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FACULTY OF MEDICINE, HEALTH AND LIFE SCIENCES

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Adaptation of Cognitive Behaviour Therapy for depression in Pakistan

By

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Thesis for the degree of Doctor of Philosophy

Jul 2011

ABSTRACT

Background

Cognitive Behaviour Therapy (CBT) in its current form might not be applicable in Non Western cultures. Differences between western and non western cultures have been reportedly widely. Psychotherapy was developed in the west and is underpinned by many beliefs and practices which might be specific only to the Western culture. However, in order to modify CBT we need to understand whether the concepts associated with the CBT might cause conflicts among people who receive therapy, the barriers in giving therapy and the views of the patients. This project was carried out mainly in Pakistan to adapt CBT for depression.

Aims

To find out if CBT can be successfully adapted in a Non Western culture

Methods

This was a mixed methods Study. The project consisted of two phases. In the first phase a series of studies were carried out, including interviews with psychologists, patients and group discussions with university students about their views regarding concepts underlying therapy. In the second phase a CBT for depression manual was modified using guidelines which were developed on the basis of studies carried out in the first phase. This manual was then tested in a small pilot project using a Randomised Controlled Trial (RCT) design. .

Results

We were able to find themes and subthemes, on the basis of studies in first phase of the project, which were used to modify a CBT for depression manual. We developed an adaptation framework on the basis of the identified factors. This framework consisted of three broad themes (name theme) with each subdivided into seven sub themes. The pilot study showed that therapists trained for a short period and under supervision can deliver CBT using a manual. Results of pilot showed that modified CBT is more effective than 'care as usual' in reducing symptoms of depression.

Conclusions

The study demonstrates that for CBT to be effective in Non Western cultures, it needs modification. This can be achieved using small scale qualitative studies locally, which explore experience of therapists working in a given culture as well as by exploring the views of patients. Further information can be obtained by talking to the members of that community about concepts underlying CBT. However, these are preliminary findings and further research needs to be done to explore this area further.

Declaration of interest None

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I dedicate this work to my teachers

Professor David Kingdon, Dr Stephen Obrien

&

Profersor IAK Tareen

and to my father

Ruh Ullah Khan Naeem

INTRODUCTION

This thesis describes the process of adaptation of cognitive behaviour therapy for depression, and evaluation of its effectiveness through a pilot project in Pakistan. This work was carried out between January 2007 and November 2009. Cognitive Behaviour Therapy (CBT) is an effective treatment for the treatment of depression. It has been found to be effective not only in treating depression, but also in prevention of its relapse. It has proven to be cost effective alongside pharmacological treatments. It can be delivered after training by health workers under supervision and therefore might be valuable in treating depression in low and middle income countries, like Pakistan. Pakistan has experienced numerous traumas and mishaps since independence in 1947. The rates of mental health problems, especially depressive illness, are considered to be fairly high in Pakistan. Adapting a cost effective intervention such as CBT might therefore be of enormous help in reducing depression in Pakistan. However, CBT would need adapting for its use in non western cultures.

The majority of the population of Pakistan is Muslim but the culture follows many Asian and Hindu traditions. Pakistani culture also draws some values from central Asian cultures due to its proximity to the central Asian regions. This means findings from the project might be more generalizable than a study carried out in a country with a more homogenous culture. Other reasons for selecting Pakistan for this project included; I am originally from Pakistan, have extensive contacts with the mental health professionals and it was convenient, because as the study was self-funded, I could stay with my parents during the relevant period.

This thesis is divided into 13 chapters. The first chapter gives an overview of the problem, i.e. depression around the globe. It starts with prevalence and moves on to discuss variations in symptomatology and presentations across cultures, theories of its causation and its relationship with suicide and finally its cost to both individual and the society. The second chapter focuses on different treatment options, for example antidepressants, psychotherapy and Electro Convulsive Therapy (ECT). The next chapter (chapter 3) is a more detailed description of CBT, which is a type of

psychotherapy. Although the main focus of this chapter is CBT for depression, it also describes the historical, theoretical and philosophical perspectives. Since CBT was developed in the west (as highlighted in chapter 3) and therefore might have been heavily influenced by the underlying cultural values, chapter 4 discusses the link between culture and CBT. This chapter first discusses issues relevant to psychotherapy and culture and then more specifically possible barriers in trans-cultural application of CBT. This chapter briefly discusses Sufism (Islamic version of mindfulness). The next two chapters focus on mental health in Pakistan in general but depression in specific. Chapter 5 describes Pakistani health system, the state of psychiatric care in Pakistan as well as traditional healing practices in Pakistan, while chapter 6 discusses current research on depressive illness in Pakistan, in particular research on management of depression.

Chapter 7 is an introduction to the project which discusses the need for the project, methodology used, the reasons for choosing CBT, and a brief description of qualitative methods which we used in our work. Since very limited information was available to help us with adaptation of CBT, we started by exploring the views of psychologists in Pakistan. Chapter 8 describes these interviews with the psychologists, the methods adopted and the results of the qualitative analyses. Based on these interviews a natural next step seemed to be exploring the patient's views about their illness and its treatment and to see what they think about CBT. These interviews and their results are described in chapter 9. It was also considered important to find out the opinions that lay persons have about CBT. To this aim, group discussions were conducted and the process, methodology and results of these are presented in chapter 10. Once information from these small scale studies was available, we developed guidelines to adapt therapy on the basis of this information which are described in chapter 11. Chapter 12 describes the pilot project which was conducted to assess the effectiveness of the adapted therapy in primary care for depressed patients using a Randomised Controlled Trial (RCT) design.

The final chapter (chapter 13), summarizes the thesis and discusses some of the findings. It also describes limitations of the project, the lessons we learned about the overall methodology and the impact this project had in Pakistan.

CHAPTER 1 DEPRESSIVE ILLNESS

Depressive illness is a highly prevalent disorder. Indeed, the experience of depressive illness is now considered to be a universal phenomenon, although the clinical features may differ significantly across different cultures. According to the World Development Report, depressive illness ranks fifth among women and seventh among men as a cause of morbidity (World Bank, 1993). Depressive illness can occur as a single episode in a lifetime, as one of many episodes, or as a part of an alternation with mania (WHO, 1992). The World Health Organization predicted that in the year 2020 depressive illness will be, worldwide, the second most important cause of disability after ischemic heart disease. More importantly, in developing countries major depressive illness is projected to be the leading cause of disease burden (Murray & Lopez, 1997).

1.1 Prevalence of depressive illness

Epidemiological studies have shown that the rates of depressive illness vary across the world. An international epidemiological study of the prevalence of depressive illness in ten countries (Weissman, Bland, et al., 1996) for example, found that the lifetime prevalence of depressive illness varied between 1.5% (in Taiwan) and 19% (in Beirut). The same study also found that women had higher rates than men in all the countries and the mean age at onset was concentrated around the late twenties in most countries. Another large study by the World Health Organization (WHO) (Sartorius, Ustun et al. 1996) investigated common psychological problems in primary care settings in 15 different countries (25 916 adults). About a quarter (24%) of the primary care attendees worldwide received an ICD–10 psychiatric diagnosis. The most common diagnosis was ‘current depressive episode’ (10.4%), while the most frequent co-morbid disorders were depressive illness and anxiety. However, marked differences were observed in the prevalence of depressive illness at different centres even after

correction for between-centre differences such as age. Different levels of awareness and recognition for cultural issues (Lecrubier, 2001), popular perceptions of the role of the doctor in each country, and different pathways to care and health systems (for example, medical care must be paid for at the Ibadan centre (Iran), which had one of the lowest prevalence rates) have been identified as some of the important contributing factors in this variation (Goldberg, 1999).

A literature review of community studies of depressive illness in Europe (Paykel, Brugha et al., 2005) concluded that although, methodological differences in survey methods, instruments, nuances in language and translation limit comparability, findings were rather consistent. Western European countries show 1 year prevalence of major depressive illness to be around 5%, with two-fold variation, probably due to methodological issues, and with higher prevalence in women, the middle-aged, less privileged groups and those experiencing social adversity. Depressive illness was also found to have very high rates of co-morbid disorders, both psychiatric and physical.

1.2 Presentation

The cultural background is likely to determine whether depressive illness will be experienced and expressed in psychological and emotional terms, or in physical terms (Desjarlais, 1995). According to the International Classification of Diseases (ICD 10) (WHO 1992), a depressive episode is characterized by; depressed mood, loss of interest or pleasure in activities that are normally pleasurable, decreased energy or increased fatigability, loss of confidence and self-esteem, unreasonable feelings of self-reproach or excessive and inappropriate guilt, recurrent thoughts of death or suicide, or any suicidal behaviour, complaints or evidence of diminished ability to think or concentrate, change in psychomotor activity, with agitation or retardation and disturbance of sleep or appetite**.** A depressive episode may be classified according to severity into mild, moderate or severe.

The experience of depressive illness is recognisable in any culture in which it has been sought, although its clinical presentation may vary widely. Even core symptoms such as depressed mood or loss of interest may not be prominent in many cultures (Bhugra and Mastrogianni, 2004). However, this is an area which needs careful analysis. The case of depressed patients presenting with somatic symptoms can be considered as an interesting example in this regard. Earlier theories of depressive illness suggested that somatisation was the cultural equivalent of depressive illness, typically occurring in non-Western cultures (Bhatt, Tomenson et al., 1989). There is now growing evidence however, that somatic symptoms are common presenting features of depressive illness throughout the world (Bhatt, Tomenson et al., 1989). The terms ‘anxiety’ and ‘depressive illness’ as used in English

both have essentially somatic roots. Colloquial British expressions such as 'I feel gutted' also describe feelings of loss and depressive illness in somatic metaphorical terms (Bhugra and Mastrogianni, 2004).

The WHO Collaborative Study on the Assessment of Depressive illness (Sartorius, 1983), conducted in Basle, Montreal, Nagasaki, Teheran and Tokyo, reported that the most common symptoms (75% of cases) across sites were sadness, joylessness, anxiety, tension, lack of energy, loss of interest, loss of ability to concentrate, and ideas of insufficiency, inadequacy and worthlessness. Feelings of guilt and self-reproach were more prominent in Basle and Montreal. Suicidal ideation ranged from 70% in Montreal and Nagasaki to 41% in Tokyo. Somatic symptoms were most common in Teheran and least frequent in Montreal. The variations in symptoms can be seen as culturally influenced.

A study of depressive illness, anxiety and somatic complaints among primary care patients in the UK, compared three groups of patients with preferred languages of English, Gujarati or Urdu on a standardized interview with regard to symptom complaint, perception and attribution of illness. Researchers also completed the General Health Questionnaire (GHQ) and Illness Behaviour Questionnaire (IBQ) (Bhatt, Tomenson et al. 1989). Patient's General Practitioners (GPs) provided diagnoses and ratings of physical and mental disorders. Compared with the English speaking group, the Gujarati speaking patients had fewer psychosocial complaints, perceived less anxiety and were more likely to attribute their complaints to physical causes and scored higher on the Hypochondriasis and Denial scales. Their GPs rated them as less likely to have relevant physical or mental disorders. The Urdu speaking group was intermediate in most respects. Although the rates of somatisation were higher in these two Asian groups with different ethnic origins, the overall levels of somatisation appeared to be high even in the English speaking group. No significant differences were found among the groups for complaints or ratings of depressive illness and the differences found in the somatisation process appeared to be related only to anxiety.

A paper describing a sub-analysis of data from the "WHO Study on Psychological Problems in General Health Care", looked into the relationship between somatic symptoms and depressive illness (Simon, VonKorff et al., 1999). The proportion of patients with depressive illness who reported only somatic symptoms ranged from 45% in Paris to 95% in Ankara (overall prevalence 69%). However, when somatisation was defined as 'medically unexplained somatic symptoms' or 'denial of psychological distress', no significant variation between centres was found. The authors concluded that the frequency of somatic symptoms depends on how somatisation is defined. It has also been

suggested that somatisation is a concept that reflects the dualism inherent in Western biomedical practice, whereas in most of the great traditions of medicine (such as Chinese or Ayurvedic Medicine) a sharp distinction between the 'mental' and the 'physical' does not occur (Kirmayer and Young, 1998). People from traditional cultures may not distinguish between the emotions of anxiety, irritability and depressive illness because they tend to express distress in somatic terms or they may organise their concepts of dysphoria in ways different from Western ones (Leff, 1977) . When the expression of depressive illness by Korean immigrants in the USA were studied it was found that they express emotions symbolically or physically (Pang, 1998). These physical terms are neither bodily nor emotional, but somewhere between. Dysphoria was expressed in holistic symptoms ('melancholy has been absorbed into my body'). The speakers were not somatising, just speaking metaphorically in expressing emotions. This is in accordance with Korean traditional medicine, which allocates symbolic functions to each body organ: the lungs are related to worry, sorrow and low spirit; the liver to anger; the kidneys to fear. A study using focus group design with depressed Punjabi women in London (Bhugra 1997) found that they recognized the English word 'depressive illness', but the older ones used terms such as 'weight on my heart/mind', or 'pressure on the mind'. Symptoms of 'gas' and 'feelings of heat' were identified, which is in accordance with traditional and Ayurvedic models of "hot and cold". All the participants were aware of the condition and of the link between bodily and emotional states. Studies from the Indian subcontinent report inconsistent results regarding the frequency of different symptoms of depressive illness as well as of somatic symptoms (Bhugra, 1996). A study from the Middle East exploring the detection of depressive illness in the United Arab Emirates found that Arab patients use a variety of somatic metaphors to describe depressive illness (Hamdi, Amin et al., 1997). Another study from Dubai in which focus groups were conducted to identify terms and descriptions used for depressive illness, reported that natives of Dubai, like other Arab populations, are more likely than Western people to associate depressive illness with aches, pains and weakness (Sulaiman, 2001). The term 'depressive illness' itself is absent from the languages of many cultures; it is used rarely in others (Hamdi, Amin et al., 1997) or it is construed differently (Abusah, 1993). Researchers seem to agree that each culture has its own emotional lexicon that encodes socially and morally significant values and its own idioms of distress – cultural ways of talking about distress. These observations are very important from the diagnostic and treatment point of view. In any case, the clinician's ability to understand these local idioms is crucial not only for accurate diagnosis, but also for the building of a therapeutic alliance (Bhugra and Mastrogianni, 2004). Understanding the culturally appropriate expressions of distress is even more important in providing psychotherapy.

1.3 Aetiology of depressive illness

The aetiology of depressive illness, the mood disorder most frequently studied, is far from ideally understood. Many cases of depressive illness are triggered by stressful life events, yet not everyone becomes depressed under such circumstances. The intensity and duration of these events, as well as each individual's genetic endowment, coping skills and reaction, and social support network, contribute to the likelihood of depressive illness. That is why depressive illness and many other mental disorders are broadly described as the product of a complex interaction between biological and psychosocial factors. The relative importance of biological and psychosocial factors may vary across individuals and across different types of depressive illness.

Our current understanding of depressive illness essentially incorporates the biological, genetic, and psychosocial factors—such as cognition, personality, and gender—that correlate with, or predispose to, depressive illness. Genes are implicated even more strongly in bipolar disorder than they are in major depressive illness, galvanizing a worldwide search to identify chromosomal regions where these genes may be located and ultimately to pinpoint the genes themselves (Rockville, 1998).

Over the past 40 years many researchers studying depressive illness have tried to search for biologic alterations in brain function, e.g. neurochemical abnormalities. From the beginning, it has been recognized that the clinical heterogeneity of depressive illness disorders may preclude the possibility of finding a single defect. Researchers have detected abnormal concentrations of many neurotransmitters and their metabolites in urine, plasma, and cerebrospinal fluid in subgroups of patients; dysregulation of the HPA (Hypothalamic-Pituitary-Adrenal) axis, elevated levels of CRF (Corticotropin Releasing Factor), and, most recently, abnormalities in second messenger systems and neuroimaging (Thase 1995; Mitchell 1998; Rush, 1998). Researchers have also focused on "how the biological abnormalities interrelate, how they correlate with behavioural and emotional patterns that seem to distinguish one subcategory of major depressive illness from another, and how they respond to diverse forms of therapy". In the search for biological changes with depressive illness, it must be understood that a biological abnormality reliably associated with depressive illness may not actually be a causal factor. For example, a biologic alteration could be a consequence of sleep deprivation or weight loss. Any biological abnormality found in conjunction with any mental disorder may be a cause, a correlate, or a consequence. What drives research is the determination to find, which of the

biological abnormalities in depressive illness are true causes?, especially those which might be detectable and treatable before the onset of clinical symptoms.

For many years the prevailing hypothesis was that depressive illness was caused by an absolute or relative deficiency of monoamine transmitters in the brain. This line of research was bolstered by the discovery many years ago that Reserpine, a medicine for hypertension, inadvertently caused depressive illness. It did so by depleting the brain of both serotonin and the three principal Catecholamines (Dopamine, Norepinephrine and Epinephrine). Such findings lead to the "Catecholamine hypothesis" and the "Indoleamine (i.e., Serotonin) hypothesis", which in due course lead to an integrated "Monoamine hypothesis" (Thase, 1995).

