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Message From The Patron In Chief:

The prevalent problems in our country have led to feelings of pessimism and insecurity in many people. The youth has especially been affected and is in danger of losing direction and purpose in life. This necessitates a meaningful action by everyone to prevent our precious possession from falling prey to depression, anxiety and other mental health problems. We need to foster qualities like commitment, honesty, optimism, self esteem, enthusiasm, faith, unity, love and tolerance among ourselves to create a vibrant, productive and resilient society. Enhancement of our level of satisfaction and the quality of life needs to be identified as our priority .We, however, appear to be in a profound state of denial, irrationality and inaction which has further aggravated our misery.

In this scenario, the emergence of Pakistan Association of Cognitive Therapists (PACT) is a welcome and timely development. Cognitive therapy does not merely promote positive thinking, but it deals comprehensively with refining one's problem solving and social skills and with cognitive restructuring. This is therefore, perfectly suited to play its proven role in the promotion of mental health as well as in the treatment of various psychiatric disorders in our country. The indigenous research by Dr Farooq Naeem is quite promising so far.

PACT has taken numerous initiatives in a very short period of time. The launching of this Newsletter on the eve of First International Conference on CBT is another laudable achievement. I congratulate the members of the editorial board as well as the contributing authors for their excellent efforts. I hope that imPACT will have an impact on stimulating the true professional attitude based on ethical and scientific principles. In the end I wish PACT best of luck and assure my full support in all her endeavors.

Lt Gen (Rtrd) Khalid Maqbool

Message From The Editor:

Cognitive Therapy (CT) was developed by the American Psychiatrist Aaron T. Beck in 1960s. The name was changed to Cognitive Behavior Therapy (CBT), as the behavioral therapy techniques became part of it. Cognitive Therapy was initially developed for depression. Soon after its development however, therapists adapted it for many other disorders, like OCD, Phobias, PTSD, Eating Disorders and Personality Disorders. During the last decade of the 20th century, techniques for psychosis were developed. Further development came during the last decade in the form of “Third wave Therapies”, when spirituality became a part of the CBT.

Research has proven CBT to be effective for a variety of mental health and emotional problems. CBT is also cost effective compared with other interventions. The strength of CBT lies in its structured approach, individualization of therapy, being able to apply techniques in various settings, for example individual, group and family etc. and for various populations, for example, children, adults and older adults. It

emphasizes the role of self help. It can be given using a manual and it can be provided by less trained professionals after a short period of training.

While CBT has been tested and found to be a highly effective psychotherapy in the western world for a wide range of conditions, its education, training and practice in Pakistan is limited, restricted and unstructured. There are currently no accredited CBT therapists in Pakistan. During the last couple of years we have noticed a positive move and mental health professionals are more interested in CBT now. The PACT (Pakistan Association of Cognitive Therapists) came into existence by the joint efforts of a group of psychologists and psychiatrists to promote training and research on CBT in Pakistan, as well as to provide a platform for indigenous research and collaboration with National and International organizations. The association also aims at introducing and promoting culturally and religiously sensitive practice of Cognitive Behavior Therapy, based on sound research integrated with existing evidence based interventions.

We started this newsletter with the aim to publish a newsletter that will develop into a journal in future to disseminate research and information about the applications of CBT from this platform. For the first newsletter the mammoth task was given to me and my team. Response to our call for papers was over whelming. We received too many articles and it was difficult to choose from. All the articles were of high quality. Most authors said in their personal correspondence, it is difficult to write for a therapy that is still not being widely practiced in this part of the world.

The idea behind this newsletter is to promote education, information, views and research regarding CBT. This issue of the imPACT is our first endeavor and we invite you to join us in this journey of learning through experience, sharing and research on CBT. Financial strain remains our main burden. We hope that our efforts will help you to be able to help your patients suffering from the agony of depression, the fear and turmoil of anxiety and the detachment from the so known normality. It is the need of the hour in this part of the world, and unless we get mastery of such an effective psychotherapeutic tool as CBT through motivated learning, dedicated good practice, indigenous research and then developing culturally acceptable and applicable formats and guidelines; we won't be able to provide the best of treatment to those who come to us with a hope that we are the messiahs, who can change their lives.

