder, or psychosis

(Aguilera et al., 2021; Agyapong et al., 2020; Alvarez-Jimenez et al., 2014). In others, the effect of message intervention was examined to reduce mothers' anxiety and depression symptoms before or after pregnancy (Barrera et al., 2021; Hussain-Shamsy et al., 2020). Therefore, according to the researcher's knowledge, this study is the first to work with a message-based intervention aimed at reducing the symptoms of depression in people who have not received any treatment, such as psychotherapy or medication.

Another strength of the present study is that; the method used in the present research is applicable in the clinical setting, as well as in companies, business environments, or occupational settings, which are the fields of expertise in industrial psychology. For instance, depression has a negative impact on employees' focus on work, regular attendance, functionality, and productivity at work (Birnbaum et al., 2010; Lerner et al., 2004). Thus, as employees' productivity decreases, companies are naturally adversely affected by this. Moreover, there is evidence that even a minor level of depression negatively affects people's work performance (Beck et al., 2011). Companies facing these problems can use the message intervention in the current study to control their employees' depression in a cost-effective, easy, and rapid way. In this way, the depression of the employees can be prevented from reaching more severe levels with the message intervention and thus, the decrease in the productivity and work performance of the people is prevented. Apart from this, a different area where message intervention can be used may be people who apply to hospitals and have chronic diseases. For example, this intervention can be given to support people with diseases such as cancer, where their body immunity is low and people are not very comfortable going out.

In this part, the limitations of the study and suggestions for future research are given together. Despite the strengths, the current study also has some limitations. Depression is one of the psychological disorders with a high probability of relapse. It has been observed that depression, which cannot be fully treated, relapses within approximately 9 months or 1 year (Paykel, 2008). In fact, as the level of depression worsens, relapse can be seen sooner (Taylor et al., 2004). That's why it's important to follow-up on people even if the treatment is over. One of the limitations of the current research is that there was no follow-up measurement. For this reason, a follow-up study can be done with the same sample in the future, or studies using message intervention in the future can add a follow-up to the research.

This study was mainly conducted on symptoms of depression. Although the messages were designed to target depression, reduction in anxiety symptoms was also seen. This result is an expected result since depression and anxiety have high comorbidities. However, this result brings to mind the idea that a similar intervention can be developed for anxiety in future studies. In addition, it can be examined whether the messages that will be designed by targeting anxiety will similarly affect depression. In addition, personality traits can be measured while making message interventions. If interventions are found to be more effective in people with certain personality traits, this finding will be valuable for targeting message interventions.

In this study, the reasons for the decrease in depression scores of individuals were discussed in light of the literature and interpreted in line with the feedback of the participants. However, what other factors cause this decrease in depression symptoms has not been investigated. Future studies may add variables such as quality of life, activity level, nature-relatedness, social relationships, self-perception, cognitions, beliefs, coping strategies, or subjective well-being to reveal these reasons. If these variables will be added, mediator and moderator analyses can be performed to understand how the variables affect the result.

Although the most widely used and researched scales in the field of psychology were used in the current research, the fact that all scales are self-report scales can be seen among the limitations of the research. The internal consistency coefficient of the BDI scale completed by the participants before the intervention was found to be lower than .70. This should be considered as a limitation of the study. Another limitation of the study may be; the sample of this study did not include people who were diagnosed, took medication, or continued psychotherapy, and because of that this study is the first of its kind. Although message intervention added to the treatment of depression is a subject that is already being researched in the world, it is an important issue that needs to be continued to be studied. Moreover, it should also be researched in Türkiye because nowadays the technology is highly developed, the importance of such internet-based applications has increased and the need for these applications has also increased.

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APPENDICIES

APPENDIX 1: SOCIAL MEDIA ANNOUNCEMENT

Merhaba! Depresyon belirtilerini azaltmaya yönelik bir kısa mesaj müdahalesi çalışmasına davetlisiniz! Çalışmada sizden bazı ölçekler doldurmanız istenecektir. Çalışma yaklaşık 10 dakika sürmektedir. Paylaşacağınız bilgiler anonim olacak ve tamamen gizli tutulacaktır. Çalışmaya katılmak için 18 yaşından büyük olmanız, ana dilinizin Türkçe olması, herhangi bir psikiyatrik ilaç kullanmıyor, şu an bir psikolog ya da psikiyatrist desteği almıyor olmanız ve cep telefonu kullanıyor olmanız gerekmektedir. Bilimin gelişmesine katkıda bulunacağınız için şimdiden teşekkürler.

APPENDIX 2: INFORMED CONSENT FORM

Sayın Katılımcı,

Bu çalışma Başkent Üniversitesi Klinik Psikoloji Yüksek Lisans programı öğrencisi Özlem İlkay tarafından Prof. Dr. Okan Cem Çırakoğlu danışmanlığında yürütülmektedir. Çalışmaya katılmak için 18 yaşından büyük olmanız, ana dilinizin Türkçe olması, herhangi bir psikiyatrik ilaç kullanmıyor, şu an bir psikolog ya da psikiyatrist desteği almıyor olmanız, cep telefonu kullanıyor olmanız, **cep numaranızı araştırmacıyla gönüllü bir şekilde paylaşıyor olmanız**, WhatsApp uygulamasında mesajların okundu bilgisini açmayı kabul ediyor olmanız gerekmektedir. Çalışmanın amacı kısa mesajların, kişilerin duygu durumları üzerindeki etkisini incelemektir.

Araştırma kapsamında öncelikle katılımcılardan çeşitli ölçekler doldurması istenecektir. **Doldurulan ölçeklerden alınacak puanlara göre katılımcıların araştırmaya dahil olup olmayacağı belirlenecektir. Araştırmaya dahil olan katılımcıların cep telefonu numaralarına araştırmanın başlayacağı gün ile ilgili kısa mesaj gönderilecektir. Araştırmaya dahil olunduğu takdirde katılımcıların verdiği telefon numarasına 1 ay boyunca, saat 9.00, 12.00, 15.00 ya da 18.00 saatlerinden herhangi birinde, WhatsApp uygulaması üzerinden günde 1 defa kısa mesaj gönderilecektir. 1 aylık sürecin sonunda, en son kısa mesaj gönderildikten sonra, sonraki gün katılımcıların cep telefon numarasına bir link gönderilecek ve en başta doldurulan ölçekleri tekrar doldurması istenecektir.** Çalışma katılımcılar için herhangi bir risk faktörü ya da rahatsız edecek bir soru içermemektedir. Bu çalışmanın sonunda katılımcılar arasından çekilişle belirlenecek olan 5 kişiye 50 TL'lik Migros hediye çeki verilecektir.

Bu çalışmada katılımcılardan telefon numarası hariç kimlik belirleyici hiçbir bilgi istenmemektedir. Katılımcıların araştırma sırasında verdileri cep telefonu numarası bilgisi tamamen gizli tutulacak, veriler anonim olarak analiz edilecek ve hiç kimseyle paylaşılmayacaktır. Çalışmaya katılmak tamamen gönüllülük esasına dayanmaktadır. Katılımcılar bir sebepten dolayı kendini rahatsız ederse çalışmadan çekilmek ya da çalışmayı yarıda bırakmak konusunda serbestlerdir.