After more than 4 or 5 decades of research, however, the "Monoamine hypothesis" has been found insufficient to explain the complex aetiology of depressive illness. One problem is that many other neurotransmitter systems are altered in depressive illness, including GABA (Gamma-aminobutyric acid) and Acetylcholine (Rush, 1998). Another problem is that improvement of monoamine neurotransmission with medications and lifting of the clinical signs of depressive illness do not prove that depressive illness actually is caused by defective monoamine neurotransmission. A frequent example cited in literature (Rush, 1998) is that of diuretic medications, which do not specifically correct the physiological defect underlying congestive heart failure, but they do treat its symptoms. Neither impairment of monoamine synthesis, nor excessive degradation of monoamines, is consistently present in association with depressive illness; monoamine precursors do not have consistent antidepressant effects and a definite temporal lag exists between the quick elevation in monoamine levels and the symptom relief that does not emerge until weeks later (Duman, 1997). To account for these discrepancies, one new model of depressive illness proposes that depressive illness results from reductions in neurotropic factors that are necessary for the survival and function of particular neurons, especially those found in the hippocampus (Duman, 1997). Despite the problems with the hypothesis that monoamine depletion is the primary cause of depressive illness, monoamine impairment is certainly one of the manifestations, or correlates, of depressive illness. Therefore, the monoamine hypothesis remains important for treatment purposes. Many currently available pharmacotherapies that relieve depressive illness or cause mania, or both, enhance monoamine activity. One of the foremost classes of drugs for depressive illness, SSRIs (Selective Serotonin Reuptake Inhibitors), for example, boost the level of serotonin in the brain.

However, an important shortcoming of the monoamine hypothesis is its inattention to the psychosocial risk factors that influence the onset and persistence of depressive episodes. The nature and interpretation of, and the response to stress clearly have important causal roles in depressive illness. The damaging effects of chronic stress on the HPA axis, the gastrointestinal tract, and the immune system of rats: adrenal hypertrophy, gastric ulceration, and involution of the thymus and lymph nodes has long been well established (Selye 1956). Researchers have provided ample evidence that brain function, and perhaps even anatomic structure, can be influenced by stress, interpretation of stress, and learning (Sapolsky, 1996). Much current research has been directed at stress, the HPA axis, and CRH (Corticotropin Releasing Hormone) in the genesis of depressive illness. Depressive illness can be the outcome of severe and prolonged stress (Ingram, 1998). The acute stress response is characterized by heightened arousal—the fight-or-flight response—that entails mobilization of the sympathetic nervous system and the HPA axis. Many aspects of the acute stress response are exaggerated, persistent, or dysregulated in depressive illness (Thase, 1995). Increased activity in the HPA axis in depressive illness is viewed as the "most venerable finding in all of biological psychiatry" (Nemeroff, 1998). Increased activity of the HPA axis, however, may be secondary to more primary causes, as was the problem with the monoamine hypothesis of depressive illness. For this reason, much attention has been focused on CRH, which is hyper-secreted in depressive illness. CRH is the neuropeptide that is released by the hypothalamus to activate the pituitary in the acute stress response. Yet there are many other sources of CRH in the brain (Nemeroff, 1998).

CRH injections into the brain of laboratory animals produce the signs and symptoms found in depressed patients, including decreased appetite and weight loss, decreased sexual behaviour and sleep, and other changes (Sullivan, 1998). Furthermore, CRH is found in higher concentrations in the cerebrospinal fluid of depressed patients (Nemeroff, 1998). In autopsy studies of depressed patients, CRH gene expression is elevated, and there are greater numbers of hypothalamic neurons that express CRH (Nemeroff, 1998). These findings have ignited research to uncover how CRH expression in the hypothalamus is regulated, especially by other brain centres such as the hippocampus (Mitchell, 1998). It is believed that shedding light on the regulation of CRH is expected to hold dividends for understanding both anxiety and depressive illness (Nemeroff, 1998).

If stressful events are the proximate causes of most cases of depressive illness, then why is it that not all people become depressed in the face of stressful events? The answer might lie in the possibility that social, psychological, and genetic factors act together to predispose to, or protect against,

depressive illness. This section first discusses stressful life events, followed by a discussion of the factors that shape our responses to them. Adult life can be rife with stressful events, and although not all people with depressive illness can point to some precipitating event, many episodes of depressive illness are associated with some sort of acute or chronic adversity (Ingram, 1998). The death of a loved one is viewed as one of the most powerful life stressors. The grief that ensues is a universal experience. Common symptoms associated with bereavement include crying spells, appetite and weight loss, and insomnia. Grief, in fact, has such emotional impact that the diagnosis of depressive illness should not be made unless there are definite complications such as incapacity, psychosis, or suicidal thoughts (WHO, 1992).

The compelling impact of past parental neglect, physical and sexual abuse, and other forms of maltreatment on both adult emotional well-being and brain function is now firmly established for depressive illness. Early disruption of attachment bonds can lead to enduring problems in developing and maintaining interpersonal relationships and problems with depressive illness and anxiety. In both rodents and primates, maternal deprivation stresses young animals, and a pattern of repeated, severe, early trauma from maternal deprivation may predispose an animal to a lifetime of over-reactivity to stress. Conversely, early experience with mild, non-traumatic stressors (such as gentle handling) may help to protect or "immunise" animals against more pathologic responses to subsequent severe stress (Plotsky, 1995).

According to cognitive theories of depressive illness, how individuals view and interpret stressful events contributes to whether or not they become depressed. One prominent theory of depressive illness stems from studies of learned helplessness in animals. The theory posits that depressive illness arises from a cognitive state of helplessness and entrapment (Seligman, 1991). The theory was predicated on experiments in which animals were trained in an enclosure in which shocks were unavoidable and inescapable, regardless of avoidance measures that animals attempted. When they later were placed in enclosures in which evasive action could have succeeded, the animals were inactive, immobile, and unable to learn avoidance manoeuvres. The earlier experience engendered a behavioural state of helplessness, one in which actions were seen as ineffectual. In humans there is now ample evidence that the impact of a stressor is moderated by the personal meaning of the event or situation. In other words, the critical factor is the person's interpretation of the stressor's potential impact. Thus, an event interpreted as a threat or danger elicits a non-specific stress response, and an event interpreted as a loss (of either an attachment bond or a sense of competence) elicits more grief-

like depressive responses. Heightened vulnerability to depressive illness is linked to a constellation of cognitive patterns that predispose to distorted interpretations of a stressful event (Ingram, 1998). For example, a romantic breakup will trigger a much stronger emotional response if the affected person believes, "I am incomplete and empty without her love," or "I will never find another who makes me feel the way he does." The cognitive patterns associated with distorted interpretation of stress include relatively harsh or rigid beliefs or attitudes about the importance of romantic love or achievement (again, the centrality of love and work) as well as the tendency to attribute three specific qualities to adverse events: global impact–"This event will have a *big* effect on me"; internality–"*I* should have done something to prevent this," or "This is *my* fault"; and, irreversibility–"I'll never be able to recover from this." According to a recent model of cognitive vulnerability to depressive illness, negative cognitions by themselves are not sufficient to engender depressive illness. This model postulates that interactions between negative cognitions and mildly depressed mood are important in the aetiology and recurrences of depressive illness. Patterns or styles of thinking stem from prior negative experiences. When they are activated by adverse life events and a mildly depressed mood, a downward spiral ensues, leading to depressive illness (Ingram, 1998).

Responses to life events also can be linked to personality (Hirschfeld, 1997). Personality may be understood in terms of one's attitudes and beliefs as well as more enduring neurobehavioural predispositions referred to as temperaments. The study of personality and temperament is gaining momentum. Neuroticism predisposes to anxiety and depressive illness (Clark et al., 1994). Having an easy-going temperament, on the other hand, protects against depressive illness (IOM, 1994). Further, those with severe personality disorder are particularly likely to have a history of early adversity or maltreatment (Browne, 1986). Temperaments are not destiny, however. Parental influences and individual life experiences may determine whether a shy child remains vulnerable or becomes a healthy, albeit somewhat reserved, adult. In adults, several constellations of personality traits are associated with mood disorders: avoidance, dependence, and traits such as reactivity and impulsivity (Hirschfeld, 1997). People who have such personality traits not only cope less effectively with stressors but also tend to provoke or elicit adversity. A personality disorder or temperamental disturbance may mediate the relationship between stress and depressive illness.

Gender differences have been well studied in prevalence of depressive illness. It is now well established that major depressive illness and dysthymia are more prevalent among women than men. This difference appears in different cultures throughout the world (Blumenthal, 1994; Weissman,

Bland et al., 1996). Understanding the gender-related difference is complex and likely related to the interaction of biological and psychosocial factors, including differences in stressful life events as well as in personality (Blumenthal, 1994). It has been suggested that something about the environment thus appears to interact with a woman's biology to cause a disproportionate incidence of depressive episodes among women (Blumenthal, 1994) . Research conducted in working-class neighbourhoods suggests that the combination of life stress and inadequate social support contributes to women's greater susceptibility to depressive symptoms (Brown, 1994). Because women tend to use more ruminative ways of coping (e.g., thinking and talking about a problem, rather than seeking out a distracting activity) and, on average, have less economic power, they may be more likely to perceive their problems as less solvable. That perception increases the likelihood of feeling helpless or entrapped by one's problem. Subtle sex-related differences in hemispheric processing of emotional material may further predispose women to experience emotional stressors more intensely (Baxter, 1987). Women are also more likely than men to have experienced past sexual abuse; as noted earlier in this chapter, physical and sexual abuse is strongly associated with the subsequent development of major depressive illness. Women's greater vulnerability to depressive illness may be amplified by endocrine and reproductive cycling, as well as by a greater susceptibility to hypothyroidism (Thase, 1995). Menopause, on the other hand, has little bearing on gender differences in depressive illness. Contrary to popular beliefs, menopause does not appear to be associated with increased rates of depressive illness in women (Pearlstein, 1997). Untreated mental health problems are likely to worsen at menopause, but menopause by itself is not a risk factor for depressive illness (Thacker, 1997). The increased risk for depressive illness prenatally or after childbirth suggests a role for hormonal influences. Similarly, there is evidence to suggest stressful life events have a role too. In short, psychosocial and environmental factors likely interact with biological factors to account for greater susceptibility to depressive illness among women.

Depressive illness, and especially bipolar disorder, clearly tend to "run in families," and a definite association has been scientifically established (Tsuang, 1990). The evidence from twin studies suggests that heritability of depression is 37-40% (Sullivan, 2000). Numerous investigators have documented that susceptibility to a depressive illness is twofold to fourfold greater among the first-degree relatives of patients with mood disorder than among other people (Tsuang, 1990). The risk among first-degree relatives of people with bipolar disorder is about six to eight times greater. Some evidence indicates that first-degree relatives of people with mood disorders are also more susceptible than other people to anxiety and substance abuse disorders (Tsuang, 1990). However, remarkable as

those statistics may be, they do not by themselves prove a genetic connection. Inasmuch as first-degree relatives typically live in the same environment, share similar values and beliefs, and are subject to similar stressors, the vulnerability to depressive illness could be due to nurture rather than nature. One method to distinguish environmental from genetic factors is to compare concordance rates among same-sex twins. At least in terms of simple genetic theory, a solely hereditary trait that appears in one member of a set of identical (monozygotic) twins also should always appear in the other twin, whereas the trait should appear only 50 percent of the time in same-sex fraternal (dizygotic) twins. The results of studies comparing the prevalence of depressive illness among twins vary, depending on the specific mood disorder, the age of the study population, and the way the depressive illness is defined. In all instances, however, the reported concordance for mood disorders is greater among monozygotic than among dizygotic twins, and often the proportion is 2 to 1 (Tsuang, 1990). One study from Denmark, found that among 69 monozygotic twins with bipolar illness, 46 co-twins also had bipolar disorder and 14 other co-twins had psychoses, affective personality disorders, or had died by suicide (Bertelsen, 1977). In studies of monozygotic twins reared separately ("adopted away"), the results also revealed an increased risk of depressive illness and bipolar disorder compared with controls (Mendlewicz, 1977). Within the major depressive illness grouping, greater heritable risk has been associated with more severe, recurrent, or psychotic forms of mood disorders (Tsuang, 1990). Those at greater heritable risk also appear more vulnerable to stressful life events (Kendler, 1996). The availability of modern molecular genetics methods now allows the translation of clinical associations into identification of specific genes (McInnis, 1993). Evidence collected to date strongly suggests that vulnerability to mood disorders may be associated with several genes distributed among various chromosomes. For bipolar disorder, numerous distinct chromosomal regions show promise, yet the complex nature of inheritance and methodological problems have encumbered investigators (Baron, 1997). Heritability in some cases may be sex–linked, or vary depending on whether the affected parent is the father or mother of the individual being studied. The genetic process of anticipation (which has been associated with an expansion of trinucleotide repeats) may further alter the expression of illness across generations (McInnis, 1993). Thus, the genetic complexities of the common depressive illness ultimately may rival their clinical heterogeneity (Tsuang, 1990).

The evidence from molecular genetic studies shows that depression shares genetic risk factors with bipolar disorder and schizophrenia, although there are some risk genes which are unique to depression (Middeldorp CM &NG. 2009). However, genetic influence might also be mediated by other factors, e.g. temperament.

1.4 Suicide

Suicide is the most catastrophic outcome of depressive illness. It is one of the leading causes of mortality worldwide, especially among young subjects. Suicide is considered the outcome of a multidimensional and complex phenomenon, which is a result of the interaction between several factors. The association between psychopathology and suicide has been extensively investigated. Major depressive illness plays an important role among the psychiatric diagnoses associated with suicide (Chachamovich, 2009). Consequent to its increasing prevalence, this condition has been considered a public health issue. Ethnicity has been recognised as an important variable in suicide research. It has been suggested that the lifetime rates of suicidal attempts vary across cultures (Sartorius, 1983). As a whole, the prevalence of deaths due to suicide is higher in East European countries, but lower in Central and South American countries. The rates in the US, Western Europe and Asia are in the middle range (Nock, 2008). Other parameters have been investigated as indicators of the impact of suicide. Its impact has been also assessed in terms of the DALYs (*disability-adjusted life years*). According to this indicator, suicide was responsible for 1.8% of the total impact of diseases worldwide in 1998. This rate varied from 1.7% in developing countries up to 2.3% in developed countries. Comparatively, these rates are similar to those of wars and homicides, and approximately twice the rate of conditions such as diabetes (WHO, 2000). The epidemiological survey of the Multisite Intervention Study on Suicide Behaviour (SUPRE-MISS) of the World Health Organization (WHO) interviewed 5,987 individuals from population samples of eight cities in South Africa, Brazil, China, Estonia, India, Iran, Sri Lanka, and Vietnam. Suicidal ideation (2.6-25.4%), suicide planning (1.1-15.6%) and suicide attempts (0.4-4.2%) varied among the centres studied. In the urban area of the city of Campinas-SP, in lifetime, 17.1% of individuals "had thought seriously about ending their lives", 4.8% even had elaborated a plan for that and 2.8% had effectively attempted suicide. Prevalence rates for the same during the previous 12 months however were, respectively, 5.3%, 1.9% and 0.4%. Suicide ideation was more frequent in women (OR = 1.7), in young adults (20 to 29 years: OR = 2.9; 30 to 39 years: OR = 3.6; compared to the group aged 14 to 19 years), among those who lived outside the family nucleus (OR = 4.2) and in those with mental disorders (OR between 2.8 and 3.8). Suicide ideation was strongly associated with depressive illness symptoms, especially with lack of energy (OR = 4.8) and depressed mood (OR = 4.4) (Bertolote, 2005).

Suicide is considered to be the outcome of a complex and multidimensional phenomenon, stemming from the interaction of several factors. There is consensus among researchers in suicidology about the notion that, there is no single factor capable of responding for the cause of suicide attempts.

Contrarily, the factors which concur for this phenomenon are consistent. Among the risk factors extensively studied in the international literature outstand prior suicide attempts, genetic factors, social and familial support, and psychopathology (Dumais, 2005). Historically, psychological theories have tried to understand the factors which concur for suicide. Psychoanalysis highlighted the pathological form of the grieving process which occurs in melancholy: the sadism would be invested against the self, identified with a lost object. Freud, when considering the importance of human aggressiveness, introduced a pulsional dualism: life instinct and death instinct (Freud, 1920;,1976). Menninger highlighted that the desire of killing, present in suicidal individuals, may be directed not only to an internal object, as the clinical experience reiteratively confirms that suicide is frequently aimed, as a revenge, to destroy the lives of the survivors (Menninger 1970). Cognitive psychology, in turn, understands that the higher the ideation, the higher the risk of suicide; the higher the desire of death, and, especially the feeling of hopelessness, the higher the suicide planning and the lethal power of the chosen method (Weishaar, 1992). Schneidman (1985) states that experiencing an unbearable emotional pain, "*psychache*", is what most characterizes the state of an individual in the imminence of committing suicide: a feeling of internal turbulence and of being caught within oneself. The idea of suicide would arise in a situation of constriction of the perceptive state (affective and intellectual narrowing).

The association between the clinical picture of major depressive illness and suicidal behaviour has been extensively described. These findings seem to be confirmed in different methodological designs and in different populations. For instance, population-based surveys in the US (National Comorbidity Survey and Epidemiologic Catchment Area), Canada and urban areas of China indicate that depressive illness is the main nosological entity associated with suicide attempts, suicidal ideation, and suicide plans (Chachamovich, 2009). It has been reported that, compared to anxiety disorders, the diagnosis of major depressive illness was associated with a nearly ten-fold odds ratio (OR = 1.9-18.5 and OR = 17.8-50.0, respectively) (Lee, 2007). Several clinical studies have also dealt with the association between depressive illness and suicide, and their conclusions point in the same direction. Using case-control studies with a diagnosis proceeding based on psychological autopsy interviews, McGill's Study Group on Suicide has consistently indicated the extensive association between major depressive illness and suicide. Lesage et al. investigated men victims of suicide and matched controls of the community of Montreal, exploring the co-morbidity patterns by means of latent class analysis (Lesage, 1994). Major depressive illness was the most frequently found Axis I diagnosis (38.7% in the studied group *vs.* 5.3% in the control group). Using an innovative data collection strategy (Life Trajectory

Instrument), which provides in detail the life events and psychological signs of the subject studied, Séguin et al. (2007) corroborated the remarkable prevalence of depressive illness in the studied sample (102 victims of suicide consecutively selected). The diagnosis of major depressive illness was the most widely found (66% of the cases), followed by substance use disorder (59%).