In the end, I am thankful to the unconditional guidance and help of Dr. Farooq Naeem, Dr. Shahid Rashid and Ms. Afifa Gull in the publication of this newsletter.

Dr Kamran Haider Bukhari

Past Events Conducted By PACT

A number of workshops, seminars and lectures have been conducted since 2003 by Dr Farooq Naeem and PACT. Through these events various mental

health professionals, general practitioners and medical students got basic training in one of the most useful psychotherapeutic tool available to-date. Some of the important past events are enlisted below.

- May 2009: Two days workshop, CBT for depression using an Urdu manual, Aga Khan Medical University, Karachi-Pakistan
- May 2009: Two days workshop, CBT for depression using an Urdu manual, Lady Reading Hospital, Peshawar-Pakistan.
- Apr 2009: Two days workshop, CBT for depression using an Urdu manual, Combined Military Hospital (CMH), Lahore-Pakistan.
- Apr 2009: Two days workshop, CBT for depression using an Urdu manual, Quaid e Azam Medical College, Bahawalpur-Pakistan.
- Mar 2009: Two days workshop, CBT for depression using an Urdu manual, Sheikh Zayed Medical College, Rahim Yar Khan-Pakistan.
- Mar 2009: Two days workshop, CBT for depression using an Urdu manual; PIMS, Islamabad-Pakistan.
- Jan 2008: Half day workshop, CBT for PTSD, Aga Khan Medical University, Karachi-Pakistan.
- Nov 2008: One day workshop on CBT for depression and anxiety, Department of Psychiatry, Aga Khan Medical University, Karachi-Pakistan.
- Apr 2008: One day workshop on CBT for depression, Seminar on Mental Health, Lahore-Pakistan.
- Nov 2007: One day workshop on CBT for Anxiety Disorders, Fountain House, Lahore-Pakistan.
- Nov 2007: One day workshop on research methods, Fountain House, Lahore-Pakistan.
- Jan 2004: Cognitive Behavior Therapy for Psychosis, One day workshop at GC University Lahore-Pakistan.
- Feb 2004: Cognitive Behavior Therapy for Psychosis, Two day workshop at FJWU, Rawalpindi -Pakistan.
- Feb 2004: Research methods in health, One day workshop at FJMC, Lahore-Pakistan.

- Mar 2003: Cognitive therapy for psychosis, One day workshop at Department of Psychiatry, Mayo Hospital and King Edward Medical University, Lahore-Pakistan.
- Feb 2003: Cognitive Behavior Therapy, An introduction (National conference for the General Practitioners, Lahore-Pakistan.)
- Dec 2003: Cognitive Behavior Therapy for depression, A Seminar for Medical Students and Junior Doctors.
- Dec 2003: Cognitive Behavior Therapy for Psychosis, One day workshop at the Department of Psychiatry, FJMC, Lahore-Pakistan.

Future Events Planned By PACT

Following are some of the significant events that would be conducted in the near future.

- Dec 21, 2010: First International CBT Conference, FJMC, Lahore-Pakistan.
- Dec 22, 2010: One day workshop, CBT for Psychosis, Fountain House, Lahore-Pakistan.
- Last week of Dec, 2010: Three days workshop, CBT for Psychosis, Karachi-Pakistan.

The Online CBT Course: A Dream Comes True

Mahwish Ali

A year ago, it was a dream for many of us to get a certificate or diploma in CBT from a recognized institute in the UK or the USA. This all changed however, with the collaboration that started between PACT (Pakistan Association of Cognitive Therapists) and OCTC (Oxford Cognitive Therapy Centre). The Oxford Cognitive Therapy Centre started an online CBT certificate course a few years ago and it helped many mental health professionals in attaining training in CBT. Although the certificate costs more than £500, we successfully negotiated a deal for Pakistani mental health professionals for £100. We are grateful to David Westbrook, who made this possible. We are also grateful to Adrian Krajewski. This certificate was warmly embraced by the mental health professionals in Pakistan. So far nearly 100 mental health professionals have registered for the certificate.

This is however only a start and we need more CBT trained professionals in mental health in Pakistan. For more information on OCTC online certificate for Pakistan please see our Google discussion group.