*Çalışmadan çekilen katılımcıların verileri analize dahil edilmeyecek ve çekilen katılımcılara hediye çeki verilmeyecektir. Hediye çeki kazanabilmek için araştırma boyunca tüm yönergelere uyarak araştırmanın tamamlanması gerekmektedir.

Çalışma hakkında daha fazla bilgi almak ya da herhangi bir soru sormak için Özlem İlkay ile iletişim kurabilirsiniz.

Bu formu imzalayarak yukarıdaki bilgileri okuduğunuzu ve bu çalışmaya tamamen gönüllülük esasıyla katıldığınızı kabul etmiş olacaksınız. Bu çalışmaya katıldığınız için şimdiden teşekkür ederiz.

○ Okudum, araştırmaya katılmayı kabul ediyorum.

Araştırmaya katılabilmeniz için araştırmacı ile cep telefonu numaranızı paylaşıyor olmanız ve WhatsApp uygulamasında mesajların okundu bilgisini açmayı kabul ediyor olmanız gerekmektedir. **Cep telefonu numaranız sadece 30 gün boyunca mesaj gönderme amaçlı kullanılacak, tamamen gizli tutulacak ve hiç kimseyle paylaşılmayacaktır.** Araştırmaya dahil olduğunuz durumda verdiğiniz numara üzerinden araştırmacı sizinle iletişime geçecektir.

Cep telefonu numaranız:

APPENDIX 3: DEMOGRAPHIC INFORMATION FORM

1. Cinsiyetiniz: Kadın Erkek Diğer Belirtmek İstemiyorum

2. Yaşınız:……..

3. Medeni durumunuz: Evli Bekar Boşanmış Dul

4. Cep telefonunuzu bir günde ortalama ne kadar süre kullanıyorsunuz?

( ) 1 saatten az ( ) 1-3 saat ( ) 3-6 saat ( ) 6 saatten fazla

5. Gün içerisinde cep telefonunuza gelen WhatsApp mesajlarını kontrol ediyor musunuz? Evet Hayır

6. Şu an bir psikiyatrist desteği alıyor musunuz? Evet Hayır

7. Şu an bir psikolog desteği alıyor musunuz? Evet Hayır

8. Şu an kullanmakta olduğunuz psikiyatrik bir ilaç var mı? Evet var Hayır yok

9. Daha önce bir psikiyatrist desteği aldınız mı? Evet Hayır

10. Daha önce bir psikolog desteği aldınız mı? Evet Hayır

11. Daha önce herhangi bir psikiyatrik bozukluk tanısı aldınız mı? Evet Hayır

12. Tanı aldıysanız ne tanısı aldınız? ……..

13. Daha önce psikiyatrik bir ilaç kullandınız mı? Evet Hayır

14. İlaç kullandıysanız ne kullandınız?.....

15. Eğitim Durumunuz / Öğrenciyseniz devam etmekte olduğunuz eğitim kurumu:

Okur-Yazar

İlkokul

Ortaokul

Lise

Yüksekokul

Üniversite

Yüksek Lisans

Doktora

16. Çalışıyor musunuz? Evet Hayır

17. Kimle birlikte yaşamaktasınız?

Ailem ile birlikte

Arkadaşlarla öğrenci evinde

Evde tek başıma

Yurtta

18. Çevrenizde kendinizi yakın hissettiğiniz, bir şeyler paylaşabildiğiniz biri veya birileri var mı? Evet Hayır

19. Son 1-2 hafta içerisinde sizi duygusal olarak etkileyen bir olay oldu mu? Evet Hayır

20. Olduysa ne oldu:……..

21. Araştırma süresi boyunca (30 gün) WhatsApp uygulamasında mesajların okundu bilgisi özelliğini açmayı kabul ediyor musunuz?

Evet Hayır

APPENDIX 4: BECK DEPRESSION INVENTORY

Aşağıda, kişilerin ruh durumlarını ifade ederken kullandıkları bazı cümleler verilmiştir. Her madde bir çeşit ruh durumunu anlatmaktadır. Her maddede o ruh durumunun derecesini belirleyen 4 seçenek vardır. Lütfen bu seçenekleri dikkatle okuyunuz. Son bir hafta içindeki (şu an dahil) kendi ruh durumunuzu göz önünde bulundurarak, size en uygun olan ifadeyi bulunuz. Daha sonra, o maddenin yanındaki harfin üzerine (X) işareti koyunuz.

1)	a. Kendimi üzgün hissetmiyorum b. Kendimi üzgün hissediyorum c. Her zaman için üzgünüm ve kendimi bu duygudan kurtaramıyorum d. Öylesine üzgün ve mutsuzum ki dayanamıyorum
2)	a. Gelecekten umutsuz değilim b. Gelecek konusunda umutsuzum c. Gelecekten beklediğim hiç bir şey yok d. Benim için bir gelecek olmadığı gibi bu durum değişmeyecek
3)	a. Kendimi başarısız görmüyorum b. Herkesten daha fazla başarısızlıklarım oldu sayılır c. Geriye dönüp baktığımda, pek çok başarısızlıklarımın olduğunu görüyorum d. Kendimi bir insan olarak tümüyle başarısız görüyorum
4)	a. Her şeyden eskisi kadar doyum (zevk) alabiliyorum b. Her şeyden eskisi kadar doyum alamıyorum c. Artık hiçbir şeyden gerçek bir doyum alamıyorum d. Bana doyum veren hiçbir şey yok. Her şey çok sıkıcı
5)	a. Kendimi suçlu hissetmiyorum b. Arada bir kendimi suçlu hissettiğim oluyor c. Kendimi çoğunlukla suçlu hissediyorum d. Kendimi her an için suçlu hissediyorum
6)	a. Cezalandırılıyormuşum gibi duygular içinde değilim b. Sanki bazı şeyler için cezalandırılabilirmişim gibi duygular içindeyim c. Cezalandırılacakmışım gibi duygular yaşıyorum d. Bazı şeyler için cezalandırılıyorum
7)	a. Kendimi hayal kırıklığına uğratmadım b. Kendimi hayal kırıklığına uğrattım c. Kendimden hiç hoşlanmıyorum d. Kendimden nefret ediyorum
8)	a. Kendimi diğer insanlardan daha kötü durumda görmüyorum b. Kendimi zayıflıklarım ve hatalarım için eleştiriyorum c. Kendimi hatalarım için her zaman suçluyorum d. Her kötü olayda kendimi suçluyorum
9)	a. Kendimi öldürmek gibi düşüncelerim yok