The importance of co-morbidity in increasing the suicide risk is also well established. One Finnish study of psychological autopsy, in a random sample of 229 suicides, has revealed that 93% of them had an Axis I psychiatric diagnosis. Only 12% of the cases received an Axis I diagnosis alone, without other associated disease. Almost half of the cases (44%) had two or more Axis I diagnoses. Most prevalent disorders were depressive illness (59%) and alcohol dependence or abuse (43%). A personality disorder diagnosis (Axis II) was suggested for 31%, and a diagnosis of non-psychiatric disease (Axis III) for 46% of suicide cases (Henriksson, 1993). In addition, a recent study on the same cases has shown that, although half of the victims considered as depressed were on psychiatric treatment at the time of suicide, only a few of them were receiving an adequate treatment for depressive illness. The results have also evidenced some factors more related to men who suffer from depressive illness: they seek less for help, they are less frequently diagnosed as depressed and receive fewer treatments for depressive illness, besides complying less with them (Isometsa, 1994). Among the depressed, drug dependence, panic attacks, severe anxiety, restlessness, and insomnia increase the chance of death by suicide (Clark, 1992). Among the elders it is common to find the coexistence of non-psychiatric diseases; among the youngest, personality disorders. In the case of bipolar disorder, the mixed states, delusions in the manic phase, and the lack of compliance with treatment increase the risk (Jamison, 1990). Interestingly, the presence of depressive illness sometimes represents the link (mediation) between anxiety and suicidality features. Diaconu and Turecki have demonstrated in a sample of outpatient psychiatric subjects with panic disorder that anxiety disorder alone was not associated with suicidality, whereas individuals with co-morbid major depressive illness showed significantly higher association of suicide intention and behaviour (Diaconu, 2007).

An extensive meta-analysis of literature on psychiatric diagnoses and suicide indicated that 87.3% of the subjects showed at least one psychiatric diagnosis prior to suicide. As a whole, 43.2% of the cases showed mood disorders, 25.7% showed substance use disorders, 16.2% had diagnosis of personality disorder, and 9.2% showed psychotic disorders. Moreover, the prevalence has shown to be significantly variable according to gender. In fact, gender seems to determine differences in the profiles of subjects with suicide attempts, among which outstand a higher prevalence and intensity of

depressive symptoms(Stefanello, 2008). McGirr et al (2008) have explored the temporal relation between suicide and depressive illness. Starting from the controversy about the peak of suicide risk in depressed patients (higher risk in the early development of depressive illness or cumulative risk along the disorder), the authors performed one case-control study and showed that 74.4% of suicides were associated with the first episode of major depressive illness, 18.8% were related to the second episode, and 6.5% were associated with more than two episodes. Moreover, the exploratory analyses of these data evidenced that impulsive and aggressive behaviours underlay these differences. Complementarily, depressive symptoms seem also to be decisive as an etiological factor of suicide ideation and suicide attempts. In one case-control study, da Silva et al. have reported that depressive symptoms (especially lack of energy and depressed mood) were consistently associated with suicide ideation, whereas the demographic characteristics were not predictors in this study (da Silva, 2006).

Although the great majority of individuals who commit suicide have some psychiatric pathology (most of them from Axis I and predominantly major depressive illness), approximately 10% of subjects who commit suicide do not have psychiatric diagnoses (Chachamovich, 2009). Ernst et al. have conducted a case-control study including a sample of suicide victims with Axis I diagnosis, a sample of victims without Axis I diagnosis and a third sample of living controls(Ernst, 2004). Measures of impulsiveness, aggressiveness, hostility, and mood were obtained in the three subsamples. The results have shown that the group of victims without Axis I diagnosis presented more similarities to the sample with the diagnosis than to the control group. Thus, the notion that psychopathological traits have an outstanding role in suicide cases is reinforced, even in cases apparently free of major psychiatric diseases. In addition, the authors emphasized the need of enhancing the understanding of the relationship between psychiatric pathology and suicide, beyond the mere association diagnosis *vs.* suicide.

1.5 Cost

Depressive illness was described to be the fourth leading cause of disease burden, accounting for 4.4% of total Disability Adjusted Life Years (DALYs) in the year 2000. The same paper suggested that depressive illness causes the largest amount of non-fatal burden, accounting for almost 12% of all total years lived with disability worldwide (Ustan 2004). The World Health Organization (WHO) data suggests that depressive illness causes 6% of the burden of all diseases in Europe in terms of disability adjusted life years (DALYs). The World Health Organization (WHO) predicted that in the year 2020

depressive illness will be, worldwide, the second most important cause of disability after ischemic heart disease (Murray and Lopez, 1997).

A study which estimated the changes in economic burden of depressive illness over time, and measured the economic burden of depressive illness to Swedish society from 1997 to 2005, was conducted in a cost-of-illness framework, measuring both the direct cost of providing health care to depressive patients and the indirect costs of the value of production that is lost due to morbidity or mortality (Sobocki, 2006). The costs were estimated by a prevalence and top-down approach. The cost of depressive illness increased from a total of Euro 1.7 billion in 1997 to Euro 3.5 billion in 2005, representing a doubling of the burden of depressive illness to society. The main reason for the cost increase was found in the significant increase in indirect costs due to sick leave and early retirement during the past decade, whereas direct costs were relatively stable over time. In 2005, indirect costs were estimated at Euro 3 billion (86% of total costs) and direct costs at Euro 500 million (16%). Cost of drugs was estimated at Euro100million (3% of total cost). The authors concluded that the cost of depressive illness has doubled during the past eight years, making it a major public health concern for the individuals afflicted, their care givers and decision makers, and that the main cost driver is indirect costs due to sick leave and early retirement. The total annual cost of depressive illness in Europe has been estimated to be at Euro 118 billion in 2004, which corresponds to a cost of Euro 253 per inhabitant. Direct costs alone totalled Euro 42 billion, comprised outpatient care (Euro 22 billion), drug cost (Euro 9 billion) and hospitalization (Euro 10 billion). Indirect costs due to morbidity and mortality were estimated at Euro 76 billion. This makes depressive illness the most costly brain disorder in Europe, accounting for 33% of the total cost. The cost of depressive illness corresponds to 1% of the total economy of Europe (GDP) (Sobocki, 2006).

A systematic literature review looked into all published "cost of illness" studies of depressive illness worldwide (Luppa, 2007). Summary estimates from the studies for the average annual costs per case ranged from $1000 to $2500 for direct costs, from $2000 to $3700 for morbidity costs and from $200 to $400 for mortality costs. However, the authors admitted that the study results were limited due to methodical differences which limited comparison substantially. Another literature review highlighted the problems in this area (Donohue, 2007). The authors suggested that barriers to improving depressive illness care exist at the patient, healthcare provider, practice, plan and purchaser levels, and may be both economic and non-economic. Studies evaluating interventions to improve the quality of depressive illness treatment have found that the cost per Quality Adjusted Life Years

associated with improved depressive illness care ranges from a low of $US 2519 to a high of $US 49500. They concluded that effective treatment of depressive illness is cost effective, but that evidence of a medical or productivity cost offset for depressive illness treatment remains equivocal, and this points to the need for further research in this area.

In summary, depressive illness is a psychiatric disorder which is common throughout the world, has significant personal, social and financial cost and which poses certain challenges in terms of its diagnosis and therefore management across different cultures. We still don't know much about its aetiology, but available information suggests an interaction between biological and psycho-social factors within a cultural context.

CHAPTER 2 MANAGEMENT OF DEPRESSIVE ILLNESS

Depressive illness is managed using a bio-psycho-social approach. The model assumes that the causes of depressive illness can be physical, psychological and social. Thus the common causes of depressive illness include; genetic predisposition, problems in early development (e.g.; parental discord in childhood and childhood abuse), personality traits (for example, obsessional and anxious dependent personality traits) and environmental factors, such as recent stressful life events and lack of social support. Traditionally the management of depressive illness focuses on developing a "formulation" which tries to answer the question, "why did this person suffer with depressive illness at this time in his life and what is maintaining his illness?" Therefore assessment of depressive illness is the first and the most important step in the management of depressive illness. This assessment consists of history taking and examination of the physical and mental state. Assessment is however an ongoing process and never ends.

2.1 Assessment & management

The psychiatric interview includes psychiatric history, including previous treatment courses; medical history; social background, including educational level and marital, employment, and legal histories; family health history; and the patient's response to important life events and changes. Developmental history, including the family atmosphere during childhood, behaviour during schooling, handling of different family and social roles, stability and effectiveness at work, sexual adaptation, pattern of social life, and quality and stability of marriage, helps in appraising personality. It also includes asking about use or abuse of alcohol, drugs, and tobacco etc. Responses to the usual vicissitudes of life—failures, setbacks, losses, previous illnesses—may help determine coping mechanisms. Asking about suicidal thoughts and plans is a vital part of the assessment. The personality profile that emerges may suggest traits that are adaptive (e.g. resilience, conscientiousness)

or maladaptive (e.g. self-centeredness, dependency, poor tolerance of frustration). The interview may reveal obsessions (unwanted and distressing thoughts or impulses), compulsions (urges to perform irrational or apparently useless acts), and delusions (fixed false beliefs) and may determine whether distress is expressed in physical symptoms (e.g. headache, abdominal pain), mental symptoms (e.g. phobic behaviour, depressive illness), or social behaviour (e.g. withdrawal, rebelliousness). The patient should also be asked about attitudes regarding psychiatric treatments, including drugs and psychotherapy, so that this information can be incorporated into the treatment plan. The interviewer should establish whether a physical condition is causing or worsening a mental condition. Many physical conditions cause enormous stress and require coping mechanisms to withstand the stress-related pressures. Most people with severe physical conditions experience some kind of adjustment disorder, and those with underlying mental disorders may become unstable. Observation during an interview may provide evidence of mental or physical disorders. Body language may reveal evidence of attitudes and feelings denied by the patient. For example, does the patient fidget or pace back and forth despite denying anxiety? Does the patient seem sad despite denying feelings of depressive illness? General appearance may provide clues as well. For example, is the patient clean and well-kempt? Is a tremor or facial droop present? However, some of these aspects might vary across cultures, reduced eye contact in an Asian patient might be due to respect for the doctor for example.

Diagnosis is an important part of the assessment. Diagnosis is based on identifying the symptoms and signs. Several brief questionnaires are available for screening. They help elicit some depressive symptoms but cannot be used alone for diagnosis. Specific closed ended questions help determine whether patients have symptoms required by ICD10 or DSM-IV criteria for diagnosis of major depressive illness. The diagnostic possibilities in this regard include:

Major depressive illness (unipolar disorder): Periods (episodes) that include ≥ 5 mental or physical symptoms and last ≥ 2 wk are classified as major depressive illness. Symptoms must include sadness deep enough to be described as despondency or despair (often called depressed mood) or loss of interest or pleasure in usual activities (anhedonia).Other mental symptoms include feelings of worthlessness or guilt, recurrent thoughts of death or suicide, reduced ability to concentrate, and occasionally agitation. Physical symptoms include changes in weight or appetite, loss of energy, fatigue, psychomotor retardation or agitation, and sleep disorders (insomnia, hypersomnia, early morning awakening). Patients may appear miserable, with tearful eyes, furrowed brows, down-turned corners of the mouth, slumped posture, poor eye contact, lack of facial expression, little body

movement, and speech changes (e.g. soft voice, lack of prosody, use of monosyllabic words). The appearance may be confused with Parkinson's disease. In some patients, the depressed mood is so deep that tears dry up; they report that they are unable to experience usual emotions and feel that the world has become colourless and lifeless. Nutrition may be severely impaired, requiring immediate intervention. Some depressed patients neglect personal hygiene or even their children, other loved ones, or pets.

Major depressive illness is often divided into subgroups. The psychotic subgroup is characterized by delusions, often of having committed unpardonable sins or crimes, harbouring incurable or shameful disorders, or of being persecuted. Patients may have auditory or visual hallucinations (e.g. accusatory or condemning voices). The catatonic subgroup is characterized by severe psychomotor retardation or excessive purposeless activity, withdrawal, and, in some patients, grimacing and mimicry of speech (echolalia) or movement (echopraxia). The melancholic subgroup is characterized by loss of pleasure in nearly all activities, inability to respond to pleasurable stimuli, unchanging emotional expression, excessive or inappropriate guilt, early morning awakening, marked psychomotor retardation or agitation, and significant anorexia or weight loss. The atypical subgroup is characterized by a brightened mood in response to positive events and rejection sensitivity, resulting in depressed overreaction to perceived criticism or rejection, feelings of leaden paralysis or anergy, weight gain or increased appetite, and hypersomnia.

Dysthymia: Low-level or subthreshold depressive symptoms are classified as dysthymia. Symptoms typically begin insidiously during adolescence and follow a low-grade course over many years or decades (diagnosis requires a course of $\geq$ 2 yr); dysthymia may intermittently be complicated by episodes of major depressive illness. Affected patients are habitually gloomy, pessimistic, humourless, passive, lethargic, introverted, hypercritical of self and others, and complaining.

Depressive illness not otherwise specified (NOS): Clusters of symptoms that do not meet criteria for other depressive illness are classified as depressive illness NOS. For example, minor depressive illness may involve $\geq$ 2 wk of any of the symptoms of major depressive illness but fewer than the 5 required for diagnosing major depressive illness. Brief depressive illness involves the same symptoms required for diagnosing major depressive illness but lasts only 2 days to 2 wk. Premenstrual dysphoric syndrome involves a depressed mood, anxiety, and decreased interest in activities but only during

most menstrual cycles, beginning in the luteal phase and ending within a few days after onset of menses.

Mixed anxiety-depressive illness: Although not considered a type of depressive illness in DSM-IV, this condition, also called anxious depressive illness, refers to concurrent mild symptoms common to anxiety and depressive illness. The course is usually chronically intermittent. Because depressive illness are more serious, patients with mixed anxiety-depressive illness should be treated for depressive illness. Obsessions, panic, and social phobias with hypersomniac depressive illness suggest bipolar II disorder.

Severity is assigned by the degree and severity of symptoms and disability (physical, social, and occupational); duration of symptoms also helps determine severity. The presence of suicidal risk (manifested as suicidal ideas, plans, or attempt) indicates that the disorder is severe. Asking about any thoughts and plans to harm themselves or others can be useful. Psychosis and catatonia indicate severe depressive illness. Melancholic features indicate severe or moderate depressive illness. Coexisting physical conditions, substance abuse disorders, and anxiety disorders may add to severity.

There are no laboratory findings which are pathognomonic of depressive illness. Tests for limbic-diencephalic dysfunction are rarely indicated or helpful. They include the thyrotropin-releasing hormone stimulation test, dexamethasone suppression test, and sleep EEG for rapid eye movement latency, which is sometimes abnormal in depressive illness. Sensitivity of these tests is low; specificity is better. PET scanning may show a decrease in brain metabolism of glucose in the dorsal frontal lobes and an increase in metabolism in the amygdala, cingulate, and subgenual cortex (all moderators of anxiety); these changes normalize with successful treatment. Laboratory testing is necessary to exclude physical conditions that can cause depressive illness. Tests include CBC, thyroid-stimulating hormone levels, and routine electrolyte, vitamin B_{12}, and folate levels. Testing for illicit drug use is sometimes appropriate.

Other mental disorders (e.g. anxiety disorders) can mimic or obscure the diagnosis of depressive illness. Sometimes more than one disorder is present. Major depressive illness (unipolar disorder) must be distinguished from bipolar disorder. In elderly patients, depressive illness can manifest as dementia of depressive illness (formerly called pseudo dementia), which causes many of the symptoms and signs of dementia— psychomotor retardation and decreased concentration. However, early dementia may cause depressive illness. In general, when the diagnosis is uncertain, treatment of

a depressive illness should be tried. Differentiating chronic depressive illness, such as dysthymia, from substance abuse disorders may be difficult, particularly because they can coexist and may contribute to each other. Physical disorders must also be excluded as a cause of depressive symptoms. Hypothyroidism often causes symptoms of depressive illness and is common, particularly among the elderly. Parkinson's disease, in particular, may manifest with symptoms that mimic depressive illness (e.g. loss of energy, lack of expression, paucity of movement). A thorough neurologic examination is needed to exclude this disorder.

Once the initial assessment has been carried out, the first decision a clinician has to make is whether the patient requires in-patient or out-patient care; the answer depends on the severity of the disorder, and the quality of the patient's resources. In judging severity, particular attention is paid to risk of suicide (or any risk to life, for example self-neglect, or welfare of family members, particularly dependent children). If the patient has no insight into his illness, assessment under the Mental Health Act, UK, 1983 is considered (Timonen, 2008). Assessment of severity of depressive illness can also help us in choosing the appropriate treatment. In this chapter we will only briefly look at the commonly used treatments.

Table 1. Assessment and management of depression

Assessment and management of depression
• Full history and examination - consider organic causes of depression, e.g. hypothyroidism, panhypopituitarism, drug abuse. • Assess safety of patient to self and others - they may need to be admitted (voluntarily or as per the Mental Health Act). • Consider whether patient needs to have treatment in secondary care, e.g. severe depression, depression with psychosis. • Assess suicidal intent at regular intervals. • Involve patients and family members (if patient's consent). One needs to consider patients cultural background and social circumstances. • Treatment of depression: needs to be multidisciplinary. This involves a combination of medication, psychotherapeutic and psychosocial interventions, e.g. self-help groups and support groups

2.2 Antidepressant medicines

When the disorder is moderate to severe and a decision has been made whether the patient should be treated as an in-patient or an out-patient, the treatment is planned next. Commonly used biological treatments include antidepressant medicines and Electro Convulsive Therapy (ECT). Several kinds of antidepressant drugs are available, and the choice should be made according to the needs of the individual patient, with particular consideration of likely side effects. Antidepressant medicines are divided into these groups: Dual or Mixed Action Reuptake Inhibitors (Tricyclic Antidepressants), for example Amitryptaline, Selective Serotonin Reuptake Inhibitors (SSRIs), for example Fluoxetine, Selective Norepinephrine Reuptake Inhibitors (SNRIs) for example Reboxitine, Non Selective Norepinephrine Reuptake Inhibitors, for example Desipramine, Newer Agents, for example Venlafaxine, and Mono Amine Oxidase Inhibitors (MAOIs), for example Phenelzine (Mann 2005). A variety of drugs are used for treating co-morbid psychiatric disorders or resistant cases of depressive illness.