(http://groups.google.co.uk/group/pak_cognitive-therapy?hl=en)

or the OCTC website (<http://octc.co.uk>).

CBT & Problem Solving Therapy

Aisha Bano

“When someone feels very low for little or no obvious reason, for more than two weeks and feels like this day after day, week after week, this is called a depressive illness” (Williams, 2002).

Cognitive Behavior Therapy is an effective psychotherapy that emphasizes the important role of thinking in how we feel and what we do. The basic concept in this therapy is the recognition that how we feel about a certain situation is not because of the situation itself, but how we perceive that particular situation. Or in other words our emotions are the result of what we think about a particular situation or event.

This therapy is directed at some common cognitive distortions, or faulty thought patterns that are considered to be responsible for depression. Beck has proposed the following types of faulty thinking to be responsible for depression in an individual;

All-or Nothing Thinking involves thinking and interpreting or categorizing experiences in either / or extremes. With such dichotomous thinking, events are labeled in black or white terms.

Overgeneralization is a process of negative generalization, claiming that things always or never happen a certain way and forgetting about the exceptions.

Arbitrary Inferences refer to making conclusion without supporting and relevant evidence. Where the person tends to expect the worst, whether or not it is actually likely to happen

Selective Abstraction consists of forming conclusions based on an isolated detail of an event. In this process other information is ignored, and the significance of the total context is missed. . The individual may focus on negative aspects only and ignore the positives.

Magnification and Minimization consists of perceiving a case or situation in a greater or lesser light than it truly deserves.

Personalization is a tendency for individuals to relate external events to themselves, even when there is no basis for making this connection.

Labeling and Mislabeling involves portraying one’s identity on the basis of imperfections and mistakes made in the past and allowing them to define one’s true identity.

How CBT Helps To Overcome Depression:-

The goal of Cognitive behavior therapy is to deactivate such negative schemas and reconstruct them in more adaptive way. Cognitive behavioral therapy has been shown as an effective treatment for clinical depression (Dobson, 1989). A large-scale study (Keller, McCullough, & Klein, 2000) showed substantially higher results of response and remission (73% for combined therapy vs. 48% for either CBT or the antidepressant Nefazodone alone) when a form of cognitive behavior therapy and that particular discontinued anti-depressant drug were combined than when either modality was used alone.

Research in Pakistan has shown that depression is associated with problems and difficulties in client's life. Problem solving is often used along with CBT and here I am going to briefly describe the steps used in Problem Solving.

Step 1: In the first step problem is defined as precisely as possible. It is not possible to deal with every problem all at once, therefore only one problem/issue is selected at a time.

To begin with, the unhelpful behavior is recorded for several days. Clients are required to keep a record of

- When the behavior/activity occurs?
- How much and how often do you carry out this behavior/activity?
- How long it lasts for?

Step 2: Encourage the client to think of alternative options. Following questions might be helpful in creating a list of all possible alternatives.

- What ridiculous solutions can I include as well as more sensible ones?
- What helpful ideas would others (e.g. family, friends or colleagues) suggest?
- What approaches have I tried in the past in similar circumstances?
- What advice would you give a friend who was trying to tackle the same problem?

Step 3: Look at the advantages and disadvantages of each of the possible solutions. The next step is to think about the pros and cons of each possible option.

Suggestion	Advantages	Disadvantages

Step 4: Choose one of the solutions.

Decide on an option.

This plan should be an option that fulfils the following criteria:

- a) Is it helpful?
- b) Is it achievable?

Step 5: Plan the steps needed to carry it out.

Now the task is to carry out the plan during the next week.

The questions for effective change

- Will it be useful for change?
- Is it a specific task?
- Is it practical and achievable (realistic)?
- Does it make clear what and when I am going to do it?
- Would it not be easily blocked or prevented by practical problems?
- You should be able to answer Yes to each of the questions.

Step 6: Carry out the plan, and pay attention to thoughts about what will happen before, during and after the client have completed the activity.

Step 7: Review the outcome.