	b. Bazen kendimi öldürmeyi düşünüyorum ama böyle bir şey yapamam c. Kendimi öldürebilmeyi çok isterdim d. Eğer bir fırsatını bulursam kendimi öldürürüm
10)	a. Herkesten daha fazla ağladığımı sanmıyorum b. Eskisine göre şimdilerde daha çok ağlıyorum c. Şimdilerde her an ağlıyorum d. Eskiden ağlayabilirdim. Şimdilerde istesem de ağlayamıyorum
11)	a. Eskisine göre daha sinirli veya tedirgin sayılmam b. Her zamankinden biraz daha fazla tedirginim c. Çoğu zaman sinirli ve tedirginim d. Şimdilerde her an için tedirgin ve sinirliyim
12)	a. Diğer insanlara karşı ilgimi kaybetmedim b. Eskisine göre insanlarla daha az ilgiliyim c. Diğer insanlara karşı ilgimin çoğunu kaybettim d. Diğer insanlara karşı hiç ilgim kalmadı
13)	a. Eskisi gibi rahat ve kolay kararlar verebiliyorum b. Eskisine kıyasla şimdilerde karar vermeyi daha çok erteliyorum c. Eskisine göre karar vermekte oldukça güçlük çekiyorum d. Artık hiç karar veremiyorum
14)	a. Eskisinden daha kötü bir dış görünüşüm olduğunu sanmıyorum b. Sanki yaşlanmış ve çekiciliğimi kaybetmişim gibi düşünüyor ve üzülüyorum c. Dış görünüşümde artık değiştirilmesi mümkün olmayan ve beni çirkinleştiren değişiklikler olduğunu hissediyorum d. Çok çirkin olduğumu düşünüyorum
15)	a. Eskisi kadar iyi çalışabiliyorum b. Bir işe başlayabilmek için eskisine göre daha çok çaba harcıyorum c. Ne olursa olsun, yapabilmek için kendimi çok zorluyorum d. Artık hiç çalışamıyorum
16)	a. Eskisi kadar kolay ve rahat uyuyabiliyorum b. Şimdilerde eskisi kadar kolay ve rahat uyuyamıyorum c. Eskisine göre bir veya iki saat erken uyanıyor, tekrar uyumakta güçlük çekiyorum d. Eskisine göre çok erken uyanıyor ve tekrar uyuyamıyorum
17)	a. Eskisine göre daha çabuk yorulduğumu sanmıyorum b. Eskisinden daha çabuk ve kolay yoruluyorum c. Şimdilerde neredeyse her şeyden, kolayca ve çabuk yoruluyorum d. Artık hiçbir şey yapamayacak kadar yorgunum
18)	a. İştahım eskisinden pek farklı değil b. İştahım eskisi kadar iyi değil c. Şimdilerde iştahım epey kötü d. Artık hiç iştahım yok
19)	a. Son zamanlarda pek fazla kilo kaybettiğimi/aldığımı sanmıyorum b. Son zamanlarda istemediğim halde iki buçuk kilodan fazla kaybettim/aldım

	c. Son zamanlarda beş kilodan fazla kaybettim/aldım d. Son zamanlarda yedi buçuk kilodan fazla kaybettim/aldım
20)	a. Sağlığım beni pek endişelendirmiyor b. Son zamanlarda ağrı, sızı, mide bozukluğu, kabızlık gibi sıkıntılarım var c. Ağrı sızı gibi bu sıkıntılarım beni çok endişelendiriyor d. Bu tür sıkıntılar beni öylesine endişelendiriyor ki başka bir şey düşünemiyorum
21)	a. Son zamanlarda cinsel yaşantımda dikkatimi çeken bir şey yok b. Eskisine göre cinsel konularla daha az ilgileniyorum c. Şimdilerde cinsellikle pek ilgili değilim d. Artık cinsellikle hiç bir ilgim kalmadı

APPENDIX 5: BECK ANXIETY INVENTORY

Aşağıda insanların kaygılı ya da endişeli oldukları zamanlarda yaşadıkları bazı belirtiler verilmiştir. Lütfen her maddeyi dikkatle okuyunuz. Daha sonra, her maddedeki belirtinin, bugün dahil son bir haftadır sizi ne kadar rahatsız ettiğini aşağıdaki ölçekten yararlanarak, maddenin yanındaki uygun yere (X) işareti koyarak belirleyiniz.

Sizi ne kadar rahatsız etti?

	Hiç	**Hafif Derecede**	**Orta Derecede**	**Ciddi Derecede**
1. Bedeninizin herhangi bir yerinde uyuşma veya karıncalanma	0	1	2	3
2. Sıcak/ ateş basmaları	0	1	2	3
3. Bacaklarda halsizlik, titreme	0	1	2	3
4. Gevşeyememe	0	1	2	3
5. Çok kötü şeyler olacak korkusu	0	1	2	3
6. Baş dönmesi veya sersemlik	0	1	2	3
7. Kalp çarpıntısı	0	1	2	3
8. Dengenizi kaybedeceğiniz duygusu	0	1	2	3
9. Dehşete kapılma	0	1	2	3
10. Sinirlilik	0	1	2	3
11. Boğuluyormuş gibi olma hissi	0	1	2	3
12. Ellerde titreme	0	1	2	3
13. Titreklik	0	1	2	3
14. Kontrolü kaybetme duygusu	0	1	2	3
15. Nefes almada güçlük	0	1	2	3

16. Ölüm korkusu	0	1	2	3
17. Korkuya kapılma	0	1	2	3
18. Midede hazımsızlık veya rahatsızlık hissi	0	1	2	3
19. Baygınlık	0	1	2	3
20. Yüzün kızarması	0	1	2	3
21. Terleme (sıcağa bağlı olmayan)	0	1	2	3

APPENDIX 6: POSITIVE NEGATIVE AFFECTIVE SCHEDULE

Bu ölçek farklı duyguları tanımlayan bir takım sözcükler içermektedir. Son iki hafta nasıl hissettiğinizi düşünüp her maddeyi okuyun. Uygun cevabı her maddenin yanında ayrılan yere (puanları daire içine alarak) işaretleyin. Cevaplarınızı verirken aşağıdaki puanları kullanın.

1. Çok az veya hiç
2. Biraz
3. Ortalama
4. Oldukça
5. Çok fazla

1. İlgili 1 2 3 4 5
2. Sıkıntılı 1 2 3 4 5
3. Heyecanlı 1 2 3 4 5
4. Mutsuz 1 2 3 4 5
5. Güçlü 1 2 3 4 5
6. Suçlu 1 2 3 4 5
7. Ürkmüş 1 2 3 4 5
8. Düşmanca 1 2 3 4 5
9. Hevesli 1 2 3 4 5
10. Gururlu 1 2 3 4 5
11. Asabi 1 2 3 4 5
12. Uyanık 1 2 3 4 5
(dikkati açık)
13. Utanmış 1 2 3 4 5
14. İlhamlı 1 2 3 4 5
(yaratıcı düşüncelerle dolu)
15. Sinirli 1 2 3 4 5
16. Kararlı 1 2 3 4 5
17. Dikkatli 1 2 3 4 5
18. Tedirgin 1 2 3 4 5
19. Aktif 1 2 3 4 5
20. Korkmuş 1 2 3 4 5