About half of moderate-to-severe episodes of depressive illness will improve with antidepressant treatment (AHCPR, 1999). Many drugs with effective antidepressant action amplify Serotonin or Norepinephrine signalling by inhibiting reuptake at the synaptic cleft. Antidepressants from the SSRI group are commonly used. Clinical trials have shown little difference in efficacy or tolerability among various available SSRIs or between SSRIs and other classes of antidepressants (AHCPR, 1999). However, some specific differences should be noted. The active metabolite of Fluoxetine has a half-life that is longer than that of other SSRIs, which permits once-daily dosing and thereby reduces the effect of missed doses and mitigates the SSRI discontinuation syndrome. However, Fluoxetine should be used with caution in patients with bipolar disorder or a family history of bipolar disorder, because an active metabolite persists for weeks and may aggravate the manic state in the event of a switch from depressive illness to mania. At higher doses, Paroxetine and Sertraline also block dopamine reuptake, which may contribute to their antidepressant action. SSRIs can be helpful in patients who do not have a response to tricyclic antidepressants, an older class of drugs, and appear to be better tolerated with lower rates of discontinuation and fewer cardiovascular effects (Peretti, Judge et al., 2000). Although tricyclic antidepressants may have greater efficacy than SSRIs in severe major depressive illness or depressive illness with melancholic features, they are less effective than SSRIs for bipolar depressive

illness, since they can trigger mania or hypomania (Gijsman, Geddes et al., 2004). SSRIs appear to be less effective than either tricyclic antidepressants or selective norepinephrine-reuptake inhibitors for depressive illness in which physical symptoms or pain is prominent (Briley, 2004). The SSRI fluoxetine is the only antidepressant that has consistently been shown to be effective in children and adolescents ((TADS) 2004), and SSRIs may be superior to selective norepinephrine-reuptake inhibitors in young adults (18 to 24 years of age) (Mulder, 2003).

The continuation phase of treatment, generally lasting six to nine months after the induction of remission, aims to eliminate residual symptoms, restore the prior level of functioning, and prevent recurrence or early relapse. Residual symptoms (partial remission) are strong predictors of recurrence, early relapse, or a more chronic future course (Judd, Paulus et al., 2000). Treatment should continue until such symptoms have resolved. Episodes lasting more than 6 months and psychotic depressive illness require a longer continuation phase, up to 12 months (Rush, 2001). The same medications and doses used to achieve relief in the acute phase are used during the continuation phase (Mann, 2005). If there is no recurrence or relapse during continuation therapy, gradual discontinuation may be planned for most patients after at least six months of treatment. Early discontinuation is associated with a 77 % higher risk of relapse as compared with continuation treatment (Melfi, Chawla et al., 1998). The tapering of medication over several weeks also permits detection of returning symptoms that require reinstitution of a full medication dose for another three to six months. It also minimizes the discontinuation syndrome, which otherwise may last days or longer and consists of physical symptoms of imbalance, gastrointestinal and influenza-like symptoms, and sensory and sleep disturbances, as well as psychological symptoms such as anxiety, agitation, crying spells, and irritability (Schatzberg, Haddad et al., 1997). The discontinuation syndrome is sometimes called the withdrawal syndrome, erroneously implying drug dependence.

Maintenance treatment for 12 to 36 months reduces the risk of recurrence by two thirds (Geddes, Carney et al., 2003). This approach is indicated for patients with episodes that occur yearly, who have impairment because of mild residual symptoms, who have chronic major depressive illness or dysthymia, or who have extremely severe episodes with a high risk of suicide (Judd, Paulus et al., 2000). The duration of maintenance treatment will depend on the natural history of the illness and may be prolonged or indefinite in the case of recurrent illness. The first choice of medication for the maintenance phase is the antidepressant that brought about remission (APA, 2000). Tricyclic antidepressants, SSRIs, MAOIs, and the newer antidepressants (Mirtazepine and Venlafaxine) all help

to prevent recurrence (Prien, Kupfer et al., 1984). Medication tolerability is particularly important during the maintenance phase, because it affects patients' adherence to treatment. Stable patients should be reviewed at intervals of three to six months while they are receiving medication. It is important to monitor adherence and breakthrough symptoms so that problems are detected early. Patient and family education reduces treatment attrition and improves the outcome (Mann, 2005).

2.3 Electro Convulsive Therapy (ECT)

Remission rates with ECT are 60 to 80 % in severe major depressive illness, though lower success rates are reported in community settings (Prudic, Olfson et al., 2004). The maximum response is typically achieved within three weeks. ECT can be a first-line treatment for patients who have severe major depressive illness with psychotic features, psychomotor retardation, or medication resistance (APA, 2000). ECT offers rapid relief for patients who are suicidal or pregnant (APA, 2000). A course of ECT usually consists of 6 to 12 treatments, rarely exceeds 20 treatments, and is administered two or three times a week, preferably by an experienced psychiatrist. Side effects include transient post-ictal confusion and anterograde and retrograde memory impairment; the latter generally improves in days or weeks (Nobler, 2001). After ECT, it is important to start prophylactic treatment with an antidepressant medication combined with an augmenting medication such as lithium, because the relapse rate is more than 50 percent (Sackeim, Haskett et al., 2001).

2.4 Psychotherapy

The need for psychological treatment needs to be considered in every case. Although antidepressant drugs are less expensive than psychotherapy in the short term, some depressed patients don’t respond to medication. Similarly, some patients might refuse to take medicines because of personal reasons or side effects. All depressed patients require support, encouragement, and a thorough explanation that they are suffering from illness and not moral failure. Similarly, counselling of spouses and family members is often required. Psychotherapies mainly used for depressive patients include; supportive psychotherapy, dynamic psychotherapy, interpersonal psychotherapy, marital therapy and cognitive behaviour therapy (CBT). The kind of psychotherapy used depends largely on the availability of a suitably trained therapist and the preference of the patients; even though more structured therapies such as interpersonal therapy and cognitive behaviour therapy have greater efficacy in the treatment of depressive illness.

Interpersonal therapy (IPT) is a systematic and standardized treatment approach to personal relationships and life problems. In an important multicentre trial, involving 240 out-patients, interpersonal therapy was compared with cognitive therapy, Imipramine with case management and placebo with clinical management. Most patients had improved after 16 weeks. In the patient groups as a whole there were few significant differences between the treatments; Imipramine was somewhat more effective, as was interpersonal therapy, but to a lesser extent. When patients with more severe depressive illness were considered separately, Imipramine was consistently better than placebo and clinical management, while interpersonal therapy was almost as effective as Imipramine (Elkin, Shea et al., 1989). One recent study however, found CBT to be as effective as IPT for mild and moderate cases, however CBT was more effective than IPT for severe depressive illness (Luty, Carter et al., 2007).

Cognitive behaviour therapy (CBT) originally incorporated techniques from cognitive therapy and behaviour therapy. CBT, However it has evolved during the last 50 years and is probably the most widely practised form of psychotherapy these days in Western Europe and North America. The results of clinical trials indicate that for moderate severity the effect of CBT is about equal to those of antidepressant drug treatment (Murphy, Simons et al., 1984). In the National Institute of Mental Health (NIMH) study mentioned above (Elkin, Shea et al., 1989), cognitive therapy was less effective than interpersonal therapy or Imipramine in severely depressed patients. However, recent findings suggest that CBT might be as effective as medication in treating moderate to severe depressive illness, especially in the initial phases of depressive illness (DeRubeis, Hollon et al., 2005) and it might be better than interpersonal therapy in treating severe depressive illness (Luty, Carter et al., 2007). Cognitive therapy may have a role in preventing relapse of depressive illness. Several follow up studies have indicated that patients receiving acute treatment with cognitive therapy had lower relapse rates and sought less treatment subsequently than patients who were treated with tricyclic antidepressants (Evans, Hollon et al., 1992).

According to the NICE guidelines (NICE, 2007) in the UK, patients with mild to moderate depressive illness should be advised exercise, CBT based self help, computerized cognitive behavioural therapy (CCBT), problem-solving therapy, brief CBT, or counselling. Antidepressants are not recommended for the initial treatment of mild depressive illness because the risk-benefit ratio is poor. For those presenting with moderate to severe depressive illness, Problem-solving therapy (PST), counselling, Couple-focused therapy, Psychodynamic psychotherapy (for the treatment of the complex

co-morbidities that may be present along with depressive illness), CBT or Interpersonal therapy should be considered along with the medication. NICE Guidelines clearly state that Cognitive behavioural therapy (CBT) is the psychological treatment of choice for moderate or severe depressive illness. Interpersonal therapy (IPT) should be considered if the person expresses a preference for it or if, in the view of the healthcare professional, the person may benefit from it. There is strong evidence from a number RCTs that CBT is as effective as antidepressants in reducing depressive symptoms by the end of treatment. There is less evidence for IPT, but a small number of RCTs suggest that it is more effective than placebo or usual care. As far as the medicines are concerned the guidelines suggest that "If there has been a previous good response to a particular drug it is sensible to prescribe this again**."** SSRIs are the first-line antidepressants in the routine management of depressive illness in adults**.** There is no clinically significant difference in effectiveness between SSRIs and TCAs. SSRIs are better tolerated than TCAs.

In summary, the management of depressive illness involves use of both biological and psycho-social approaches. Although the choice of treatment should take into consideration the individual needs of the patient as well as evidence, the evidence so far suggests that antidepressant medicines, ECT, IPT and CBT all are effective. Overall, CBT is as effective as medicines, but better than medicines in prevention of relapse and in the light of recent evidence probably better than Interpersonal Therapy.

CHAPTER 3 CBT FOR DEPRESSIVE ILLNESS

Since its early days during the 1960's, Cognitive Therapy has become one of the main forms of psychological treatment. Although initially limited to the treatment of depressive illness (Beck, 1979), it has proved to be effective for anxiety disorders (Wells 1998) phobia (Butler 1989), obsessional disorders (Salkovskis, 1989), somatic problems (Salkovskis, 1989), eating disorders (Fairburn, 1989), sexual dysfunction (Hawton, 1989), borderline personality disorders (Linehan, 1993) & schizophrenia (Cormac, 2002). Cognitive Therapy has been evaluated in different settings including primary, secondary and tertiary care (Stanley, 2003). It has also been used effectively in different age groups with success (Thompson, 2001).

There is sufficient evidence to suggest that CBT is an effective treatment for depressive illness (Embling, 2002) and it is now included in National Treatment Guidelines (APA, 2000; NICE, 2007). It can be provided in both individual and group settings (Hooke, 2002). Cognitive therapy has been provided in less intensive forms after a shorter duration of training, using a manual and under supervision (Turkington, 2002) CBT has been shown to be effective for prophylaxis (Shaw, 1989) and for the prevention of depressive relapse (Paykel, Scott et al., 2005) . CBT has also been used in the form of self help (Warrilow, 2009).

3.1 Historical background

The philosophical origins of cognitive therapy can be traced back to stoic philosophers, particularly, Zeno of Citium, Chrysippus, Cicero, Seneca, Epictetus and Marcus Aurelius. Epictetus famously wrote in "The Enchiridion", "Men are disturbed not by things but by the view which they take of them". Like Stoicism, Eastern Philosophies such as Taoism and Buddhism have emphasized that human emotions are based on ideas. Control of most intense feelings may be achieved by changing one's ideas (Beck, 1979). The emphasis on conscious subjective experience in modern

philosophical tradition comes from the work of Kant, Heidegger and Husserl. This "phenomenological movement" has substantially influenced the development of modern psychology. Many psychologists and psychiatrists became interested in the application of phenomenological approach to specific pathological states (for example, Jaspers, Binswanger, Straus and Piaget).

During the middle of the last century personal construct therapy was developed to alter the patient's ongoing conscious daily experiences (Kelly, 1955). In "fixed role" therapy, the patient assumes a role based on assumptions about the world or himself which are not congruent with his usual beliefs. In this new role the patient is brought face to face with assumptions he had been making about himself and his interaction with others. Kelly referred to these underlying assumptions or beliefs as personal constructs. During the same time period other therapists added different methods and conceptualizations to therapies designed to alter the ongoing conscious experience or cognitions of the patients (Frank, 1961; Berne, 1964). Rational Emotive Behaviour Therapy (REBT), the first cognitive behaviour therapy was developed in this background (Ellis, 1957; Ellis, 1962). Ellis links the environmental or Activating events (A) to the emotional Consequences (C) by the intervening Beliefs (B). Thus this therapy aims at making the patient aware of his irrational beliefs and the inappropriate emotional consequences of these beliefs. REBT is designed to modify these underlying irrational beliefs. Cognitive Behaviour Therapy (CBT) originated with the formulation of a cognitive model of depressive illness, which evolved from systematic clinical observations and experimental testing (Beck, 1963; Beck, 1964).

3.2 Principles and practice

Cognitive therapy is an active, directive, time-limited, structured approach used to treat a variety of psychiatric disorders. It is based on the principle that an individual's affect and behaviour are largely determined by the way in which he perceives the world (his cognitions). These cognitions are based on attitudes or assumptions, developed from previous experiences. Therapeutic techniques are used to identify, reality test and correct distorted conceptualizations and the dysfunctional beliefs underlying these cognitions. The therapist helps the patient to think and act more realistically and adaptively about his psychological problems and thus reduce symptoms. Thus the therapy is aimed towards testing specific misconceptions and assumptions through (1) monitoring negative automatic thoughts, (2) recognizing the connection between cognition, affect and behaviour, (3) examining the evidence for and against automatic negative thoughts, (4) substituting more reality-oriented interpretations for these biased cognitions and (5) learning to identify and alter dysfunctional beliefs

which predispose him to distort his experience (Beck, 1979). Therapy starts with giving the patient rationale for cognitive therapy. Next he is trained to recognize, monitor and record his thoughts. The cognitions and underlying assumptions are discussed and examined for logic, validity and adaptiveness. The patient learns to question his own thinking patterns. Behavioural techniques are used with more severely depressed patients to change behaviour as well as to elicit cognitions associated with specific behaviours. CBT also assumes that our thoughts, emotions, behaviours, bodily symptoms and events are linked and that by making changes in our thoughts and some of the behaviours we can change the way we feel and act in certain situations. Commonly used techniques include, cognitive restructuring, downward arrow technique, Socratic dialogue and behavioural experiments. However therapists also teach patients how to solve problems, improve relationships, manage conflicts and improve communication and social skills.

The patient usually meets with a therapist for between 8 to 20 sessions. The sessions are usually arranged weekly. Each session will last for nearly an hour. The first and sometimes the second session involve a detailed assessment. In the next few sessions the therapist will help the patients in formulating and finding solutions to their problems, and changing the way they think or communicate with others especially with the family members. The therapy has certain routines. At the end of each session the therapist will give the patient some material to read or listen to on tapes. They will also ask them to do some exercises. Each new session will start with feedback from the previous session and then the therapist will agree with the patient on what needs to be done or discussed in the current session. The therapist will take feedback from the patient during each session; clarify if there is something that needs further explaining.

3.3 How is CBT different from other therapies?

Cognitive therapy differs from conventional psychotherapy in two important respects: in the formal structure of the interviews and in the kinds of problems that are focused upon. Cognitive therapists use the approach, "collaborative empiricism" in dealing with their patients. This means the therapist is continuously active and deliberately interacting with the patient. The therapist structures the therapy according to a particular design which engages the patient's participation and collaboration, using his resourcefulness to stimulate the patient to become actively engaged in the various therapeutic operations. In contrast to psychoanalysis, CBT is focused on "here and now"

problems. Little attention is paid to childhood recollection except to clarify present observations. The therapist is more concerned with investigating the patient's thinking and feeling during the sessions and between the therapy sessions. The cognitive therapist actively collaborates with the patient in exploring his psychological experiences, setting up schedules of activities and making home work assignments. Cognitive therapy contrasts with behaviour therapy in its greater emphasis on the patient's internal experiences such as thoughts, feelings, wishes and day dreams and attitudes. The overall strategy of cognitive therapy may be differentiated from the other schools of therapy by its emphasis on the "empirical investigation" of the patient's automatic thoughts, inferences, conclusions and assumptions.

3.4 The cognitive model

3.4.1 The cognitive triad

The cognitive model of depressive illness evolved from the experimental method in science. The interplay of a clinical and experimental approach has allowed progressive development of the model and of the psychotherapy derived from it. The cognitive model postulates three specific concepts to explain the psychological basis of depressive illness; (a) the cognitive triad, (b) cognitive errors and (c) the schemas (Beck, 1979).

The cognitive triad consists of three major cognitive patterns that induce the patient to regard himself, his future and his experiences in an idiosyncratic manner. The first component of the triad revolves around the patient's negative view of himself. He sees himself as defective, inadequate, diseased or deprived. He tends to attribute unpleasant experiences to a psychological, moral or physical defect in himself. In his view the patient believes that because of his presumed defects he is undesirable and worthless. The second component of the cognitive triad consists of the depressed person's tendency to interpret his ongoing experiences in a negative way. He sees the world as making exorbitant demands on him or presenting insuperable obstacles to reaching his life goals. He misinterprets his interaction with animate or inanimate environment as representing defeat or deprivation. The third component of the cognitive triad consists of a negative view of the future. The depressed person anticipates that his current difficulties or suffering will continue indefinitely. *3.4.2 Cognitive errors*

Cognitive errors are the results of faulty information processing. These thinking errors maintain the depressed person's belief in the validity of his negative concepts despite the presence of contradictory evidence (Beck, 1979).