Q. Was the selected approach successful?

Q. Did it help me to tackle the target problem?

Q. Were there any disadvantages to using this approach?

Q. What have I learned from doing this?

Planning for the Future:

CBT also helps an individual to set targets for future

- Short-term target: Thinking about changes you can make today, tomorrow and the next week;
- Medium-term targets: Changes to be put in place over the next few weeks;
- Long-term targets: Where you want to be in six months or a year.

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CBT For The Treatment Of Psychological Disorders: Evidence From Research

Dr Farhana Kazmi

Cognitive behavior therapy (CBT) is based on the idea that emotions are shaped not only by the events in a person's surroundings but they way person behaves also depends on his thinking pattern. Cognitive behavior therapy not only focuses on overt behavior but also on dysfunctional thoughts and beliefs, and maladaptive behaviors.

CBT appears to have an enduring effect in the treatment of depression, anxiety disorders that reduce risk for subsequent symptom return with respect to depression, panic, social phobia, and OCD (Hollon, Stewart, and Strunk, 2006). It is useful in the treatment of anxiety and depression along with medication (Holmes, 2010; Butler, et al, 2005; Gilliland, et al 1994). Crowther, et al (2010) argued that it often works well with depression of older rural adults.

CBT focuses on repairing the damage from repeated negative thought patterns and unhelpful behaviors and can be used effectively in treatment of bipolar disorders (Brooks, 2009). During the course of treatment, people learn how to identify and change destructive or disturbing thought patterns that have a negative influence on behavior (Cherry, 2010). CBT has been reported to treat Attention Deficit

Hyperactivity Disorder [ADHD] in adults (Safren et al, 2010). ADHD, co-morbid anxiety, depression and low self-esteem and self-efficacy (Bramham et al., 2009), panic attack (Manjula, et al 2009) as well as other problems with living such as couples distress (Roth et al 2002). It has also been successfully used both in isolation and in combination with drugs in India (Ranjan, 2003) for depression, anxiety and eating disorders (Senghas, 2007). Froggatt et al (2006) have used it to treat depression, anxiety disorders, obsessive-compulsive disorder, agoraphobia, specific phobias, posttraumatic stress disorder, eating disorders, addictions and hypochondriasis (Froggatt, 2006). Similarly, it has been used and found to be effective for the treatment of bulimia nervosa (Wilson, 1997). In most studies, CBT provided worthwhile improvements in pain-related behavior, self-efficacy, coping strategies and overall physical function (Bennett et al, 2006; Keefe, 1996).

Longabaugh and Morgenstern (1999) and Kadden (2002) used Cognitive-behavioral coping-skills training (CBST) for changing drinking behavior of the alcohol dependent persons. CBT has proven to be effective for; anger management (Beck and Fernandez, 1998), primary insomnia (Edinger and Means, 2005) and for social phobia (Rapee et al, 1997), vocational rehabilitation of the schizophrenic patients (Lysaker, et al, 2005), treatment of schizophrenia along with antipsychotic drugs (Turkington, et al, 2006). CBT techniques such as self control, systematic desensitization, in vivo flooding etc. have been found effective in reducing the intensity of PTSD symptoms (Keane et al, 1996).

Telephone administered cognitive behavior therapy is effective and well tolerated, at least for people with obsessive-compulsive disorder without major depression (Taylor et al, 2003). CBT for pre-school-age children provides a relatively unique adaptation of cognitive therapy (Knell, 1998).

Naeem, et al (2010) have reported that CBT might be acceptable across cultures with some minor adjustments. They have adapted CBT for local use in Pakistan. They have reported a framework that can be used in adapting CBT for use in Pakistan (Naeem et al, 2009) CBT was found to be effective when counseling older Chinese people suffering multiple diseases to change irrational thoughts into more positive ones and reduce their distress (Wong et al, 2007). In Pakistan, Rehman et al, (1999, 2000) have reported the use of CBT through case studies and found it to be helpful in reducing the intensity and duration of anger, obsession and depressive feelings, treatment of generalized anxiety disorder. Yusaf et al (2006) have described their experience of training mental health professionals in CBT for PTSD and possibly combining it with Muslim ideology. Rahman et al (2009) have described the use of CBT based intervention for pregnant mothers through health workers, using a clustered randomized controlled trial. They found it to be effective.