APPENDIX 7: TEXT MESSAGES

1. Gün içerisinde aklımıza otomatik olarak bir sürü düşünce gelip gitmektedir. Bu otomatik düşüncelerin çoğu olumsuz olma eğilimindedir. Bu olumsuz otomatik düşünceler gerçekmiş gibi davrandığımızda hatalı varsayımlara dayalı bir şekilde hareket edebiliriz. Ani duygu değişimleri yaşadığınız, mutluyken bir anda huzursuz, kaygılı ya da kötü hissettiğiniz anlarda önce bir durun. Aklınızdan hangi olumsuz otomatik düşüncelerin geçtiğini bulmaya çalışın.
2. Bir durum sırasında aklımıza gelen olumsuz otomatik düşünceler nasıl hissettiğimizi, hissettiğimiz şey de davranış şeklimizi etkiler. Öncelikle durup aklınızdan geçen olumsuz otomatik düşünceyi belirleyin. Daha sonra bu düşüncenin gerçekliğini araştırın. Örneğin bir arkadaşınız aynı durumda olsa ve sizin düşündüğünüz gibi düşünüyor olsaydı ona ne söylerdiniz?
3. Kendinizi kötü hissetmenize sebep olacak bir olay olduğunda aklınıza "beni sevmiyor, başarısız biriyim ya da çok beceriksizim" gibi düşünceler gelebilir. Böyle düşüncelerinizi fark ettiğinizde bu düşüncenizi destekleyen kanıtlar bulun. Sonrasında ise bu düşüncenizi desteklemeyen birkaç kanıt bulun. Son olarak en başta aklınıza gelen düşüncenin daha gerçekçi, alternatif bir düşüncesi ne olabilir diye düşünün. Bunu yaptığınızda en baştaki kadar kötü hissetmediğinizi göreceksiniz.
4. Mutluluğunuz gün içerisinde neler düşündüğünüze, hissettiğinize ve neler yaptığınıza bağlıdır. Daha mutlu hissetmek için olumsuz otomatik düşüncelerinizin farkında olmalı ve bu düşüncelerin size ne hissettirdiğini bulmaya çalışmalısınız. Düşünceleriniz ve hisleriniz sonucunda yaptığınız şey duygu durumunuzu nasıl etkilemiş olabilir?
5. Düşünce hataları işlevsel olmayan ve gerçeğe dayanmayan düşünce kalıplarıdır. Örneğin genellikle zihin okuma düşünce hatasına düşerek birinin ne düşündüğünü bildiğimizi sanırız. Sonuç olarak düşünce hataları, olaylara gerçekte olduğundan daha olumsuz bakmanıza neden olur. Her insan zaman zaman, özellikle kendini kötü hissettiği zamanlarda düşünce hataları yapar. Çünkü bu insan olmanın bir parçasıdır. Ancak düşünce hataları sıklaşırsa psikolojik sağlığımız bu sebepten dolayı kötü etkilenebilir.
6. Kendiniz hakkında kötü hissetmeniz bunun doğru olduğu anlamına gelmez. Örneğin bir kişinin bir testten başarısız olması onun beceriksiz biri olduğu anlamına gelmez. Belki de sadece çalışmak için yardıma ihtiyacı vardır. Olumsuz otomatik düşüncelerinizin farkında olun ve bu düşüncelere alternatif, daha gerçekçi düşünceler üretin.

7. Hissettiklerinizi kendimize saklamak ve ifade etmemek yerine bir ifade yolu bulmak daha faydalı olabilir. Örneğin yazmak, hissettiklerimizi ifade etmek konusunda faydalı bir araç olabilir. Bir kağıt ve kalem alın. Sorunları yazmaya başlayın. Sorunlar yazıldığında ve duygular ifade edildiğinde yönetilmesi daha mümkün hale gelir. Tabi ki dilerseniz sonrasında bu kağıdı yırtıp atabilirsiniz.
8. Kontrol edemediğimiz kötü şeyler olduğunda, genelde değiştiremeyeceğimiz şeylere odaklanırız. Bugün kendinize yardımcı olmak için yapmanız gereken tek şey kontrol edebileceğiniz şeylere odaklanmak. Olumsuz otomatik düşüncelerinizin ve yaptığınız düşünce hatalarının farkında olup onları kontrol edebilirsiniz.
9. Bir sabah uyandığınızda bir mucize gerçekleştiğini hayal edin. Sıkıntılarınızın tamamen ortadan kalkmış ve tüm problemler bir anda çözülmüş. Tüm sıkıntılarınızın bittiğini fark etmenizi sağlayacak en basit ve küçük şey ne olurdu? Daha sonra ne yapardınız?
10. Üzgün hissettiğiniz anlarda yaptığınız şeyleri bırakın ve gözlerinizi kapatın. Kendinizi mutlu ve güvende hissettiğiniz bir yeri hayal edin. Neredesiniz, yanınızda kimler var kafanızda canlandırmaya çalışın. Bir süreliğine burada kalın ve her üzgün hissettiğinizde bunu tekrarlayın.
11. Gelecekteki haliniz için kendinize adım adım çok küçük hedefler belirleyin. Bu hedef yarın sabah uyanır uyanmaz bir bardak su içmek olabilir. Diğer günkü hedef ise su içtikten sonra yüzünüzü yıkamak olabilir. Bu hedefleri gerçekleştirebildiğinizi gördükçe iyi hissedeceksiniz.
12. Elinize kâğıt, kalem alın ve bir liste yapın. Bugüne kadar başarılı olduğunuzu düşündüğünüz en az 3 şey yazın. Örneğin birinin arkadaşı olmakta başarılı olmuş olabilirsiniz. Bir yemeği yapmak, bir yere gitmek ya da canınızın istediği herhangi bir şeyi yapmak konusunda başarılı olmuş olabilirsiniz.
13. Eskiden keyif aldığınız aktivitelerin şu an size zevk vermediğini hissediyor olabilirsiniz. Yapmaktan hoşlandığınız, size iyi gelen aktivitelerden 3 tanesini bir kağıda yazın. İçinden bir tanesini seçin. Seçtiğiniz aktiviteyle ilgili bir plan yapın. Örneğin müzik dinlemeyi seviyor olabilirsiniz. En çok sevdiğiniz şarkıyı açıp dinleyebilir ya da farklı şarkılardan oluşan yeni bir liste yapmaya başlayabilirsiniz.
14. Her an iyi hissetmek zorunda değilsiniz. Kendinizi üzgün, yorgun, suçlu ya da pişman hissediyor olabilirsiniz. Bunun için kendinizi suçlamayın. Böyle hissettiğinizde yaptığınız şeyi durdurup rahat bir oturuşa geçin ve yavaşça gözlerinizi kapatın. 2 saniye boyunca nefes

alın, 1 saniye tutun, 4 saniyede boşaltın ve sonra 1 saniye durun. Bunu yaklaşık 2-3 dakika boyunca tekrarlayın. Kendinizi kötü hissettiğiniz her an bunu yapabilirsiniz.

15. Geçmişte bazı hatalar yapmış olabilirsiniz. Kendinizi cezalandırmak yerine hata yapmanın insan olmanın bir parçası olduğunu hatırlayın. Geçmişin geçmişte kaldığını ve asıl bundan sonra ne yapacağınızın önemli olduğunu unutmayın. İyileşme sürecinizi hayatınızda yeni çözümler bulmak için bir fırsat olarak düşünün.

16. Güçlü yönlerinizi düşünün. Hangi konularda kendinizi başarılı hissediyorsunuz, hangi yönlerinizi takdir ediyorsunuz, ne yapmakta iyisiniz? En az 3 tanesini bir kağıda yazın ve bu kağıdı görebileceğiniz bir yere koyun.