1. Arbitrary inference (Jumping to conclusions) refers to the process of drawing a specific conclusion in the absence of evidence to support the conclusion or when the evidence is contrary to the conclusion

2. Selective abstraction consists of focusing on a detail taken out of context, ignoring other more salient features of the situation and conceptualizing the whole experience on the basis of this fragment

3. Overgeneralization refers to the pattern of drawing a general rule or conclusion on the basis of one or more isolated incidents and applying the concept across the board to related and unrelated situations

4. Magnification and minimization are reflected in errors in evaluating the significance or magnitude of an event that are so gross as to constitute a distortion

5. Personalization refers to the patient's proclivity to relate external events to himself when there is no basis for making such connection

6. Absolutistic, dichotomous (black and white) thinking is manifested in the tendency to place all experiences in one of two opposite categories; for example, flawless or defective, immaculate or filthy, saint or sinner. In describing himself, the patient selects the extreme negative categorization.

3.4.2 Dysfunctional attitudes

The concept of "dysfunctional attitudes" is used to explain why a depressed patient maintains his pain inducing and self defeating attitudes despite objective evidence of positive factors in his life. Dysfunctional attitudes reflect the content of stable cognitive schemas (Beck, 1991). It is presumed that when a person faces a particular circumstance, a schema related to the circumstance is activated. The schema is the basis for moulding data into cognitions. Thus a schema constitutes the basis for the screening out, differentiating and coding the stimuli that confront the individual. He categorizes and evaluates his experiences through a matrix of schemas. Thus the kind of schemas employed

determines how an individual will structure different experiences. A schema may be inactive for long period of time but can be energized by the specific environmental inputs. The schema activated in a specific situation directly determines how the person responds.

In summary, cognitive behaviour therapy evolved over many years and has its philosophical basis in stoic philosophy. It focuses on the patient's cognitive errors and underlying beliefs and tries to change these through looking at the evidence which contradicts these cognitions through collaborative empiricism. However, psychotherapies were developed in the Western world and therefore we need to look into the interaction between psychotherapies, in particular CBT, and different cultures.

CHAPTER 4 CBT AND CULTURE

Many authors have pointed out that cultural differences can influence the process of counselling and psychotherapy (Pande, 1968; Sue, 1990; Sue, 2000; Laungani, 2004). During the last few years many counselling therapists have tried to address the issues surrounding cultural sensitivity (for example, (Bass, 1982; (Dwairy, 1998:, Falicov, 1998:, Goupal-McNicol, 1993; Pauwels, 1995)). It has been suggested that "because most counselling 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" (Scorzelli, 1994). Similarly, it has been suggested that CBT is as value laden as any other psychotherapy (Hays, 2006).

4.1 Culture

Although the term 'culture' forms a part of our everyday vocabulary, there is still a great deal of uncertainty about just how the term itself, let alone the phenomenon to which it refers, should be understood (Parveen, 2001). Hence, for example, in everyday use the terms 'culture', 'ethnic group' and 'race' are regularly used as if they were wholly interchangeable. There are many different ways of describing the term culture. For example Triandis prefers a broad-brush approach, with the result that he includes the physical as well as the subjective aspects of the world in which we live in his definition of culture (Triandis, 1980). On this basis he argues that environmental features such as roads, buildings and so forth can be seen as constituting the 'physical' elements of culture, as opposed to myths, values and attitudes and so forth which he identifies as its more 'subjective' elements. Similarly Fernando suggests that "in a broad sense, the term culture is applied to all features of an individual's environment, but generally refers to its non-material aspects that the person holds common with other individuals forming a social group" (Fernando, 1991). In contrast to this all-inclusive approach, Reber defines culture much more specifically, as "the system of information that codes the manner in which people in an organised group, society or nation interact with their social

and physical environment" (Reber, 1985). In arguing that cultures are systems and structures that people must learn, he identifies culture quite specifically as a *cognitive* phenomenon. However, we need to keep in mind the physical manifestations of this phenomenon.

According to anthropologists there are three components of the culture: things or artefacts, ideas and knowledge and patterns of behaviour. They also suggest that the most fundamental concept of culture and the one which essentially distinguishes it from animals is the use of symbols. The term "culture" traces its roots back to German Romanticism and the idea of the *Volksgeist* (the "spirit" of a people), which was adapted for anthropological use. The term diffused into British anthropology and later into American anthropology. The term "culture" denotes the *totality* of the humanly created world, from material culture and cultivated landscapes, via social institutions (political, religious, economic etc.), to knowledge and meaning. Culture has been defined as "the set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and that it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs" (UNESCO, 2002).

4.2 Culture and psychological interventions for mental health problems

Most of the literature in this area was published in the west by mental health professionals working in the Western world and mainly focuses on cultural differences rather than actual comparison of psychotherapy techniques. 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 there are four core value dimensions that distinguish Western culture from the Asian culture (Laungani, 2004). Although not entirely dichotomous, these can be considered as; individualism-communalism, cognitivism-emotionalism, free will-determinism and materialism-spiritualism. Asians (Indians) are more likely to be community oriented, to make less use of a reasoning approach, can be inclined towards spiritual explanations and prone to a deterministic point of view of life. An emotional approach towards problem solving, for example, not only affects how people cope with their emotional and day-to-day difficulties but also the long-term development and

maintenance of problems. This is also relevant to how people communicate with each other, especially during a conflict. The notion of the 'script of life' being already written has enormous implications (Laungani, 2004). For example, it directly dictates how much of an effort one should put into changing his life. Discovery of the self and self-awareness is a vital part of spiritual development. These concepts are important parts of the four main religions of the east, Christianity, Islam, Hinduism and Buddhism. This can affect life in many ways, starting from help seeking behaviours to the way patients may harbour feelings of guilt and shame. The Islamic view is that some aspects of life, like life and death are predetermined (taqdeer) others are under a person's control. However, in the Islamic faith there is special emphasis on seeking treatment for an illness. This belief definitely controls the way people think. The Hindus believe in a similar "karma". Buddhism on the other hand takes a non-linear view of life. The principles of mindfulness (defined as "a kind of non-elaborative, nonjudgmental, present-centred awareness in which each thought, feeling, or sensation that arises in the attentional field is acknowledged and accepted as it is") derived from Buddhism, are being researched in the West (Teasdale, 2000).

Similarly, it has been suggested that Western societies are work and activity centred while Asian societies are relationship centred (Pande, 1968). This has important implications in delivering therapy in that the therapy should possibly involve family members as well because it is possible that people in such cultures might be behaving, thinking and feeling in communion with the family rather than as individuals. Similarly, they might be thinking of the needs, rules, aspirations and dreams of the family rather than their own. One of the features of most Asian cultures is the importance of social hierarchies (Laungani, 2004).This can be based on caste, sect, race, language or even colour, which certainly means conferring certain advantages and disadvantages to people from some groups. This also leads to the ideas of purity, pollution and genetic superiority of the races and the resultant identity. Some of these ideas however, might be readily recognisable in the Western cultures. But the implications of these beliefs are significant when coping with stress and distress.

Shame and guilt are important day-to-day emotions in Asian cultures. Shaming is seen as the most effective method of social control (Lewis, 1971). Shame can also lead to feelings of intense guilt. Similarly anger is another emotion that needs considering within the context of Asian cultures. Anger might be due to a person's inability to express himself. This is common since the concept of respect of elders means contradictory opinions are not expressed in situations of conflict. Finally, cultures with a strong religious component are likely to be associated with issues concerning sin and guilt.

Attitudes people hold towards health and the health system also affect their health seeking behaviours. Asian patients tend to look for 'cures'. It is common for Asian patients to see more than one doctor for a problem (Laungani, 2004). Whether this applies to psychotherapists too is difficult to say. However, if the Asian model of health seeking follows the Asian model of spiritual leadership, the concept of the guru or peer, who is followed throughout one's life time, it is possible that patients might go to their therapists for reasons of faith rather than reason. Asian clients see their therapists in a more respectful position. This also means that the therapist can never go wrong. This however can be used by therapists to the patient's advantage. Common strategies to treat and reduce mental health problems include religious activities, marriage etc. and the therapist needs to be aware of these. It will be interesting to point out however, that when it comes to faith healers people usually follow them for the rest of their lives. It has been suggested that the Western concepts of psychotherapy for example taking responsibility for one's own life experiences might cause conflict in Asian patients (Jayakar, 1994). However, most of such theories come from observations of the writers rather than being based on a scientific study of the culture.

4.3 CBT & the Culture

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 towards 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 are however, some positive aspects of CBT which may assist in applying therapeutic principles to individuals from a range of cultures. An important aspect of Cognitive Therapy is that it is tailored to the individual's needs. A collaborative negotiated approach can help therapists understand and adapt to the culture of the client, providing they know how to read cultural cues.

It has been suggested that Asian patients prefer a more structured and directive approach (Iwamasa, 2006). They may not feel very comfortable in discussing ideas with the therapist who is trying to ask for their opinion, and might even develop serious doubts about his competence. Although

some suggest that Asian clients might use an emotional approach in solving their problems others say that Asian clients like focusing on thoughts rather than emotions (Iwamasa, 1993). Sue et al (1990) have proposed that Asian clients find it helpful if the presenting problem is addressed directly and some progress is evident in the first session.

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. However, this is an emerging area and only a limited amount of research work has been carried out in this area so far (Hays, 2006). Various cognitive therapists have described their experience of working with American Indians, Alaska native people, Latinos and Latinas, African Americans, Asian Americans, people of Arab heritage and Orthodox Jews (Hays, 2006). However, in our literature search we found no randomised controlled trial of CBT for depressive illness with any of the ethnic minority groups in the west.

In summary, cultural factors should be taken into consideration while giving psychotherapy in non Western cultures. However, culture is a complex phenomenon and a "dynamic process" rather than a static entity or event and our understanding of principles which might need consideration while adapting psychotherapy, particularly CBT, is limited. Although evidence in the form of Randomised Controlled Trials is limited, there is some literature available from Western countries describing experience of cognitive therapists working with ethnic minorities.

It should be pointed out here that in the real world a pure CBT model is hardly used by expert therapists. Psychotherapists from both psychology and psychiatry backgrounds use an eclectic approach. Modern CBT is not a monolithic structure, but a broad movement that is still developing, and is full of controversies. The newer ideas in CBT such as third wave therapies are exciting developments and highlight the evolving nature of CBT. The examples of third wave therapies include mindfulness and acceptance and commitment therapies. These therapies have their origin in eastern religious tradition (mindfulness for example was derived from Buddhism). Therefore it might be relevant to briefly describe here mindfulness and the Islamic tradition of mindfulness (sufism).

4.4 Mindfulness & Sufism (Islamic Mindfulness)

Mindfulness based techniques have been applied in human endeavours for thousands of years. They have been found of great value by Hindus, Buddhists, Muslims and Christians; in India, Asia,

Europe and America; in the far past, in the Middle Ages and in modern times (Knight, 2007) . Like Christianity and Judaism, Islam developed its mindfulness tradition well after its foundation about 610 CE . It was not until the 9th century CE however, that the mystical tradition of "tasawwuf" (Sufism) developed out of a reaction to a growing legalism in Islam (Armstrong, 2002). The heart of Sufism is a search for a direct confrontation with the Divine, often visualized as Love or as an all consuming fire (Fadiman, 1997). Sufism is a large family of tariqat (teaching) lineages, employing a vast variety of techniques, but the most familiar of these will be that practiced by the Persian Mevleviye order—the moving meditation of the 'whirling dervishes,' in which the practitioner whirls for hours, even days, steadily counter clockwise on the left foot, with the right arm high, palm skyward, and the left arm down, palm earthward. This distinctive practice is a visualization of the movement of the world, with God in the still centre, energy coming down from heaven and into the earth through the body of the whirler (Knight, 2007).

To enter the way of Sufism, the seeker begins by finding a teacher, as the connection to the teacher is considered necessary for the growth of the pupil. The teacher, to be genuine, must have received the authorization to teach (ijazah) of another Master of the Way, in an unbroken succession (silsilah) leading back to Sufism's origin with Muhammad. It is the transmission of the divine light from the teacher's heart to the heart of the student, rather than of worldly knowledge transmitted from mouth to ear, that allows the adept to progress. In addition, the genuine teacher will be utterly strict in his adherence to the Divine Law (Wikipedia, 2009). Scholars and adherents of Sufism are unanimous in agreeing that Sufism cannot be learned through books. To reach the highest levels of success in Sufism typically requires that the disciple live with and serves the teacher for many, many years. For instance, Baha-ud-Din Naqshband Bukhari, considered founder of the Naqshbandi Order, served his first teacher, Sayyid Muhammad Baba As-Samasi, for 20 years, until As-Samasi died. He subsequently served several other teachers for lengthy periods of time. The extreme arduousness of his spiritual preparation is illustrated by his service, as directed by his teacher, to the weak and needy members of his community in a state of complete humility and tolerance for many years. When he believed this mission to be concluded, his teacher next directed him to care for animals, curing their sicknesses, cleaning their wounds, and assisting them in finding provision. After many years of this he was next instructed to spend many years in the care of dogs in a state of humility. Sufis used poetry and spoke in stories and used symbols. Probably the most renowned Sufi in the Western world is Rumi. One popular means of communication of Sufi ideas is qawali, particularly in South East Asia.

Sufi philosophy has influenced many areas of thinking both within and outside of Islam, drawing primarily upon three concepts. Human beings are dominated by a lower self called the nafs, a faculty of spiritual intuition called the qalb or spiritual heart, and a spirit or soul called ruh. These interact in various ways, producing the spiritual types of the tyrant (dominated by nafs), the person of faith and moderation (dominated by the spiritual heart), and the person lost in love for God (dominated by the ruh). Love is an important concept in Sufism. Other have described Lataif-e-Sitta ("the six subtleties or faculties"): Nafs, Qalb, Sirr, Ruh, Khafi, and Akhfa. These lataif (singular: latifa) designate various psycho-spiritual "organs" or, sometimes, faculties of sensory and supra-sensory perception. They are thought to be parts of the self in a similar manner to the way glands and organs are part of the body. Similar concepts in other belief systems include Chinese traditional or vedic chakras.

Sufies have described the following stages of the development of the (1) Nafs; (1) Nafs-i-Ammara (The Commanding Self): This has seven heads that must be defeated; False Pride (Takabbur), Greed (Hirs), Envy (Hasad), Lust (Shahwah), Back Biting (Gheebah), Stinginess (Bokhl) and Malice (Keena). (2) Nafs-i-Lawwama (The Regretful Self): This is the stage of awakening. On this level the conscience is awakened and the self accuses one for listening to one's ego. One repents and asks for forgiveness. (3) Nafs-i-Mulhama (The Inspired Self): A good deed must be done immediately and there should be no laziness. Tehqeer or Contempt. You must look at your good acts with contempt otherwise you will become self-righteous. Ikhfa or Secrecy. You must keep your good acts secret otherwise people will praise you and it will make you self-righteous. (4) Nafs-i-Mutma'inna (The Contented Self) & (5) Nafs-i-Radiyya (The Pleased Self): On this level one is pleased with whatever comes from Allah and doesn't live in the past or future, but in the moment. One thinks always: 'Ilahi Anta Maqsudi wa ridhaka matlubi'. One always sees oneself as weak and in need of Allah. (6) Nafs-i-Mardiyya (The Pleasing Self): On this level the two Ruhs in man have made peace. One is soft and tolerant with people and has good Akhlak (good manners). (7) Nafs-i-Safiyya (The Pure Self): On this level one is dressed in the attributes of the Insan Kamil (The perfected man), who is completely surrendered to and inspired by Allah. One is in full agreement with the Will of Allah. The Quran also refers to "the Nafs at peace" (Qur'an 89:27). This is the ideal stage of ego for Sufis. On this level one is firm in one's faith and leaves bad manners behind. The soul becomes tranquil, at peace. At this stage Sufis have relieved themselves of all materialism and worldly problems and are satisfied with the will of God.

The devotional practices of Sufis vary widely. This is because an acknowledged and authorized master of the Sufi path is in effect a physician of the heart, able to diagnose the seeker's impediments to knowledge and pure intention in serving God, and to prescribe to the seeker a course of treatment appropriate to his or her maladies. The consensus among Sufi scholars is that the seeker cannot self-diagnose, and that it can be extremely harmful to undertake any of these practices alone and without formal authorization. Commonly used practices involve, dikar (remembrance of god), muraqba (meditation), breathing and exercises of focusing and pilgrimage (visiting tombs of saints, great scholars, and righteous people).

Millions of devotees visit the Sufi saints whose tombs and shrines are dotted all across India and Pakistan. These adherents range from the more serious-minded, who seek self knowledge as a path to knowing God through contemplation, meditation and Quranic recitations, to the far more numerous who flock to these shrines to beseech the saints to answer their prayers, leave offerings of gratitude and to celebrate the popular festivals cantered around the Urs (death anniversary) of their respective saint. An Urs is a festive celebration because the word literally means wedding night to signify the saint’s union with God after death. Most of the Sufis of Pakistan travelled from Turkey, Iran and Central Asia during the period of the Delhi sultanate and Mughal Empire of India. Today their tombs are called Dargah and usually are attended by many people every day.

In South Asia, four major Sufi orders persist, namely; the Chishti Order, the Qadiriyyah, the Naqshbandiyya, and the Suhrawardiyya. Of them the Chishti order is the most visible. Khwaja Moinuddin Chishti introduced the Chishtiyyah in India. He came to India from Afghanistan in 1192 AD and started living permanently in Ajmer in 1195. Centuries later, with the support of Mughal rulers, his shrine became a place of pilgrimage. The emperor Akbar would visit the shrine every year. In India, Sufi saints have emerged periodically to reshape the sacred in society. Although Sufi teachings convey the message of love and harmony, many movements, including the Wahabi movement (a strict version of radical Islam that considers Sufism as close to Hinduism), arose against the developments in Sufism which appeared during the reign of Akbar. During the recent years with the spread of Saudi-funded 'Wahabism', Sufism is on the decline in Pakistan, especially in many areas of North Western Pakistan. To discourage Sufism among the masses, Wahabi preachers argue that many rituals of Sufism, like 'Qawali' and visit to shrines, are close to Hinduism (Khan, 2009).