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Trauma Focused CBT

Afifa Gull

Most of us, at some point in our lives experience some kind of traumatic events, e.g., death of a loved one, severe illness, an accident or a natural disaster. Such distressing events are likely to create feelings of distress, guilt, helplessness, horror and anger. But most of the time people successfully cope with the aftermath of such events without developing any serious psychological or emotional problems.

Some individuals might develop symptoms of a psychiatric problem, called Post Traumatic Stress Disorder (PTSD) in response to trauma. There is sufficient evidence from research to suggest that people are more likely to suffer with PTSD if the disaster is man-made compared with a natural disaster. Terrorism is an example of a man-made disaster. “Terrorism is a deliberate act of violence, which aims at provoking intense fear and shattering all sense of personal and community security in a person or group” (Hall et. al. 2002). Whether it is a massive attack or a single act of violence the warfare are not limited to the physical damage inflicted, instead psychological consequences also result. The degree of psychological consequences may vary depending upon the severity of exposure and personal susceptibility.

Keeping in mind, the difference between a natural traumatic event and a deliberate act of terrorism, we find that terrorism has become a monstrous problem throughout the world and Pakistan is unfortunately at the centre stage. On one hand, after repeated attacks of violence against common people in different parts of Pakistan, nation is in a constant state of insecurity and on the other hand, Pakistan’s current war against terrorism has forced the nation to live in constant state of hyper vigilance.

Individuals exposed to such terrorist acts may exhibit a number of complex psychological and emotional responses, but most common psychological reactions immediately after a terrorist attack may include a chronic state of high stress, paranoia, hyper vigilance, persistent feeling of anxiety, inability to sleep, nightmares, confusion, uncertainty, depression, reduced resilience and increased demoralization. Although, exhibiting such high stress symptoms is thought to be a normal response, and most people recover from it, but some become so overwhelmed by the questions arising in their minds after a close escape to death (e.g. why it happened? why did it happen to me? Am I safe now? If it happens again would I be able to survive? etc.), that they fail to recover completely and successfully. Thus, they may develop Post Traumatic Stress Disorder (PTSD).

CBT has been found to be an effective intervention for the reduction of PTSD symptoms, especially when combined with Prolonged Exposure (PE). According to Gould, et al (1997) CBT is more effective than medication in treating anxiety disorders. That is simply because of CBT's ability to challenge the negative cognitions/thoughts regarding the event (e.g. I am not safe at a market or any other crowded place) and then replacing it with more positive thought/interpretation about the exposure (e.g. It is not necessary that something catastrophic will always happen at a crowded place). Trauma focused CBT has eight important components, which are applied in a number of sessions with the client. Child Welfare Information Gateway (CWIG; 2007) has accurately summarized all these essential components in one word i.e. PRACTICE where;

P: Involves Psycho-education about the traumatic event in general and common emotional and behavioral responses to such events and teaching the clients how to communicate his/her feelings in an appropriate manner.

R: Stands for Relaxation, helping the client to relax, teaching him various relaxation techniques like guided imagery, deep breathing, muscles relaxation, etc.

A: This component is all about affect. Teaching the client to be expressive as well as exerting control on his/her emotions and fears.

C: Correcting the inappropriate or negative thoughts of the client.

T: Trauma Narrative involves the recounting of traumatic event verbally or in writing.

I: In Vivo Exposure to the videos or images of the related event to inculcate a sense of security in the client as well as to aid him in developing coping strategies if he/she is confronted with any such traumatic event in future.

C: Co-joint sessions with family members to increase client's sense of social support and security.

E: This components deals with Enhancing sense of personal security, allowing the client to deal with the memories of previously experienced trauma as well as handling future challenges in more effective ways.

So, in view of all this we can say that, incorporating the basic components of trauma focused CBT in traditional CBT and while planning and implementing the treatment of PTSD, can prove to be extremely effective in the real sense. This is essentially important since Pakistan has seen numerous natural disasters in addition to nonstop terrorism during the last few decades.