17. Hayatta herkes hata yapabilir. Önemli olan hataya verdiğiniz tepkidir. O şey oldu ve bitti. Kendinize şefkatli davranın, her zaman en doğru şekilde hareket edemeyebilirsiniz. Unutmayın bugüne kadar hata yapa yapa geldiniz.
18. Kendinize zarar vermek gibi düşünceleriniz ya da buna yönelik bir planınız varsa bunu en yakın hissettiğiniz kişiyle paylaşın ve bir uzmana başvurun. Herkes hayatının bir aşamasında başkalarının desteğine ihtiyaç duyar. Yalnız değilsiniz. Destek almak kötü bir şey değildir.
19. Zaman zaman bazı duygularımızı daha yoğun yaşarız. Bazı zamanlarda eskisinden daha sık ağlamak ya da ağlama nöbetleri yaşamak normaldir. Böyle zamanlarda kullanmak için bir "başa çıkma kiti" hazırlayın. Bu kite kendinizi daha iyi hissetmenize yardımcı olacak sağlıklı şeyler ekleyin. Örneğin, sizi mutlu eden bir şarkı, ilham verici mesajlar veya bir arkadaşınızın telefon numarası gibi.
20. Şu anda nasıl hissettiğinizi adlandırmaya çalışın (üzgün, kızgın, stresli, sinirli, endişeli...). Hangi düşünceler bu duygunuzun ortaya çıkmasına sebep olmuş olabilir? Bu düşünceler %100 doğru mu? Aksini ispatlayabilecek karşıt kanıtlar mevcut mu?
21. Bazen yalnız kalmaya ihtiyaç duyabilir ve yalnız olmaktan keyif alabilirsiniz. Ancak çoğu zaman birileriyle olmak, onlarla bir şeyler paylaşmak, birlikte bir şeyler yapmak bizi iyi hissettirir. Yanında iyi hissettiğiniz, size en yakın olan bir ya da iki kişi belirleyin. Birlikte vakit geçirmek için bir plan yapın.
22. Bazen seçim yapmakta ya da bir şeylere karar vermekte zorlanırız. Böyle zamanlarda karar vereceğiniz şeyle ilgili artı eksi tablosu yapmak karar vermenizi kolaylaştırabilir. Kağıdın sol tarafına artıları sağ tarafına eksileri yazarak sıralayın. Hangi tarafta daha çok şey yazıyorsa kararınızı o yönde verin.

23. Ayağa kalkın ve aynaya bakın. Vücudunuzda en çok beğendiğiniz 3 yer bulun. Bu 3 yeri inceleyin. Neden bu bölgeleri seçtiniz? En çok hoşunuza giden tarafları neler keşfetmeye çalışın. Daha sonra aynaya karşı en saçma suratı yapın! Kendinize gülün. Her şey yolunda.
24. Her zaman bir şeyler yapmak için eşit seviyede istekli ve hevesli olamayabiliriz. Bazen bir işe başlamak bile gözümüzde büyür. Böyle durumlarda yapacağınız şeyin sonuçlarına odaklanmak yerine o işle ilgili yapmanız gereken en küçük şeye odaklanın. Örneğin birini aramanız gerekiyor. Bu konuşma sonucunda neler olacağına odaklanmak yerine sadece elinize telefonu almaya odaklanın. Bu şekilde devam edin.
25. Uykuya dalmakta güçlük çekiyorsanız yatağa yattığınızda bir süre boyunca gevşeme egzersizi yapın. Ayaklarınızdan başlayarak yukarıya, başınızın en tepesine doğru her bir uzvunuzu sırayla 5-10 saniyeliğine sıkın ve bırakın. İlk önce ayaklarınızı sıkın ve bırakın. Daha sonra alt arka bacakları, sonra dizleri, sonra üst bacakları, karnınızı, ellerinizi, kollarınızı… Bu şekilde devam edin.
26. Her zamankinden daha yorgun ya da bitkin hissediyor olmanızın sebebi depresyon olabilir. Fiziksel aktivite yapmak, duygu durumunuzla doğrudan ilgili bir beyin kimyasalı olan dopaminin salgılanmasını sağlar. Kendinizi en az yoracak ama sizi iyi hissettirecek fiziksel bir aktivite bulun. Örneğin kısa bir yürüyüşe çıkın. Bu size iyi gelecek.
27. Kendimizi kötü hissettiğimizde canımız hiçbir şey yemek istemeyebilir. Ama bir şeyler yememek enerjimizin düşmesine sebep olur. Dolayısıyla duygu durumuz daha da kötüleşir. Daha iyi hissetmek için az da olsa size iyi gelen ve sevdiğiniz bir şeyler yiyin.
28. Sağlıklı bir yaşam tarzı sürmek önemlidir. Gün içinde yeterli beslenmeli, egzersiz yapmalı ve iyi uyumalıyız. Bunları günlük rutininizin bir parçası haline getirmeye çalışın. Her gün çok sağlıklı beslenemeyebilir, iyi uyuyamayabilir ya da bunlar için kendinizi yeterince enerjik hissetmeyebilirsiniz. Bunun için kendinize kızmayın. Yapmak için çabaladığınızda bir düzene oturduğunu göreceksiniz.
29. Gün içerisinde her an kaygılı olmak mide ağrısı, kabızlık gibi bedensel sağlık sorunlarına yol açabilir. Aklınıza endişe verici düşünceler geldiğinde yaptığınız işi bırakıp 5-4-3-2-1 yöntemini uygulayın. Etrafınızda görebildiğiniz 5 adet nesne sayın. Sonra 4 farklı şeye dokunun. Etraftan kulağınıza gelen 3 farklı sesi fark edin. Daha sonra 2 farklı şeyi koklayın. Son olarak da dilediğiniz 1 şeyin tadına bakın. Bu egzersizi kaygılandığınız anlarda tekrarlayın.
30. Cinsel aktivitelere eskisi kadar ilgi duymuyor olabilirsiniz. Hepimiz hayatının bir bölümünde böyle şeylerle karşı karşıya kalabiliriz. Bunun için kendinizi suçlamayın. Duygu durumunuz iyileştikçe ilgi kaybınız da azalacak. Kendinize biraz zaman tanıyın.

APPENDIX 8: INFORMATIONAL MESSAGE

Pre-Measurement

Merhaba. Ben Başkent Üniversitesi klinik psikoloji yüksek lisans öğrencisi Özlem İlkay. Araştırmaya katıldığınız için teşekkür ederim. Araştırma 20 Ekim 2022 Perşembe (experimental group) / 20 Kasım 2022 Pazar (control group) günü başlayacaktır.

Telefon numaranıza 30 gün boyunca, saat 9.00, 12.00, 15.00, 18.00 saatlerinden herhangi birinde, WhatsApp uygulaması üzerinden günde 1 defa kısa mesaj gönderilecektir. 30 günlük sürecin sonunda, sonuncu kısa mesajdan sonraki gün cep telefonu numaranıza bir link gönderilecek ve en başta doldurduğunuz ölçekleri tekrar doldurmanız istenecektir. Araştırma süresi boyunca (30 gün) WhatsApp uygulamasında mesajların okundu bilgisini açık tutmanız gerekmektedir. Lütfen size gönderilen mesajlara cevap vermeyiniz.