The above paragraphs highlight the acceptance of Islamic mindfulness (Sufism) in Pakistan. Field observations suggested that it might be helpful to have some understanding of Sufism to work as a

psychotherapist in Pakistan. However, this is a vast field and might require a detailed study of Sufism in Pakistan.

CHAPTER 5 HEALTH SYSTEM IN PAKISTAN

5.1 Pakistan

Pakistan is located along either side of the historic Indus River, (the name India comes from Indus, which was the name given to the valley of the Indus river) following its course from the valleys of the Himalayas down to the Arabian Sea. Pakistan's 796,095 square kilometres of territory include a wide variety of landscapes, from arid deserts to lush green valleys to snow covered mountains. Agriculture accounts for about a fifth of the economy and employs more than half of the workforce. Social development has remained slow, and inequality between social classes, genders and rural and urban areas has led to widespread poverty. The most recent estimates of the Pakistani population are nearly 150 million. The literacy rate was 47.1% in 1997–2000 and higher in males (59.0%) than females (35.4%). There are 20.39 million children in school, more boys than girls. No figures are available on nonattendance at school.

There are four major ethnic groups in Pakistan—Punjabi (55.6%), Pathan (12.0%), Sindhi (18.2%) and Baluchi (3.6%). In addition, the latest invasion of Afghanistan by the USA resulted in a fresh influx of 200,000 refugees, mainly women and children (Actionaid, 2002). This has had definite implications for Pakistan's health system. Its GDP was £0.5 billion and its national debt was £0.3billion in 2000–2001. The annual per capita income was £309 in 1998 with 33.5% of the population living below the poverty line. The unemployment rate is 5.9% and the proportion of the population with access to safe drinking water, 50% in rural and 71% in urban areas. The proportion of the population with access to adequate sanitation is 25% in rural areas and 42% in urban areas.

The geographical situation of Pakistan both historically and currently creates threats and opportunities. The Khyber Pass in the north of Pakistan has been the gateway to India for thousands of

years for both foreign traders and to invaders. This also meant a lot of mixes of the cultures and traditions. The fertile valleys of the Indus River attracted hordes of invaders one after another as well as providing an opportunity for the creation of the most effective and the biggest canal based irrigation system for farming lands. Persians, Greeks, Romans, Turks, Arabs, Central Asians, British and the Russians (in that order), have all been there. The famous silk route passes through Pakistan. The northern areas of Pakistan are described to be the origin of the Hinduism and cradle of Buddhism. What is now known as Pakistan resisted most foreign invaders (for example, this area was the last to become part of the British Empire, the North never accepted British rule and the empire had a loose treaty with the tribal elders). On the other hands the area of the so called (by the British) "Martial Race", which provided soldiers for the world wars, also came from what is now known as Pakistan. This historical background highlights the rich, colourful and sometimes conflicting and agonizing history of the region that is called Pakistan. This reflects nicely in healing traditions that are followed in Pakistan today. For example we see even today in Pakistan physical healers using, old Greek, Arabic, Hindu and Chinese methods of healing, and on the other hand, faith and religious healers using magic, palmistry, numbers, cards and sufism to help people.

Since her independence Pakistan has faced multiple traumas. Independence in itself was a bloody and traumatic event, causing death and destruction on both sides of the borders. Pakistan has experienced some of the worst floods and earthquakes in the region (4 major earthquakes between 1945 and 2009, causing the death of 200,000 and making nearly 4 million people homeless) . Northern areas of Pakistan experienced earthquakes in 1971 and 2005. People from the North were involved in the Pak-Afghan-Russian war (1979-1989) and were engaged in war at various levels. Extreme Muslim views from Saudi Arabia (supported by Western powers) enormously influenced the Pakistani culture. Although at the end of the war the USSR's break up meant the freedom of Eastern Europe, and removed the fears for the USA and Western Europe, the situation in Afghanistan and Pakistan got worse. The west was not interested now in this area and Pakistani society went through further break down due to rapid "Talibanization", the burden of Afghan refugees and by the civil war in Afghanistan. The Western world became interested in this area after 9/11, when the terrorism spread outside Pakistan. This brought further destruction to the region and finally affected the lives of ordinary Pakistanis, who faced further sanctions by the west and experienced terror in the form of bomb blasts, which are now a part of the daily lives of many Pakistanis.

The wars with the neighbouring India lead to not only death and destruction but one of the wars lead to the separation of half of the country. The conflict with India meant Pakistan spent all her resources on producing weapons including an atomic arsenal, but at the cost of overall economic and national growth and army rule. Pakistan has been ruled for more than half of her life by army dictators, who were often supported by the West. It is therefore not surprising that people find it difficult to trust anything with the label, "Made in the West". Dictatorship not only had an impact on the economy and stability of the country, but also prevented the rule of law being established. The worst thing about military dictatorship is the message that "might is right". People witnessed political workers and leaders, human rights activists and ordinary citizens being imprisoned and tortured both in private and in public by the army. One prime minister was murdered through the "judicial system", other was forced to exile and an ex prime minister was murdered on the street after return from exile. The psychological effects of these traumatic events were never studied, but they have definitely left long term scars on the psyche of the people. Similarly, one dictator tried to "Islamise" the country, while the last dictator tried to "Westernise" the country forcibly. One must wonder how these forced values affected people. Democracy is not only a system of government, it also affects the way people think in their day to day lives. Dictatorship on the other hand might make people insecure, fearful, helpless and rigid in their thinking. The army dictators were not answerable to people and therefore in spite of the immense potential very little progress was made by Pakistan. The health system suffered the most.

5.2 Health system in Pakistan

The government of Pakistan spends 3.1 % of its GDP on economic, social and community services and 43 % is spent on debt servicing (Budget, 2001-2002). About 0.8 per cent (0.7% in 2009) is spent on health care (the comparative figures according to WHO for up to 2005 were, USA 14%, UK 7%, France 8.9%, Spain 7.5, Greece 9.5%, Poland 6.3%, Mexico 6.0%, Sri Lanka 4.4%, India 5.2% & China 5.8%). The health care system in Pakistan comprises the public as well as private health facilities. In the private sector, there are some accredited outlets and hospitals, but also many unregulated hospitals, Medical General Practitioners, Homeopaths (practising homeopathy), Hakeems or Jirrah (practicing old Greek, Arab or Indian healing practices), Faith/Spiritual Healers, Herbalists, Bonesetters and Quacks (Karim 1999). Non governmental organizations (NGOs) are also active in the health and social sector. In urban parts of the country, some public–private partnership initiatives exist through franchising of private health outlets. These have been successful to a large extent in raising the level of awareness of positive health behaviour among the people. For instance, the increasing contraceptive prevalence rate is due to the efforts of the NGO sector and the LHWs of the government

(Management, 2002). Nevertheless, primary health care activities have not brought about expected improvements in health practices, especially of rural population groups. In some areas of rural Pakistan, more than 90 per cent of deliveries are performed by untrained or semi-trained *dais* or Traditional Birth Attendants (TBAs) (Islam, 2002). Among other diverse and multi-faceted reasons, a poorly functioning referral system may be partly to blame.

Pakistan has an extensive network of basic health facilities. At the community level, the Lady Health Worker (LHW) Programme of the Ministry of Health and the Village Based Family Planning Worker (VBFPW) Programme of Ministry of Population Welfare of Government of Pakistan have been established. These programmes gained an international reputation due to their grass root coverage plans. These workers are supported by an elaborate network of dispensaries and basic health units (BHU) (each serving 10 000–20 000 population) and rural health centres (RHC) (each serving 25 000–50 000 population). The next levels of referral are the taluka/tehsil hospital (serving 0.5–1 million population) and the tertiary level hospital (serving 1–2 million people). The nationwide network of medical services consists of 796 hospitals, 482 RHCs, 4616 BHUs and 4144 dispensaries (Pakistan 2001). However, these basic level facilities have restricted hours of operation, are often located distant from the population. Manpower is constituted of approximately 90 000 doctors, 3000 dentists, 28 000 nurses, 6000 Lady Health Visitors and 24 000 midwives. Only 25 per cent of the BHUs and RHCs have qualified female health providers (Islam, 2002). A variety of factors have been identified as the leading causes of poor utilization of primary health care services in developing countries. In Pakistan, cultural beliefs and perceptions, socio-demographic status, women's autonomy, low literacy level of the mothers and large family size, economic conditions, physical and financial accessibility of the health services and disease pattern and health service issues, all affect health seeking behaviours of the population (Shaikh, 2004).

5.3 Psychiatry in Pakistan

An estimated ten to sixteen percent of the general population in Pakistan suffers from mild to moderate psychiatric illnesses. One percent of the population suffers from severe mental illnesses (Gadit, 2002). Nearly 16 per 1000 of the children between three to nine years of age suffer from severe mental retardation. The prevalence of epilepsy was found to be 9–16 per 1,000. There are no data for other psychiatric conditions or on neuropsychiatric conditions (Karim, 2004).

There are currently four mental hospitals in the country. The last ten years have witnessed opening of numerous medical colleges in Pakistan. . Every medical college has a psychiatry department. The standard of care varies among different government sector medical colleges. This gap widens among the private sector medical colleges. Most of the medical colleges in the country, including those in the public sector, have psychiatry departments. Currently there are 131 districts in Pakistan. Each district has a hospital attached, and these also have mental health units. However, basic health units, which provide primary care to rural populations, do not have mental health professionals attached to them. Patients with psychiatric problems can directly present themselves to the out patient departments of district and teaching hospitals. It has been estimated that there are nearly 1.5 inpatient beds per 100 000 population in Pakistan (the number of psychiatrists for the same population is 0.3). Majority of these psychiatrists are based in major urban centres in Pakistan (Gadit, 2002). Psychology is also an underdeveloped discipline. Although universities are conducting MSc programmes in psychology (which is not a clinical degree), there are only limited facilities for further education and even rarer job opportunities. Most departments of psychiatry are without an attached psychology department. The state of nursing is even worse. There were only 52 trained psychiatric nurses in 2001. There is no programme for mental health social workers (Naeem, 2005).

5.3.1 Traditional healing practices

A description of the mental health system in Pakistan probably would not be complete without talking briefly about the traditional healers. Spiritual leaders, homeopathic doctors, magicians, Hakims (practitioners of Greek/Indian medicine), palmists and other fortune tellers, also offer help for sexual, psychological and relationship problems. It has been suggested however that the limited number of mental health professionals wouldn't be able to cope, if these people stopped working! (Naeem, 2005). It has been suggested that the use of the services of spiritual healers might be greater in Islamic society(Al-Krenawi, 2001). Faith healers in Pakistan have been reported to be the major source of care for people with mental health problems, particularly women with little education (Farooqi, 2006). Similar findings have been reported from neighbouring India (Chadda, 2001), and in Bangladesh (Roy, 1997).

A number of alternative healing methods are used in Pakistan, including: homeopathy, naturopathy (Tib), acupuncture, Jerrahs (treatment through opening veins), Islamic faith healing, Sufism based healing, spiritual healing, sorcery and danyalism (form of magic). People usually attend one of these for their physical or emotional problems, or others such as, pirs, amils, hakims,

magicians, palm readers, folk healers (Farooqi, 2006). The main reasons for consulting these healers are: proximity, affordable fee, availability, family pressure and the strong opinion of the community (Shaikh & Hatcher 2005). A study of prevalence of Psychiatric Morbidity among the Attendees of a Native Faith Healer at Rawalpindi using GHQ reported that about 40% of the total attendees had a psychiatric diagnosis, the most common being depressive illness, psychosis and epilepsy. There were marked gender disparities in the diagnostic labels, with depressive illness and dissociative disorders being more common in females and psychosis among the males (Saeed, 2000). A similar study found that patients with different psychiatric disorders sought multiple traditional healing methods for their problems, including; somatoform (73%), personality/conduct disorder (73%), schizophrenia (70%), affective disorder (68%) and anxiety disorders (55%). More male than female patients used multiple traditional healing practices (Farooqi, 2006).

However, it is important to note that traditional healers are not only contacted for mental health problems. A survey of patients attending the family physician department at a teaching hospital in Karachi reported that 45 (11.6%) of the respondents were also attending spiritual healers(Qidwai, 2003). The common reasons for seeing faith healers included recommendation of someone, having belief in spiritual healers, doctors could not cure and spiritual healers are reliable and effective. Musculo-skeletal problems, headache, high blood pressure & angina, headaches, fever and jaundice were the main conditions for consulting them. Other problems included: diabetes mellitus, epilepsy, gastro-intestinal problems, eye diseases, asthma and pneumonia, sexual problem. The common reasons for not seeing the faith healers among the remaining 342 (88.3%) patients included: lack of belief in spiritual healers, allopaths (practitioners of modern medicine) are more effective, spiritual healers are un-scientific. With regards to the future use of the services of spiritual healers, 29 (64.4%) of the respondents indicated their willingness to see them, if needed. However, one should keep in mind that Karachi is a city with relatively higher rates of literacy and the sample might not be representative of rest of Pakistan. This is further highlighted by the fact that the majority of patients were young, well educated and better placed socio-economically. Other reasons for under-reporting might be that the respondents were attending a medical centre and might not feel comfortable. Some people also do not like to admit seeing faith healers for fear of ridicule. The same authors (Qidwai, 2004) in a study of patients' perceptions with regard to spirituality in medical practice found that ninety-two (92%) respondents believed in physicians having healing powers given by God, 78 (78%) felt that physicians should consider the religious needs of the patient during treatment and 44 (44%) believed it is the competence of a physician that results in his/her healing ability. Thirty (30%)

respondents sought treatment from faith healers and believed that medical care should include faith healing. Ninety-four (94%) respondents believed that praying and reciting the Quran helps in healing. Patient's expectation that "a physician be regular with regard to prayers, fasting, zakat (charity that every muslim should offer once a year) donation and avoiding riba (sins)" were reported by 91 (91%), 89 (89%), 97 (97%) and 63 (63%) respondents respectively. The study highlighted the role of the religion and spirituality in healing in Pakistani society as well as the expectations people have from the healers.

CHAPTER 6 DEPRESSIVE ILLNESS IN PAKISTAN

6.1 Introduction

A systematic review of the literature from Pakistan (20 studies, of which 17 gave prevalence estimates and 11 discussed risk factors) found that the mean overall prevalence of anxiety and depressive illness in the community population was 34% (range 29-66% for women and 10-33% for men) (Mirza, 2004). The factors positively associated with anxiety and depressive illness were found to be, female sex, middle age, low level of education, financial difficulty, being a housewife, and relationship problems. Arguments with husbands and relational problems with in-laws were positively associated with depressive illness and anxiety in 3 out of the 11 studies. Those who had close confiding relationships were less likely to have anxiety and depressive illness. There were no rigorously controlled trials of treatments for these disorders published until then. The reviewers concluded that the available evidence suggests a major social cause for anxiety and depressive illness in Pakistan; this evidence is however, limited because of numerous methodological problems.

6.2 Studies of prevalence of depressive illness

Mumford and colleagues studied prevalence of depressive illness in Chitral, Pakistan using Bradford Somatic Inventory (BSI) as a screening measure (Mumford, 1996). They estimated that 46% of women and 15% of men suffered from anxiety and depressive illness. Literate subjects had lower levels of emotional distress than the illiterate. Higher socio-economic status was associated with less emotional distress. Members of joint and nuclear families were similar. A survey to estimate the prevalence of anxiety and depressive illness in women from the Northern (Gilgit) areas using the Hospital Anxiety and Depressive illness Scale (HADS) found that 50% of the women had anxiety and/or depressive illness; 25% suffered only from anxiety, 8% from depressive illness and 17% had features of both (Dodani, 2000). A survey conducted in a semi urban community of Karachi, using the Aga Khan University Anxiety and Depressive Illness Scale (AKUADS) found prevalence of 30% among women in the community. Increasing age, lack of education and verbal abuse were the associated factors found to have an independent relationship (Ali, 2002). However, point prevalence of depressive illness among adult women in a fishing community from the same area was found to be 7.5%. Only 13% reported treatment from government facility and 14% reported previous consultation with a psychiatrist. Nearly 16% of women were aware of the local mental health facility, while 27% reported that they had received treatment from traditional healers. The characteristics that

demonstrated a statistically significant association related to risk factors were increasing age, being married, more than four children in family, illiteracy and financial difficulties at home (Nisar, 2004). In the only study of prevalence of mental health problems among women attending primary care, one-third (30.4%) were found to suffer with major depressive illness. Stressful life events, verbal violence and battering were positively correlated with psychiatric morbidity and social support, using reasoning to resolve conflicts and education were negatively correlated with overall psychiatric morbidity (Ayub, Irfan et al., 2009).

In a study which used Self Report Questionnaire (SRQ) to detect depressive illness among attendees of medical outpatients in Pakistan, 16% of men and 58% of women were reported to present with medically unexplained symptoms (Husain, 2004). In men, 80% of patients with medically unexplained symptoms had a probable depressive illness, compared to 40% of those with symptoms caused by a recognized physical illness. In women, the respective proportions were 55.4% and 49.6%. Depressive illness is probably very common in medical outpatients in Pakistan, especially in men with medically unexplained symptoms.