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Introducing Cognitive Behavior Therapy in Schools

Tamkeen Malik

School-wide mental health service is an entirely new concept in Pakistan and many of our fellow professionals feel reluctant while talking about such ideas here. The questions of such sort generally come in our way as “what is the need of such services?”, “From where we can seek such services?”, “Do our school administrations consider it as one of the priorities?” and most importantly “Who will fund such services?” It’s true that in current situation a general attitude, awareness and understanding in this regard is lacking. However, in our big cities like Islamabad, Karachi and Lahore many private school systems have started looking for mental health services now. They look for it in two ways, first to seek help for those children who have problem behaviors and learning difficulties, and second to train their teachers for effective management strategies. The primary purpose is generally to train them for how to manage aggression, and violence in classrooms. At times school administrations also look towards professionals for management of conduct related issues of students.

However, extreme shortage of trained professionals in this area is a major hurdle. Newly trained Psychologists are usually not willing to work in educational settings while those who are working there are not well trained. However, this challenge can surely be encountered by seeking in depth understanding of Cognitive Behavior Therapy. A reader can surely ask, why cognitive behavior therapy should be prioritized in school settings? Answer is simple; the present-oriented and solution-focused approach of CBT provides us a flexible model. It has been found to work across different cultures. It is also a short term intervention and has established evidence base as well as proven to be cost effective. This approach can fit well into the problem-solving and critical thinking skills used in schools. Research also suggests that a parallel exists between cognitive-behavior therapy (CBT) and existing

educational services of schools. This can enhance the likelihood that the services will be accepted by educators and school administrations.

Such programs generally exist at three levels—universal school-wide interventions provided to all students, target interventions with at-risk students, and intensive interventions with students in need. A single article doesn't offer much space to write about these school-based CBT programs in detail. So, I would only give some snapshots of universal interventions.

Many of these programs generally focus on teaching all students the fundamental skills needed for effective social behavior. Generally such programs include skills like (1) self-awareness (2) social awareness (3) self-management (4) relationship skills, (5) responsible decision-making.

The I Can Problem Solve Program (ICPS) is one example of such programs (Shure, 2001a). Originally known as Interpersonal Cognitive Problem Solving, it is effective for violence prevention and general problem solving for age 4-12 years. This program can be effectively instituted by both parents and teachers and is meant to last between 20 and 45 minutes daily or every other day for 4 months. Games, dialogue, and fictional children are used throughout the activities. The program's purpose is to teach children "how to think and not what to think." This is done through developing brainstorming skills and creating alternative solutions that will finally resolve conflicts (Shure, 2001a). Another example of such programs is Promoting Alternative Thinking Strategies Curriculum (PATHS). This CBT based curriculum focuses on emotional development, self-regulation, and social problem solving skills. Interestingly, this intervention requires little training and school teachers can also implement the program at universal level. Components of the program are taught through various methods, like puppets, role plays and stories. Responding in Peaceful and Positive Ways (RIPP) as another CBT based program which focuses on violence prevention and pro-social behavior, which occurs through team building and class-wide lessons. Readers interested for more details about this program can try this URL http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=95.

Interested readers can also consult *Cognitive-Behavioral Interventions in Educational Settings: A Handbook for Practice* (Mennuti, et al, 2006). This book provides a comprehensive review of these interventions along with the possible challenges which can be encountered to service providers. However, an important question is the cultural relevance and effectiveness of such programs for our Pakistani children, especially in the context of different school systems and mediums of instruction. Although many of these programs have proven to be effective for many cultural groups, the practitioners should show a greater degree of precaution and sensitivity while implementing these programs here.

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Should We Add More Pills?