Bu çalışmanın sonunda katılımcılar arasından çekilişle belirlenecek olan 5 kişiye 50 TL'lik Migros hediye çeki verilecektir. Hediye çeki kazanabilmek için araştırma boyunca tüm yönergelere uyarak araştırmanın tamamlanması gerekmektedir.

APPENDIX 9: DEBRIEF FORM

Geri bildirimleriniz ve araştırmaya katıldığınız için teşekkür ederiz! Bu mesaj bu araştırmanın yapılma amacıyla ilgili ayrıntılı bilgi vermek amacıyla sunulmaktadır.

Katılmış olduğunuz bu araştırma Prof. Dr. Okan Cem Çırakoğlu danışmanlığında Başkent Üniversitesi Sosyal Bilimler Enstitüsü Klinik Psikoloji Yüksek Lisans programından Özlem İlkay tarafından yürütülmektedir. Çalışmanın amacı depresif belirtiler gösteren ancak herhangi bir psikolojik ya da psikiyatrik destek almayan ve psikiyatrik bir ilaç kullanmayan kişilerin depresyon semptomlarını azaltıcı bir müdahalenin etkisine bakmaktır. Katılımcılara bir ay boyunca günde bir defa destekleyici ve bilgilendirici mesajlar atılmış ve bunun depresyon belirtileri üzerindeki etkileri incelenmiştir. Katılımcılar iki gruba ayrılmıştır. Bir grubun mesaj müdahalesi anında başlatılmış diğer grubun müdahalesi ise bir aylık bekleme süresi sonrasında başlatılmıştır. Bu şekilde, anında müdahale yapılan grup ile bekleme grubunu karşılaştırmak hedeflenmiştir. Yapılan bu kısa mesaj müdahalesinin, kişilerin depresif belirtilerini azaltacağı hipotez edilmiştir. Literatürde daha önce yapılmış çalışmalarda kısa mesaj müdahalesinin depresyon belirtilerini azalttığı görülmüştür (Agyapong et al., 2012; Agyapong et al., 2017; Hartnett et al., 2017).

Önceden belirtildiği gibi bu çalışmaya katılmak gönüllülük esasına dayanmaktadır. Elde edilen bilgiler sadece bilimsel araştırma ve yazılarda kullanılacaktır.

Araştırmanın sonuçlarını öğrenmek, daha fazla bilgi almak için ya da bu çalışmaya katılmanızın bir sonucu olarak olumsuz bir reaksiyon ile karşılaştıysanız mesajların gönderildiği telefon numarası üzerinden araştırmacıya ulaşabilirsiniz. Bu araştırmaya gönüllü olarak katıldığınız ve bilime katkıda bulunduğunuz için tekrar teşekkür ederiz.

APPENDIX 10: FEEDBACKS

Effective

- Araştırma boyunca aldığım mesajların bana çok iyi geldiğini düşünmekteyim. Özellikle olumsuz düşüncelerle ya da stresle savaşırken tam o anda gelen mesajların kaygımı ve üzüntümü hafiflettiğini düşünmekteyim.
- Merhaba ilk başta mesajların tam benim ihtiyacıma göre denk geldiğini düşünüyordum ama sonra üzerine düşününce aslında herkesin ihtiyacına göre yorumlayabileceğini fark ettim. Yani herkesin fayda görebileceği mesajlar olduğunu düşünüyorum. Özellikle kendime daha şefkatli yaklaşmamı ve teknikleri gün içinde hatırlamamı ve uygulamamı sağladı. WhatsApp'tan geldiği için hiçbir mesajı kaçırmadım. Bir uygulamadan bildirim geldiğinde o an müsait değilsem bildirimi göremiyordum ama sizin mesajlarınızı o an müsait değilsem ve okuyamayacaksam açmadım. Müsait olunca açtım ve uyguladım. Bu anlamda verimli oldu. Birinin her gün nasıl olduğuma bakmamı hatırlatması, motive etmesi, bir şeyleri normalleştirmesi çok iyi geldi. Her şey için çok teşekkürler umarım daha çok kişiye iyi gelir. Ayrıca ben gibi teknikleri önceden bilen ya da terapide öğrenen kişiler için gün içinde uygulamayı çok rahatlattığını düşünüyorum. Yani yalnızca öğrenmek yetmiyor hatırlatmak ve ufak kolaylaştırıcı sorular sorulması uygulamam için çok iyi oldu. Hep mesajlar gelsin istedim ara ara eskiye dönüp okuyacağım.
- Güzel bir çalışma yürüttüğünüzü düşünüyorum. Bazen gönderdiğiniz mesajlar tam olumsuzluk hissettiğim anlarda bana ulaştı. O durumlarda mesaj içeriğine göre değişkenlik gösterir şekilde duygularım hakkında düşünmeme ve kendimi düzenlememe yardımcı oldu. Bazı günler sadece hak verip geçecek kadar nötrdüm. Kimi zaman üzerinde düşünmek istemeyecek kadar olumsuzdum ancak bir aylık süreç benim için güzel bir deneyimdi. Çalışmanızda başarılar diliyorum. İyi günler.
- Merhaba. Öncelikle bilgilendirmeler ve telkinleriniz için teşekkür ederim. Yazdığınız telkinler günlük yaşantımızda kolaylıkla uygulayabileceğimiz ve genel yaşantımızı kolaylaştıracak konular, elimden geldiğince uygulamaya çalışacağım. Yazılarınızdan yaptığım çıkarımı okuduğum bir kitaptaki bilgiler ile eşleştirmek isterim; 24 saatlik bir zaman diliminde yaptığımız sesli konuşmalarımız, düşündüklerimizin (kendimizle konuşmamızın) %1 den çok daha az. Yani birkaç saatlik derin uyku hariç, 24 saatin büyük bir bölümünü kendimiz ile konuşarak geçiririz ve hayatımıza yön veren kararların büyük bir kısmını kendimizle konuşarak alırız. O günkü düşüncelerimizin negatif veya

pozitif olması, kararlarımıza da yanlış veya doğru etki ediyor. Yazdığınız telkinler veya öneriler de günlük yaşantımızda negatif düşüncelerimizi pozitife çevirmek için kullanabileceğimiz araçlar olacak. Tekrar teşekkürler. Başarılar.