6.3 Presentation of depressive illness

Patients with depressive illness and anxiety often present with somatic complaints in Pakistan. In one of the first studies published from Pakistan on this topic, it was shown that the Dhat complaint (undue concern about the debilitating effects of the passage of semen, ICD10, F48.8 Other specified neurotic disorders) was reported by 30% of men attending medical clinics, and to an equal extent by patients with 'functional' and 'organic' diagnoses (Mumford, 1996). It was strongly associated with depressed mood, fatigue symptoms, and a DSM-III-R diagnosis of depressive illness. They have argued that the Dhat complaint should be primarily regarded not as the focus of a culture-bound syndrome, but as a culturally determined symptom associated with depressive illness

6.4 Depressive illness in pregnancy

High rates of depressive illness and anxiety have been reported in Pakistan among pregnant women. One such study which investigated the prevalence of anxiety and depressive illness during pregnancy in females presenting in the antenatal clinics and using Present State Examination (PSE) found that 34.5% of females were suffering from anxiety and 25% were suffering from depressive illness. Young age, loss of parent during childhood, past history of psychiatric illness, family history of psychiatric illness were identified as possible risk factors to develop anxiety and depressive illness

during pregnancy (Niaz, 2004). A similar study which looked into the effects of maternal depressive illness on breast feeding behaviour using a cross-sectional study design used the Hospital Anxiety and depressive illness Scale (HADS) in breast feeding women. Women who had stopped breast feeding (38%) had a mean score of 19.7 on HADS compared with those who were breast feeding their infants (62%), and who had a mean score of 3.27 on HADS. Out of the non breast feeding mothers 36.8% reported that their depressive symptoms preceded cessation of breast feeding (Taj 2003). A study to evaluate the relative power of social relations and social conditions in predicting depressive illness among pregnant women in Pakistan using combined qualitative and quantitative methodology found that besides increasing age and less education, husband, in-laws, household work and pregnancy symptoms were significantly associated with depressive illness scores. They concluded that social relations compared to social conditions might be more relevant for determining depressive illness in pregnant women (Kazi, 2006).

Rahman and colleagues have earned an international repute for their extensive work on depressive illness among women and its effect on their children in Pakistan. They interviewed women in their third trimester of pregnancy, 6 weeks before delivery (N = 632) and again at 10-12 weeks after delivery (N = 541), using WHO Schedule for Clinical Assessment in Neuropsychiatry (SCAN), Personal Information Questionnaire (PIQ) and Brief Disability Questionnaire (BDQ) (Rahman, 2003). The point prevalence of ICD-10 depressive illness was 25% in the antenatal period and 28 % in the post-natal period. Depressed mothers were significantly more disabled, had more threatening life events, and poorer social and family support than non-depressed mothers. Vulnerable mothers were more likely to be depressed during pregnancy, rather than have an onset in the post-natal period. They also studied the effect of mother's depressive illness on their children. They found that maternal depressive illness in the prenatal and postnatal periods predicts poorer growth and higher risk of diarrhoea in infants. In the same study they found that exposure to maternal mental distress is associated with under nutrition in 9-month infants in urban Pakistan (Rahman, 2004). At one year follow up they found that Infants of depressed mothers had significantly more diarrhoeal episodes per year than those of controls (Rahman, 2007).

6.5 Risk factors associated with depressive illness

Earlier researchers tried to look into social correlates of depressive illness among depressed patients, for example, one case control study to investigate vulnerability factors among depressed patients found that lack of an intimate, confiding relationship, was statistically significantly associated

with depressive illness (Naeem, 1992). A case register-based descriptive survey of social problems of general hospital psychiatric patients in Pakistan found that 47.2% of psychiatric patients had a social problem. Problems with primary support group occurred in 33.4%, while 14.2% had relational problems and 7.8% had problems relating to bereavement or death. Social problems were more common in females and patients who had adjustment disorder or depressive illness. Psychiatric patients had more social problems than those who were diagnosed as having a physical problem only. Female depressed patients experienced problems with their in-laws more frequently than other types of social problem (Bender, 2001).

Hussain and his colleagues have studied depressive illness and its associated risk factors in Pakistan. In one of their studies they found prevalence of depressive illness to be 25.5% in males and 57.5% in females. Comparison of the cases and non-cases indicated that cases were less well educated, had more children and experienced more marked, independent chronic difficulties. Multivariate analysis indicated that severe financial and housing difficulties, large number of children and low educational level were particularly closely associated with depressive illness (Husain, 2000). In another study of risk factors for depressive illness in Pakistan, a total of 145 women were screened. High depressive illness score was associated with low educational status, not having a confidant, having four or more children, being older, not being married and living in a house with more than three people per room. Experiencing both housing and financial difficulties was a significant risk factor for depressive illness in women with secondary education, but not for those without secondary education (Husain N 2004). They also studied depressive illness in the North West Frontier Post (NWFP) and found that Sixty per cent (95/158) of women and 45% (140/313) of men scored 9 or more on the SRQ. High SRQ score was associated with few years of education, higher social problem score, less social support and greater disability. High social problem score was the strongest correlate (Husain, 2007).

A study from an urban squatter settlement in Karachi, using Aga Khan University Anxiety and Depressive illness Scale (AKUADS) looking into the factors associated with mental disorders in general found that the proportion of probable cases of depressive illness was 28.8% (Rabbani, 2000) . The most frequently expressed psychiatric symptoms were "being worried" and "crying". Amongst somatic complaints the most frequently reported was headache. Study also suggested that women in the older age group and those with longer duration of marriage are more likely to be mentally distressed. Arguments with husband or in-laws, husband's unemployment not having permanent

source of income and lack of autonomy in making decisions significantly contributed towards mental illness. Another study from Karachi, described depressive illness in upper and upper-middle class urban population. A total of 835 patients were diagnosed with depressive illness. 33% were male patients and 67% were female patients. In single women, parental conflicts (4.3 %), conflicts with boyfriends (3.3 %), adjustment problems (2.3 %), and father`s alcohol abuse were the factors linked with their depressive illness. In married women, marital conflicts (31%), bereavement (9.8%), domestic violence (3.6%), work stress (3.2%), daughter`s marriage (1.3%), traumatic experiences (7%) were found to be associated with their depressive illness (Niaz, 2005).

In a population-based survey of all 16 to 18-year old unmarried women in one rural community in Rawalpindi District, Punjab, Pakistan depressive illness and psychological distress were assessed using the Structured Clinical Interview for DSM-IV Disorders (SCID) and Self-Reporting Questionnaire (SRQ) respectively. 337 eligible women were identified of whom 321 (95%) were interviewed. Fourteen (4.4%) had depressive illness; one third scored 9 or more on SRQ. On multivariate analysis a high SRQ score was associated with childhood experience of poverty, father's education, stressful life events, disturbed family relationships and mother's depressive illness (Rahman, 2009).

6.5 Suicide

Suicide is an understudied subject in Pakistan. There are many social, legal, and religious sanctions against it. National rates of suicides are not known (Khan, 2009). Contrary to the findings of other Muslim countries, 45% of patients in one study showed suicidal psychopathology. Female patients showed more suicidal ideation and significant association was found between severity and duration of depressive illness with these symptoms (Javed, 1996). According to a study which compared suicide potential and suicide attempts in 50 Pakistani and 50 American psychiatric patients all of whom reported a positive history of suicide attempts during the past 1-5 years, the American sample reported a higher degree of suicide potential on the Firestone Assessment of Self-Destructive Thoughts (FAST), more suicide attempts, and a larger number of suicide precipitants (family conflicts, work pressure, wish for death, loneliness, financial problems, and mental disorders/drug withdrawal) than did the Pakistani sample. For suicide attempts, effects of 3-way interaction for gender, marital status and nationality were found significant. However, these effects were non-significant for respondent's potential for suicide (Farooqi, 2004).

Khan and his colleagues have published many papers on this subject. A 2-year analysis of all suicidal reports in a major newspaper in Pakistan showed 306 suicides reported from 35 cities. Men (n = 208) outnumbered women by 2:1. While there were more single than married men, the trend was reversed in women. The majority of subjects were under 30 years of age and "domestic problems" was the most common reason stated. More than half the subjects used organophosphate insecticides, while psychotropics and analgesics were used infrequently (Khan, 2000). Another study reported on increasing rates of suicide in Pakistan. In this study, police data from the Sindh province were examined to provide a unique picture of trends of suicide over 15 years (1985-1999). During this period there were 2,568 reported suicides (71% men, 39% women; ratio 1.8). The lowest number was 90 in 1987 and maximum was 360 in 1999. Poisoning by organophosphates was the most common method followed by hanging (Khan, 2006). Suicide rates in Pakistan were determined, based on analysis of suicide reports from six cities in Pakistan. Rates varied from 0.43/100,000 in Peshawar to 2.86/100,000 in Rawalpindi. Rates for men were consistently higher than women; highest rates for men were 7.06/100,000 between the ages 20-40 years in Larkana, Sindh province (Khan, 2008). The authors suggested that given the legal, socio-cultural, and religious stigma of suicides in Pakistan, these figures might be an underestimate. They also calculated suicide rates of women in the Ghizer District of the remote Northern Areas of Pakistan. During years 2000 to 2004, 49 women committed suicide. Taking average mean population for women for 5 years as 65,783, they calculated annual crude suicide rates for women as 14.89/100,000/year. For women over the age of 15 years, rates were 33.22/100,000/year; age-specific rates for 15-24 years were 61.07/100,000 per year (Khan, 2009). In another study they tried to identify major risk factors associated with suicides in Karachi, Pakistan. It was a matched case-control psychological autopsy study. Interviews were conducted for 100 consecutive suicides, which were matched for age, gender and area of residence with 100 living controls. Both univariate analysis and conditional logistic regression model results indicate that predictors of suicides in Pakistan are psychiatric disorders (especially depressive illness), marital status (being married), unemployment, and negative and stressful life events. Only a few individuals were receiving treatment at the time of suicide. None of the victims had been in contact with a health professional in the month before suicide. The authors concluded that suicide in Pakistan is strongly associated with depressive illness, which is under-recognized and under-treated. The absence of an effective primary healthcare system in which mental health could be integrated poses unique challenges for suicide prevention in Pakistan (Khan, 2008)

6.6 Beliefs about depressive illness

Depressive illness and attached stigma as well as knowledge of depression has been studied previously in Pakistan among the doctors and students at university, including medical students in Lahore, Pakistan (Naeem, 2005; Javed, Naeem et al., 2006; Naeem, Ayub et al., 2006). This study highlighted the lack of awareness of the concepts of mental illness among these groups. There was no difference between the medical and non medical groups in terms of not being aware of commonly known mental illnesses. 50% of the medical students and professionals claimed that they had not heard about depressive illness. A significant proportion of all the people surveyed had a negative attitude towards depressed patients. One study which explored the feelings of stigma among patients attending a psychiatric service found that 47% of the patients felt stigmatized. Males had slightly more feelings of stigma. People from urban areas were also carrying more feelings of stigma but it was statistically insignificant. Apart from people with no formal education who had maximum stigma feelings, education level was found to increase such feelings, in the population studied (Ansari, 2008).

6.7 Family structure and depressive illness

Although it seems an important aspect of studying depressive illness in Pakistan, family structure has been poorly studied. There is some evidence from the UK, on family structure and mental health of Muslim mothers in Britain. One study for example found that Mothers living in extended families reported feeling more depressed and anxious than those in nuclear families; their children, however, were better adjusted (Shah, 1995). The same group also reported that rates of depressive illness and anxiety among the mothers in the study were high. Grandmothers had more traditional attitudes to child rearing than did mothers. Intergenerational discrepancy over child rearing was more marked in more acculturated families. Discrepancy was associated with higher levels of mothers' anxiety and depressive illness. They concluded that the unusually high levels of depressive illness and anxiety displayed by Muslim mothers living in extended families can in part be accounted for by patterns of intergenerational discrepancy (Sonuga-Barke, 1998). They replicated the study and extended it by exploring the impact of nuclear and extended family living on the mental health of three generations (children, mothers and grandmothers) in British Hindu as well as Muslim communities. They found that children and grandmothers were better adjusted in extended families than nuclear families. In

contrast, mothers were better adjusted in nuclear families. This interaction between family type and generation was evident in both Muslim and Hindu families and did not appear to be mediated by other variables such as acculturation. Furthermore, mothers' and children's adjustment was significantly correlated with grandmothers', but not mothers', mental health in extended families (although not in nuclear families) (Sonuga-Barke, 2000).

6.8 Cost of depressive illness

It has been reported that 85% of the psychiatric patients attending a psychiatric facility in Karachi were spending over Rs. 3,133 (51.40 US dollars) per month as general expenses on health (Gadit, 2004) . Sixty-five percent of the subjects were earning below Rs. 5,000 ($86.00). The majority used the public bus for transportation, costing the family Rs. 83 (1.40 US dollars) per trip. Laboratory investigation costs were negligible as there is a lesser emphasis on lab tests in psychiatry. A study of demonstration cost-outcome in Pakistan and India screened four rural populations for psychiatric morbidity. Individuals with a diagnosed common mental disorder were invited to seek treatment, and assessed prospectively on symptoms, disability, quality of life and resource use. Between 12% to 39% of the four screened populations had a diagnosable common mental disorder. In three of the four localities there were improvements over time in symptoms, disability and quality of life, while total economic costs were reduced (Chisholm, 2000).

6.9 Management of depressive illness

6.9.1 Pharmacological treatment

The main treatment for depressive illness in Pakistan is use of antidepressants. However, there were only a few original trials available on literature search in this area from Pakistan. One trial which reported compared efficacy of Sertaline and Imipramine in depressed patients in 50mg twice-daily dose involved 80 patients (40 patients received Sertaline and 52 received Imipramine in 50mg twice-daily dose for 4 weeks). The results showed that 33 patients in the Sertaline group and 40 patients in the Imipramine group completed the trial; 24 (72%) and 29 (72%) in each group showed improvement whereas 9 (27%) in Sertaline and 11 (27%) in Imipramine showed no change (Haider 2001). A similar trial compared Sertraline and Nortriptyline in 40 years or older population over 12 weeks of flexible dose treatment with Sertraline (50-150 mg) or Nortriptyline (25-100 rug). Both treatments significantly improved depressive illness. At weeks 10, 12, and endpoint, Sertraline demonstrated a

significantly greater reduction in depressive illness, compared to Nortriptyline. Sertraline treatment had significantly more positive effect, when compared to Nortriptyline, across almost all associated measures of cognitive function, energy, anxiety and quality of life and was better tolerated than Nortriptyline, with a lower attrition rate/side effect burden (Siddiqui, 2000). One study which assessed the efficacy and tolerability of Paroxetine 20mg daily, for the treatment of depressive illness and depressive illness associated with anxiety, reported that a total of 88% patients achieved a reduction in the final HAMD-D score at the end of treatment. The total HAM-D score reduced to 10 or less in 73% patients at 6 weeks and by this week 76% and 92% patients achieved a score of 1 or 2 for CGI-S and CGI-I, respectively. The mean Clinical Anxiety Scale score reduced from 12.6 at the baseline to 4.4 at the end of treatment. Safety data was evaluated in all 112 patients and Paroxetine was well tolerated. Adverse events were experienced by 10% of patients of whom 4% were dropped from the study. Nausea was the commonest adverse event reported (Chaudhry, 2002) . It should be emphasized however that these trials had a methodological problem and failed to report the source of sponsorship.

A look at the local Pharmacopia shows that antidepressants, especially tricyclics, are cheap in Pakistan. However, there is at least some evidence that non-compliance to medication is high in Pakistan and that non-affordability of medication is the main reason for this. One study reporting the frequency and reason for non-compliance to medication in a sample of psychiatric outpatients in a cross sectional study screened 343 patients and among them 56 (16.32%) had stopped their medication. The commonest cause for discontinuation was inability to afford medication. In a similar study which involved 200 follow up patients with a definite psychiatric illness, the commonest reasons for non-compliance were unawareness of the benefits of treatment (43%), non affordability of drugs (33.5%), physical side effects (28.5%), no awareness given by the doctor (03%) and unfriendly attitude of doctors (02%). The commonest illnesses leading to non-compliance were major depressive illness (31.5%), schizophrenia (19.5%) and bipolar affective disorder (19%) (Taj, 2005).

6.9.2 Psychotherapy in Pakistan

A randomised controlled trial assessed the onset and duration of benefit of counselling by minimally trained community counsellors on level of anxiety and/or depressive illness in women of their own community. Therapy was provided for 4 to 8 weeks by minimally trained community women in a lower middle class, semi-urban community in Karachi, Pakistan. In the baseline survey, 366 anxious and/or depressed women were identified and randomized to intervention and control

arms. The intervention arm was re-screened for anxiety and depressive illness after 4 and 8 weeks of counselling and again 8 weeks after the last counselling session. As the results showed a significant benefit in the intervention arm, for ethical reasons the controls were also counselled; and were screened in the same way. A significant reduction in the mean scores of both the groups was found after 4 weeks of counselling which further improved at 8 weeks. The gradient of improvement was steeper at 4 weeks. At 8 weeks post counselling some loss of effect was detected but the levels still remained below the initial mean score. This study indicates that literate women from semi urban communities can be trained as counsellors and their counselling can lead to a significant benefit in just 4 counselling sessions of 1 hour each, and could last at least till 8 weeks after the last session. Keeping in view the current high prevalence, the available facilities for treatment and the stigma attached to psychiatric treatment in our communities, this modality of intervention at the PHC level could be an alternative strategy for the management of depressive illness. They also found that, as a result of learning and then providing counselling, the community counsellors' self esteem, self confidence and sense of competence were enhanced and they developed a more positive attitude towards life(Ali, Rahbar et al., 2003).