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Treatment Resistance is a term which is not only popular in Psychiatry but is frequently used in other specialties. Mostly we try to follow guidelines wherever available and applicable. Sometimes we try alternative methods. And the most common approach though not evidence based and that is we love to add more pills. This method being popularly adopted has done more harm rather than good to patients as it exacerbates resistance and gives unnecessary side effects and sometimes potentially life threatening situations like Neuroleptic Malignant Syndrome and Serotonin Syndrome. A great deal of data exists about the dangers of poly-pharmacy. People with psychiatric disorders are at increased risk for adverse drug interactions because of the great frequency with which multiple medications are used (Preskorn et al, 2005). Using multiple antipsychotics concomitantly has been associated with increased mortality in patients with schizophrenia (Joukamaa et al, 2006). Reports of adverse effects of poly-pharmacy in Psychiatry are abundant, including increased duration of hospital stay (Parks et al, 1997). Antipsychotic poly-pharmacy has been linked to a greater incidence of adverse reactions (Centorrino et al, 2007), which in turn may lead to increased hospitalizations (Col et al, 1990). Data are only sparse in support of antidepressant combinations for depression (Joel et al, 2010) and sedating-medication combinations for anxiety. The rationale for antidepressant combinations in bipolar disorder is questionable. Antipsychotic combinations, which have become much more common in recent years, are not only generally ineffective but also convey an increased risk for metabolic and possibly cardiovascular adverse effects (Peter et al, 2009). The addition of aripiprazole to risperidone or quetiapine was not associated with improvement in psychiatric symptoms (Kane et al, 2009).

What should be done in such cases of Resistant Schizophrenia, Depression, bipolar disorders, OCD and other anxiety disorder? Is there an answer to this burning question? Can we do something to prevent and treat resistance? There is an answer and that is quite evidence based. Cognitive behavior therapy is today an answer to Treatment Resistance in Depression, OCD, Anxiety Disorders and Schizophrenia. Recent literature provides fairly strong evidence that cognitive behavior therapy in addition to antipsychotic medication is effective in the management of acute as well as chronic schizophrenia, However, despite its proven efficacy, it remains a rarely used intervention, especially outside the developed world. In the reviews by Rector and Beck in which they studied seven randomized controlled trials testing the efficacy of CBT for schizophrenia (Rector et al, 2001) and by Pilling et al included the results from eight randomized trials (Pilling *et al*, 2002), CBT seemed to be particularly effective in helping people with the psychopathology of schizophrenia. It was reported to be more effective in improving overall symptoms at the end of treatment and at 9-12-month follow-up in comparison with standard care and other

psychological approaches. Gould et al. reported a large effect size with CBT in residual positive symptoms at the end of therapy (Gould et al, 2001).

Pills work really wonders, yet cognitive therapy preserves its magical effect and can turn impossibilities to possibilities. Therefore following the evidence, it should be applied wherever applicable and feasible.

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Cultural Adaptation of the CBT

Dr Farooq Naeem

It has been pointed out that cultural differences can influence the process of counseling and psychotherapy (for example, Pande 1968). During the last few years many counseling therapists have tried to address the issues surrounding cultural sensitivity and development of culturally adapted CBT. Scorzelli (1994) for example has asserted that “because most counseling theories were developed by white males from America or Europe, it is possible that they may conflict with the cultural values and beliefs of third world or minority individuals”.

Most of the literature in this area was published by mental health professionals working in the West and mainly focuses on cultural differences rather than actual comparison of psychotherapy techniques in clients from different ethnic groups. It is noticeable that most of the published work describes personal opinions and observations of these authors. A literature search, however, makes it very obvious that modern Western psychotherapy is not widely practiced in most non Western countries. It should be noted that the available literature on psychological interventions in non white populations has mainly focused on Asian cultures (particularly Indian and Chinese living in the West) and is full of conflicts and contradictions.

It has been suggested that CBT is as value-laden as any other psychotherapy (Hays 2006). Although this assertion needs to be tested through scientific methods in different cultures, it has an intuitive appeal. There is some evidence to suggest that this might be the case. For example, one study from India reported that 82% students felt that principles underlying cognitive therapy conflicted with their values and beliefs (Scorzelli 1994). Of these, 46% said that therapy conflicted with their cultural and/or family values and 40% described conflict with their religious beliefs.

CBT involves exploration and attempts to modify core beliefs. People with depressive illness and anxiety usually have beliefs about the self, others and the world that are unhelpful. Such core beliefs, underlying assumptions and even the content of automatic thoughts might vary with culture (Padesky 1995). There is some evidence from Hong Kong (Taam, 2007) that this might be the case. Role performance within family, familial harmony, fate, face and fairness were described as culture specific themes in the study from Hong Kong. Similarly, work on one study from Turkey (Sahin, 1992) pointed out that some dysfunctional beliefs might not be considered as dysfunctional in another culture.