- Hazırladığınız metinlere cevap vermemek zor olmuştu, böyle bir feedback talep etmeniz iyi olmuş :) Çünkü düşünsene çalışıyorsun odaklanmışsın veya o an geçmişle ilgili bir düşünce var kafanda 'ping' mesaj geliyor ve sana bir şeyleri hatırlatıyor ya da yeni bir pencere açıyor, özetle hoştu... Umarım araştırmanızın sonucunu verimli bir şekilde alabilirsiniz. Neyse, asıl gelelim benim gözlemlediğim etkilere: Günün 3-4 farklı saatinde geldi diye hatırlıyorum mesajları, gün içerisindeki duygu durum değişikliğime göre gülümsettiği ve düşündürdüğü anlar oldu. Öğle aramda ana odaklanmakla ilgili bir mesaj alıp, cidden mesajın düşüncelerimi olumlu yönde etkilediği hatta bir süreliğine enerjimi yükselttiği, ufak bir dış motivasyon kaynağı olduğu söylenebilir. Serendipity konusunda, o anlık rahatlatıcı ve farkındalığı arttıracak bir etkisi olduğunu söyleyebilirim. Birkaç arkadaşımla mesajların üzerine konuşup fikir alışverişi yaptığımı hatırlıyorum. Bazı verdiğin bilgiler sonucunda da araştırdığım şeyler oldu. Beni araştırmaya sevk ettiğini söyleyebilirim. Sanırım keyifli ve olumlu bir etki bıraktı diyebilirim kısaca özetlemek gerekirse...
- Göremediğim farkında olamadığım olaylara durumlara karşı mesajlarınızla birlikte bakış açım değişti. Teşekkür ederim böyle bir çalışmanın içinde olmaktan mutlu oldum.
- Mesajlarınız ilham verici oldu ve her güne, dolayısıyla hayata daha olumlu bakabilmemi sağladı. Verdiğiniz önerileri uyguladım ve uygulamaya devam edeceğim. Teşekkürler.
- Merhaba araştırma boyunca her gün çeşitli saatlerde gelen mesajlar beni olumlu etkiledi. Hatta zaman zaman yoğun bir günün içerisinde bolca stresin olduğu bir zamanda mesajları okumak iyi geldi. Teşekkürler.
- Merhaba. Gelen mesajlar etkili yol gösterici. Bende durup düşünme etkisi yarattı yönergeleri de uygulayınca işe yarıyor.
- Çok bilgilendirici ve destekleyici mesajlardı. Üstüne düşünmek ve mesajdaki şeyleri yapmak bana çok iyi geldi. Çok teşekkür ederim.
- Merhaba, araştırmanıza katıldığım için kendimi şanslı hissediyorum çünkü süreç boyunca mesajları okumanın ve bu mesajlar üzerine düşünmenin bana çok katkısı olduğunu düşünüyorum. Baştan sona keyifli bir süreçti. Teşekkür ederim.
- Mesajlar gün içerisinde kendime dönüp duygularımı değerlendirmeme yardımcı oldu.

- Kısa süreli etkileri olduğunu söyleyebilirim, anlık bir farkındalık yarattı. Alandan biri olmamla alakalı da olabilir. Herhangi biri üzerinde daha etkili olacağını düşünüyorum.
- Çoğu zaman kötü hissettiğimde, tesadüfen mesajınızın bildirimi geliyor telefonuma. Okuyorum ve gerçekten iyi hissediyorum. Bazen kendimi bu mesajları okuyarak sakinleştirdim ve bazı şeyleri fark etmemi sağladılar.
- Önerilen tekniklerin bazılarını uyguladım ve kendimi daha iyi hissetmeme sebep oldu. Hayata daha geniş bakma ve umutlu hissetmemi sağladı. Emekleriniz için teşekkür eder çalışmalarınızda başarılar dilerim
- Mesajların her gün gelmesini dört gözle bekledim. Benim üzerimde etkisi olumlu yönde oldu. Motivasyonumu geliştirmede ve hayata bakış açımı değiştirmede yararı dokundu.
- Mesaj ve yönergeler olumlu ve pozitifti. Bu durum bana, herhangi bir olumsuz durumda daha serinkanlı, öngörülü ve kontrollü duruş kazandırdı. Çok istediğim halde bulunduğum bölge ve ekonomik şartlar sebebi ile profesyonel psikolojik destek alamadım. Ki bu noktada (farklı eğitim alıp lisans üstü psikoloji alıp yeterlilik sagla/madan/yamadan bu işi yapan mecradaki kişiler yüzünden) kafa karışıklığı yüzünden alabilecek durumda bile olsam doğru kişiyi bulabilir miydim, pek sanmıyorum. Ez cümle, bu mesajlarla bile olumlu bir adım atabiliyorsam, profesyonel bir yardımla çok daha büyük adımlar atabileceğimi görmüş oldum. PS: nefes tutma egzersizi ve benzeri önerilerinizi gerçekleştirmedim, kendi oluşturduğum bazı alternatifler var ve bende işe yarıyor
- Kendimi çok kötü hissediyorum. Depresif halimden sadece kısa sürelerde kurtulabiliyorum ve bu durum yüzünden olaylardan kaçma, işleri erteleme gibi kaçışlar yapıyorum istemsizce. Mesajlarınız ilk iki hafta kadar çok işime yaradı, dediklerinizi yapabildim. Fakat sonrasında dediklerinizi yapamamaya başladım ve bir katkısı olmadığını düşündüm. Yine de mesaj almak, hiç mesaj almamaktan daha iyi geldi, daha iyi hissettirdi beni. Mesajlarınızı sonrası için kendime sakladım, arada hala açıp okuyorum. Teşekkür ederim.
- Her gün hayata dair olumlu mesajlar almak hatta bazı günler içinde bulunduğun durumu bilircesine motive edici olmaları çok güzeldi. Çok faydalandım. Emeğinize sağlık çok teşekkür ederim. Başarılarınız daim olsun.
- Birkaç gün boyunca aynı konseptte mesajlar gelmesi özellikle güzeldi. Her gün farklı konuda mesaj gelmesi etkiyi düşürüyor bence. Bir konuyu bölümlere ayırıp

aşamalandırabilirsiniz. Telefonumda bir anda beklenmedik pozitif bir mesaj görmek bana iyi geldi.

- Bazı zamanlar özellikle de kendimi kötü hissettiğim zamanlarda motive edici mesajlar almak beni bir şeylere teşvik etmeye çalışan birilerinin olduğunu bilmek mutlu ve güvende hissettirdi mesajlardaki tavsiyelerin çoğuna uyuyorum ve uymaya devam ediyorum her şey için teşekkürler.
- BDT hakkında ön bilgim olduğu için mesajlarda yazanlar bildiğim fakat biliyor olsam da çoğu zaman uygulamadığım şeylerdi. Günlük hayatta ansızın bu bilgilerin bana hatırlatılması bazen duygularımı düzenlememe yardım etti. Örneğin hatalarımla ilgili kendimi çok yargıladığım ve kötü hissettiğim bir anda herkesin hata yapabileceği ile ilgili bir mesaj gelmişti. Onun dışında gün içinde aklımdan geçen olumsuz otomatik düşünceleri ve düşünce hatalarımı yakalayıp fark etme konusunda benim için iyi bir hatırlatıcı oldu.
- Merhaba. Emeğiniz için teşekkür ederim öncellikle. Yaklaşık 1 ay boyunca bazen mesajları sabırsızlıkla beklediğim bazen unuttuğum oldukça keyifli bir süreçti. Benim için tamamen "görünmeyen bir destek" gibiydi. Gelen bazı mesajlar o anda yaşadığım süreçle oldukça ilişkiliydi. Çoğu tekniği denemeye çalıştım. Özellikle ayna etkinliği için teşekkür ederim. Çalışmanızda kolaylıklar dilerim.
- Bazen kötü bir gün geçiriyorken gelen mesajları okuyunca sadece kendimin böyle hissetmediğini düşünmek iyi geldi.
- Merhaba, bazı günler bazı mesajları okumaya gerçekten de ihtiyacım varmış gibi hissettirmişti. Ancak sanıyorum ki her gün uygulanması gereken belli faaliyetleri içerdiği için bazen biraz bunaltıcı geldiği anlar da oldu diyebilirim. Dürüst olmak gerekirse her faaliyeti her gün uygulayamadım. Bu belki mesaj sıklığı ile alakalı olabilir, ama tabii ki benimle de ilgili olabilir. Yine de kendimi gözden geçirmeye teşvik eden bir çalışma süreci olduğunu düşünüyorum. Ayrıca her gün birinin benimle ve düşünce yapımla ilgilendiğini hissettirmesi de oldukça hoştu diyebilirim. Teşekkür ederim. Çok değerli bir çalışmanız var, umarım pek çok insana katkı sağlayabilecek bir sonuç elde edersiniz. Kolaylıklar dilerim.
- Bana farklı ve iyi bakış açıları kazandırdı. Güzel hissettirdi. Teşekkürler.
- Nasıl hissettiğim ve düşündüğüm konusunda düzenleyici oldu diyebilirim. Büyük oranda gönderilen saatlerde okumaya gayret ettim. Sıkıntı duyduğum anlarda yeniden okuduğum da oldu. Teşekkürler.

- Mesajların hepsini okudum, olumlu hisler uyandırdı. Bazı durumların, düşüncelerin olağan olduğunu hissettirdi ve olumsuz durumlarla, düşüncelerle nasıl başa çıkmam gerektiğiyle ilgili yardımcı oldu. Teşekkür ediyorum katkılarınızdan dolayı.
- Günlük olarak motivasyonumu sağlamaya katkı sağladı. Genel duygularım konusunda büyük değişiklikler yapmasa da o anlık rahatlattı ve düşündürdü.
- Kendim BDT terapisti olduğum için mesajlardaki bilgiler benim için yeni değildi. Ama mesajlar bildiğim teknikleri üzerimde uygulamam için iyi birer hatırlatıcı oldular.
- Başta hoşuma gitmişti. Güzel bir etkinlik gibiydi her gün bir mesaj almak. Arada yazılan önerileri de yapmaya çalıştım. Yapabildiklerim yardımcı oldu bazı konularda. Maalesef çoğunluğunu erteledim. Yine de daha sonra yapacağım umarım. Sonra çok kötü bir an yaşarken üstüne mesajınız geldi ve orda her şey anlamsızlaştı. Çok sinirliydim ve yazılan şeyler samimiyetsiz gelmeye başladı. Anlatabildim mi bilmiyorum :)
- 1 ay boyunca gelen mesajlar sanki tam da o anda duymam gereken şeyleri söylüyor gibiydi. İhtiyacım olduğunda hâlâ dönüp aynı mesajları okuyorum. Bazen böyle şeyleri duymaya ihtiyacım olduğunu fark ettim.
- Mesajlar için çok teşekkür ederim. Gelen mesajların içeriği bazen benimle oldukça ilgili bazense alakasızdı. Ancak genel olarak oldukça öğretici, ilham verici ve motive ediciydi. İçerikler çoğunlukla kendimizi tanımamız ve sağlıklı bir rutin oluşturmak üzeydi. Verdiğiniz tavsiyeleri hayatıma uygulamaya çalışacağım ve yakın çevreme de ileteceğim. Mesajların saatleri bazen benim günlük rutinim içinde çok ters saatlerde geldi. Bu yüzden bazı mesajları kaçırdım. Ancak çoğu mesajı okuyup kendimle ilişkilendirmeye çalıştım. Çalışmanız için tebrik eder, başarılarınızın devamını dilerim.
- Merhaba. Araştırma boyunca atılan mesajlar sayesinde gün içinde modum etkilenebildi. Örneğin, modumun düşük olduğu günlerde tavsiye gibi olan mesajlar iyi hissetmemi sağladı. Bazen mesajları bekler hale geldim :) Araştırmaya kabul ettiğiniz için teşekkürler. Başarılar dilerim.
- Gerçekten öğrendiğim güzel teknikler oldu her gün iyi veya kötü hissettiğim anlarda beklemediğim saatlerde güzel mesajlar almak benim için güzel bir tecrübe oldu teşekkür ederim.

Not effective

- Mesajların çoğuna tam dikkatli bakamadım. Birçoğunu tam okuyamadım. Gönderdiğiniz saatler tam iş saatleriydi ya da benim için öyleydi. Yeterince verim aldığımı söyleyemem. Elinize sağlık her şey için.
- Mesajların benim üstümde herhangi bir etkisi olmadı. Mesajlar, kısa bir süre bile olsa psikolog veya psikiyatristten danışmanlık almış herkesin bildiği şeyler. Mesajların bana yararı, ifade etmekte zorlandığım belli konuların bazılarının daha iyi ifade edilmiş hâlini okumak oldu.
- Pek bir etkisi olduğunu söyleyemem. Mesaj bildirimi geldiğinde herhangi bir motivasyon uygulamasından gelen otomatik bir bildirim gibi hissettirdi. Evet bir mesaj çok şey değiştirebilir ama olay mesajın içeriği değil maalesef. Katılmak güzeldi teşekkür ederim.
- Mesajlar geldikçe belki 1 2 dakika üstüne düşündüm. Kendi hayatımdaki işleyişe baktım. Sonrasında 1 2 gün etkisini görmüş olabilirim ama daha sonrasında hayatıma hiçbir etkisi olmadı.
- Merhaba. Bana gelen mesajların içeriğini eyleme dökmenin gerçekten önemli olduğunu düşünüyorum. Ancak gün içinde gelen bu tip mesajların benim üzerimde etki uyandırmadığını düşünüyorum. Bazı paylaşılan bilgiler çok önemliyken bazıları önemsiz geldi gözüme. Ayrıca gün içinde gönderilen mesajların bir çoğu arada kaynadı. Göz ucuyla okuyup unuttuğum günler oldu. Genel anlamda benim özelimde etkisiz olduğu kanaatindeyim ancak bu geliştirilebilir olmadığı anlamına gelmez. Bir dahaki sefere kişinin belirttiği problemler özelinde mesajlar gelirse kişi bu mesajları okumak ve uygulamak adına daha hevesli olabilir.
- Hayatımda bir değişiklik yaratmadı. Yazılan hiçbir şey aklımda kalmadı. Gördüğüm an üzerine biraz düşünüp unuttum ve gündelik hayatıma etkilenmemiş bir şekilde devam ettim.
- Genel olarak mesajlar düşünmemi sağladı, her gün bugün ne mesajı gelecek diye meraklanmamı sağladı, onun dışında çok büyük bir etkisi olmadı.
- Üzülerek söylüyorum ki pek bir etkisi olmadı başarılar diliyorum yolunuz açık olsun.

Neither effective nor not effective

- Araştırmanızın bir parçası olduğum için teşekkür ederim. Ancak beklentilerimin aksine maalesef olumlu ya da olumsuz yönde bir etki göremedim. İyi çalışmalar dilerim.
- Genelde daha önceden benzerini okuduğum, tahmin ettiğim tavsiyeler olmakla birlikte sürekli dikkate alındığında faydası olacağına inanıyorum. Ben (birkaçı hariç) uygulayamadığım için net bir fikir veremeyeceğim.
- Ruh halim üzerinde büyük bir etkisi olmadı ama mesaj gelmesine alıştığım için mesajın gelmesini her gün bekledim, geldiğini görünce biraz da olsa rahatlıyordum.