Most research on CBT originates from the UK and the USA. Since both these countries have a significant population of ethnic minorities it is not a surprise that recently some researchers in this area have focused on applying CBT techniques to members of ethnic minority groups. Some US therapists working with ethnic minority patients have developed guidelines for adaptation of therapy. It has been suggested that three main areas need considering, when treating clients from an ethnic minority: culture bound communication styles, socio-political facets of non-verbal communication and counseling as a communication style (Sue, 1990). Bernal and colleagues (Bernal, 1995) created a framework for culturally sensitive interventions, which consists of the following dimensions: language, person, metaphor, content, concepts, goals, methods and context. Hwang 2006, on the basis of his work with Chinese clients in the USA, proposed a more detailed framework which consists of six therapeutic domains and 25 therapeutic principles. The therapeutic domains include the following: (a) dynamic issues and cultural complexities, (b) orienting clients to psychotherapy and increasing mental health awareness (c) understanding cultural beliefs about mental illness, its causes and what constitutes appropriate treatment (d) improving the client-therapist relationship (e) understanding cultural differences in the expression and communication of distress and (f) addressing cultural issues specific to the population. Pamela Hays (Hays

2006) has offered a framework for therapists using CBT with their ethnic minority clients which can be abbreviated as ADDRESSING, and consists of the following areas of importance: (A) age and generational influences, (D) developmental or (D) acquired disabilities, (R) religion and spiritual orientation, (E) ethnicity, (S) socioeconomic status (S) sexual orientation, (I) indigenous heritage, (N) national origin and (G) gender. Another framework (Tseng, 2001) proposes that three level of cultural adjustments need to be made in psychotherapy; i.e. technical adjustments, theoretical modifications and philosophical reorientation. Technical adjustments include: orientation towards and expectations of psychotherapy, therapist-patient relationships, communication and explanation of illness, therapeutic focus, cognition or experience and selection of mode of therapy. Theoretical modifications need to be considered in: concept of self and ego boundaries, interpersonal dependence and independence, the concept of interface between body and mind and theories of personality development and parent-child complex and defense mechanisms and coping. Philosophical reorientation needs to address: choice of lifestyle, acceptance versus conquering, soul and spirituality and the goal of therapy, normality and maturity. It should be pointed out that most of the above mentioned frameworks were described by therapists working with Chinese Americans and address wide therapeutic issues rather than issues pertaining to any particular type of therapy. Similarly none of the above frameworks was developed as a direct result of the research to address this issue but instead described the experience of therapists.

While these admirable attempts were being made in the West, limited efforts have been made in non Western cultures to systematically address the issue of the adaptation of CBT taking into consideration the local needs. CBT was developed in the West, just like many other psychological treatments. However, these treatments were developed within the context of social, medical, political and financial environment of the West. Pharmacological and surgical treatments are easier to transfer across the cultures, since influencing factors (e.g., training of professionals or infrastructure) can be easily controlled. However, to adapt psychological therapies, additional cultural barriers including language need to be overcome. Differing health systems might pose problems which might need radical solutions. The practice of CBT is entwined with the current western system of health as well as psychological and social support. Distance from the psychiatric facility and the number of mental health professionals trained in CBT might be obvious barriers in using CBT in developing countries. Another issue here is that the psychological interventions need the active participation of the recipients, compared with the passive involvement of the recipient in the case of physical treatments. As highlighted above therapists in the West practicing CBT are of the opinion that CBT needs adapting for ethnic minority clients. We also discovered that Pakistani psychologists feel that CBT needs to be adapted according to the local cultural needs (Naeem et al, 2009).

We have successfully adapted CBT for depression and Psychosis in Pakistan. Our work consisted of a series of qualitative studies (Naeem et al, 2009, Naeem et al, 2010, Naeem et al, under review). It was part of Developing Culturally Sensitive CBT Project in Southampton, UK. Adapted CBT was found to be successful in a pilot project (Naeem et al, in press). But this is just the beginning of a new branch of CBT, which I tentatively call “ethno CBT”, or study of CBT across cultures.

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