Rahman and colleagues have described a cognitive behaviour therapy-based intervention which they integrated into the routine work of community-based primary health workers in rural Pakistan and assessed the effect of this intervention on maternal depressive illness and infant outcomes (Rahman, 2008). It was the biggest reported trial of such an intervention in this community. They randomly assigned 40 Union Council clusters in rural Rawalpindi, Pakistan, in equal numbers to intervention or control. Married women (aged 16-45 years) in their third trimester of pregnancy with perinatal depressive illness were eligible to participate. In the intervention group, primary health workers were trained to deliver the psychological intervention, whereas in the control group untrained health workers made an equal number of visits to the depressed mothers. The primary outcomes were infant weight and height at 6 months and 12 months, and secondary outcome was maternal depressive illness. The interviewers were unaware of what group the participants were assigned to. Analysis was by intention to treat. The number of clusters per group was 20, with 463 mothers in the intervention group and 440 in the control group. At 6 months, 97 (23%) of 418 and 211 (53%) of 400 mothers in the intervention and control groups, respectively, met the criteria for major depressive illness (adjusted odds ratio (OR) 0.22, 95% CI 0.14 to 0.36, $p<0.0001$). These effects were sustained at 12 months (111/412 [27%] vs 226/386 [59%], adjusted OR 0.23, 95% CI 0.15 to 0.36, $p<0.0001$). The differences in weight-for-age and height-for-age Z scores for infants in the two groups were not

significant at 6 months (-0.83 vs -0.86, p=0.7 and -2.03 vs -2.16, p=0.3, respectively) or 12 months (-0.64 vs -0.8, p=0.3 and -1.10 vs -1.36, p=0.07, respectively). They reported that they had modified the intervention using qualitative methods to adapt it to the local needs (Rahman, 2007).

In summary high rates of depressive illness have been reported in Pakistan. Depressed patients present with somatic symptoms. Recent publications have highlighted the increasing rates of suicide. As far as management of depressive illness is concerned, mostly antidepressants are used for this purpose; although antidepressants are not costly, rates of non compliance have been described to be high and possibly non affordability of drugs is one of the major factor. There is emerging evidence that psychological interventions, especially CBT based interventions, might be effective in helping patients with depressive illness in Pakistan.

CHAPTER 7 DEVELOPING CULTURALLY SENSITIVE CBT IN PAKISTAN

7.1 Background

Chapter 5 demonstrated that Cognitive Behaviour Therapy has become established as the most researched and effective psychological intervention for a wide range of mental disorders including depressive illness, anxiety, eating disorders and schizophrenia within developed countries. Although there have been limitations on availability, often due to cost currently, there is an emphasis on cognitive therapy being made available across the developed world. Currently, however, there is only very limited evidence to support the effectiveness of the CBT for depressive illness in non Western, developing countries and availability is very rare. However, paradoxically, there is at least some evidence which suggests that it is the cost of medicines in the developing world that inhibits effective treatment availability there. Due to low cost human resources available, psychological help may be less costly to provide with additional therapeutic benefits and as an alternative to medication. Cultural factors are important in the application of psychotherapy as beliefs about the nature of illness and the likely effectiveness of interventions may vary. This means that a Westernized approach is likely to need modification to be optimally effective for other cultures.

There was no published literature from outside the western world at the time this project was being planned, which could be used for guidance. I found only some indirect guidance from available research literature on developing new interventions and guidelines based on the experience of therapists working in the west with ethnic minority clients as highlighted in chapter 4.

The "Stage Model of Development of Psychotherapies" describes three stages which can be followed in establishing new therapies (Rounsaville, 2001). According to this model, generally the first stage involves pilot or feasibility testing, manual writing, training program development, and therapist fidelity or adherence and competence measure development for new and untested treatments.

The second stage consists of controlled clinical trials to evaluate the efficacy of manualized therapy which has already been tested in a pilot project. In the third stage generalizability and implementation strategies for psychotherapies need to be measured through at least two Stage clinical trials. The Medical Research Council, UK, has provided guidelines for developing and evaluating complex interventions (MRC, 2000 & 2006). According to the guidelines; "the development-evaluation-implementation process consists of; developing an intervention, piloting and feasibility, evaluating the intervention, reporting and implementation. Development of the complex intervention consists of the following steps; identifying the evidence base, identifying/developing appropriate theory and modelling process and outcomes. The above guidelines however are not intended for adapting therapy outside the Western Cultures. They focus on developing interventions in developed world. I therefore used the guidelines loosely and planned a mixed method study with incorporation of both qualitative and quantitative research strategies, in order to develop, implement and evaluate the structure, process and outcomes associated with introducing a model of CBT in a given environment. It is worth mentioning here a framework which suggested a sequence for developing adaptations for ethnic minorities in the West, that consist of the following phases; (a) information gathering, (b) preliminary adaptation designs (c) preliminary adaptation tests and (d) adaptation refinements (Barrera, 2006).

7.2 Why CBT?

A relevant question here might be, given the significance of relationships in non Western cultures, why Interpersonal Therapy (IPT) should not be used in these cultures, instead of the CBT? It can certainly be argued that psychotherapies such as IPT might be more suitable for non Western cultures. IPT has an established evidence-base and an emphasis on work with relationships. However, the following factors helped us in choosing the therapy;

1. Relationships may not be the only or prime source of stress contributing to depressive illness, in fact

2. In developing societies the family has a more central role and will often be a source of support, in addition

3. Changing values in many non Western cultures might mean the nature of relationships is changing,

4. CBT addresses relationships in addition to cognitions and beliefs. The cognitive model of the CBT clearly suggests that the focus of therapy is on patients' relationship (1) with self, (2) with others and (3) future.

5. CBT has an established evidence base and is the most researched psychotherapy

6. There is some evidence to suggest that CBT can be used in non Western cultures and especially that it has been tried in Pakistan, as I already reported in a previous chapter

7.3 Research questions

How can CBT be adapted for use in Non Western settings (e.g. Pakistan)?

Is adapted CBT effective?

7.4 Aims of the study

To develop a culturally adapted version of a Cognitive Behaviour Therapy Manual for depressive illness in Pakistan and to evaluate its effectiveness

7.4 Objectives of the study

1. To identify those factors which need to be taken into consideration for incorporation into a CBT Manual for depressive illness for it to be culturally sensitive

2. To develop guidelines which can be used to adapt a CBT for depressive illness manual for use in Pakistan

3. To use a pilot study to establish whether such a manualised CBT delivered by psychology graduates after CBT training can reduce depressive symptoms

7.5 Pakistan CBT Project

The project consisted of two stages. The first stage of the project comprised development (drawing on the experience in the design of manuals by the applicants and the relevant literature (Duncan, 2004)) and adaptation of a CBT manual (evidence base, new knowledge generated through a series of studies; interviews with psychologists, patients and university students, therapy with patients

and field observations, all of these led to the development of a theory in the form of an adaptation framework, which guided our manual). In the second stage a pilot project was conducted.

7.5.1 Stage 1, design and development of a CBT manual for depressive illness

I started with a blank canvas. I felt that any method to investigate the issue in hand (i.e. what should be done to culturally adapt CBT) should include talking to local mental health professionals who are providing psychological help (psychologists in this case) about their experience of providing psychotherapy and if possible CBT. I thought this might help me to elicit culture and working practices; including values and norms, rituals, reward systems, formal and informal communication structures and organisational symbols. I felt that this knowledge could then be used in drawing principles which might be used to adapt CBT. I also considered that I will have to talk to patients to ascertain what they think of their illness, its causes and its treatment, in particular of psychotherapy. Similarly when asking the general public what they think about the concepts underlying CBT, it is important to avoid any problems. A few months after I started working I came to realize the importance of the language. I prepared a relaxation tape in Urdu. I also realised from my work as well as initial interviews with the psychologists that for patients to get any sense the terminology should be in colloquial Urdu, rather than using literal translations. I also felt that having some direct experience of therapy with patients would be helpful. I worked in Lahore and then in Rahim Yar Khan as an Assistant Professor in Psychiatry. I saw patients both as a psychiatrist and as a CBT therapist. Working in a hospital helped me to access patients and deirectly observe the system, its limitations and the perceptions and attitudes of professionals by being a part of it ("How can you be a CBT therapist?", one psychologist colleague said to me in the first week, "You are a doctor"). This approach was essentially borrowed from ethnography, in which one of the most common methods for collecting data is direct, first-hand observation of daily participation.

Once the relevant information was available from these small scale studies using mixed methods, I developed a framework for adaptation (Southampton Adaptation Framework for CBT). This was the basis of my adaptation of the manual which I had written at the start of the project (based on my experience of CBT with depressed patients in the UK as well as available literature search).

7.5.2 Stage 2, pilot project to test the manual

Once the manual was adapted I trained psychology graduates for 6 weeks and the manual was field tested. The pilot project was carried out in primary care. The pilot project showed that mental

health professionals can be trained and deliver therapy which was effective in reducing symptoms of depressive illness

7.5.3 Steps of the project

In an attempt to adapt a CBT for depressive illness manual I followed the following steps;

1. Review of the current literature on evidence base for psychological interventions for depressive illness, cultural adaptation of CBT and current picture of depressive illness research in Pakistan
2. Planning the adaptation study- informed by ethnographic principles (see discussion on ethnography, under next paragraph, qualitative methods and data analysis) to elicit cultural factors
3. Generation of new knowledge (information gathering) using mixed methods studies: psychologists, patients, students, focus groups for translation
4. Field observations
5. Experience of therapy with patients
6. Literature search and development of adaptation framework (guidelines through the development of theory)
7. Adaptation of manual
8. Translation of manual into Urdu
9. Preparation of supplementary material, for example audio tapes for relaxation in Urdu
10. Pilot project
11. Further changes in manual

7.6 Qualitative methods and data analysis

Methodology for each study will be described separately. Here the focus will be on the main issues and strategies used in the qualitative research within the wide context of the qualitative methods. There were a few options and possibilities in terms of methodology. Intention was to interview the psychologists and patients and conduct focus groups with students. However, I had to adapt the methodology. As the study proceeded, methodology needed adaptation as new data emerged

and I learned new insights into local practices. Overall it was a mixed method study in which I used both qualitative and quantitative methods. In order to ascertain cultural factors, a modified ethnographic approach underpinned the first stage of the project.

7.6.1 Ethnography

Ethnography has been defined as, the descriptive study of a particular human society. Contemporary ethnography is based almost entirely on fieldwork. The ethnographer lives among the people who are the subject of study for a year or more, learning the local language and participating in everyday life while striving to maintain a degree of objective detachment. He or she usually cultivates close relationships with "informants" who can provide specific information on aspects of cultural life. While detailed written notes are the mainstay of fieldwork, ethnographers may also use tape recorders, cameras, or video recorders. Contemporary ethnographies have both influenced and been influenced by literary theory. Cultural anthropology on the other hand is the branch of anthropology that deals with the study of culture. The discipline uses the methods, concepts, and data of archaeology, ethnography, folklore, linguistics, and related fields in its descriptions and analyses of the diverse peoples of the world. Called social anthropology in Britain, its field of research was until the mid 20th century largely restricted to the small-scale (or "primitive"), non-Western societies that first began to be identified during the age of discovery. Today the field extends to all forms of human association, from village communities to corporate cultures to urban gangs. Two key perspectives used are those of holism (understanding society as a complex, interactive whole) and cultural relativism (the appreciation of cultural phenomena within their own context). Areas of study traditionally include social structure, law, politics, religion, magic, art, and technology. One of the most common methods for collecting data in an ethnographic study is direct, first-hand observation of daily participation. This can include participant observation. Another common method is interviewing, which may include conversation with different levels of form and can involve small talk to long interviews. One important issue in data collection is whether the observer is from inside or outside the culture. I felt that I was both inside and outside the culture (Hammersley & Atkinson, 2007). I was returning to Pakistan after spending nearly 12 years in the UK. I tried to keep a diary and I tried to be as mindful as possible to be objective.

I made notes and wrote “memos” throughout the research project. These later served as memory joggers. I was not following any particular themes and recorded anything that attracted my attention. They also provide an insight to the emergence of or presence of bias-reflexivity. These memos

consisted of occasional observations in the field, especially, insights from therapy sessions and conversations with mental health professionals. (Examples of field notes may be found in appendix 1)

7.6.2 Interview as a research tool

We used interviews as the main tool for studies involving psychologist and patients. Interviewing involves direct interaction between the researcher and a respondent or group. Qualitative research interviews have been defined as "attempts to understand the world from the subjects' point of view, to unfold the meaning of peoples' experiences, to uncover their lived world prior to scientific explanations(Kvale, 1996).

It has been suggested that there are certain stages which need to be followed in designing and implementing an interview study (Kvale, 1996). Both studies (study involving psychologists and patients) therefore involved the following stages;

1) Thematising – the purpose of each study was decided as well as topics which needed to be investigated (for example, one topic in the study of psychologists' experience was "what barriers do psychologists experience in providing therapy to depressed patients in Pakistan?").

2) Designing - The overall design for the study, including the later stages of analysing and reporting was planned. We planned open interviews with a list of possible topics to be covered. However, once we had interviewed some patients, we realised that we needed a more structured approach and therefore we adapted our methods accordingly as the study proceeded.

3) Interviewing - The interviewer is the instrument in this type of evaluation. I have been trained as a psychiatrist in interview methods over many years, but using a tape recorder was something I had never tried before and I had to spend some time not only in choosing a recording device but also in getting used to recording while interviewing. I also decided to interview the participants in their hospitals to ensure that interviews would take place at the agreed dates and times and at their convenience.

4) Transcribing – Each interview was transcribed as soon as it was completed. Only one interview took place in two sittings, the rest were all completed in one sitting.

5) Analysing - Data analysis was carried out initially by myself. Analysis began as soon as the interviews had been transcribed.

6) Verification- I tried to be careful during interviews and sent the transcribed interviews to interviewees to confirm whether they agreed or disagreed and wanted to add or remove anything

7) Reporting- Once the analysis was complete I wrote the results for journals and for this thesis. Interviewees' names were not mentioned in any of these reports.

Three basic types of qualitative interviews have been identified, i.e., the informal conversational interview, the interview guide approach, and the standardized open-ended interview. In the interview guide approach, the interviewer has an outline of topics or issues to be covered, but is free to vary the wording and order of the questions to some extent. The major advantage is that the data are somewhat more systematic and comprehensive than in the informal conversational interview, while the tone of the interview still remains fairly conversational and informal. We used open interviews to start with for both studies, however, we had a list of topics prior to the interviews, but we freely moved to areas which seemed to be pointing towards our overall aim of finding factors which could influence adaptation of CBT in Pakistan. In this way our method could be called a mixture of both open ended and interview guides approaches.

7.6.3 Analyses

I gathered data from both qualitative (psychologists and patients study) and quantitative studies (for example students study and pilot trial). This data was analyzed as and when a study was completed. All qualitative analyses, regardless of the specific approach, involve: comprehending (the phenomenon under study), synthesising (a portrait of the phenomenon that accounts for relations and linkages within its aspects), theorising (about how and why these relations appear as they do), and re-contextualising (or putting the new knowledge about phenomena and relations back into the context of how others have articulated the evolving knowledge) (Patton, 1990). The analysis begins with coding and categorising and mainly involves techniques to search for themes, patterns and insights. I wanted to analyse data without too much of interpretation. I used thematic content analysis to analyse our data. This is the most basic type of qualitative analysis and is basically an analysis of the content of the data to categorize the recurrent or common "themes" (Green, 2004). Thematic analysis is based on the identification of themes in qualitative material, while content analysis is defined as "a research technique for the objective, systematic, and quantitative description of manifest content of communications"(Patton, 1990). Content analysis is a research tool focused on the actual content and internal features of the available information. It is used to determine the presence of certain words, concepts, themes, phrases, characters, or sentences within texts or sets of texts and to quantify this

presence in an objective manner. There are two general categories of content analysis, conceptual analysis and relational analysis. Conceptual analysis can be thought of as establishing the existence and frequency of concepts in a text while relational analysis builds on conceptual analysis by examining the relationships among concepts in a text. Thematic Content Analysis (TCA) has been described as a descriptive presentation of qualitative data (Anderson, 2007). A satisfactory TCA portrays the thematic content of interview transcripts (or other texts) by identifying common themes in the texts provided for analysis. The researcher's own feelings and thoughts about the themes or what the TCA themes may signify are largely irrelevant to a TCA. That is, the researcher forestalls interpretation of the meaning of the identified themes until later in the research report, typically in the Discussion (Anderson, 2007). Themes developed in this way were later used as guiding principles in adapting therapy.

7.6.4 Stages of thematic content analysis

In order to analyse the data, the following stages were adopted (Anderson, 2007);

1. The process started with preparing transcripts of the interviews. Before beginning the Thematic Content Analysis (TCA) I made multiple copies of interview transcripts. I read these transcripts many times before starting the actual analysis.
2. All descriptions that were relevant to the topic of inquiry were marked with different coloured highlighters. Each interviewee was assigned a number and each line in a transcript was also given a number (so, I_6 will mean Interviewee 6)
3. From the highlighted areas, each distinct unit of meaning (code) was marked. Meaning units were separated distinguished through different colour. These units varied in text length.
4. The units were cut out and similar units were put together in a pile. Each unit was coded according to the Interviewee number and the line number (see example appendix 2).
5. Each pile was labelled as initial categories (themes) using key words or phrases copied from highlighted texts. These categories were revised as we continued to code data.
6. I went through the entire interview transcript identifying distinct units, grouping and regrouping similar and dissimilar units, and re-labelling categories as we went along.
7. I read through all meaning units per category and redistributed units as appropriate as well as re-labelled categories as appropriate. At this stage some categories were merged into each other or subdivided.

8. After one to two weeks, the original interview transcripts were re-read and categories initially made were reconsidered. Further changes were made when appropriate.
9. Interviews were separately analysed by two other researchers (MG and MA)
10. The same process was repeated for each interview transcript.
11. Once all the interviews in a given study had been analyzed in this way I combined categories/themes for all interview transcripts and notes. Categories were collapsed or subdivided as appropriate. When it was considered necessary categories were re-labelled.
12. After a few days, total categories were re-read as a whole to make overall sense of the interview transcripts.
13. The process was repeated and involved a lot of contemplation and reflection and continued till I was satisfied that the categories reflected the experience of the interviewees.

7.6.5 Issues in qualitative research

Now we would like to highlight some of the issues in qualitative research which we came across during the literature review(Patton, 1990; Kvale, 1996) and discussions with the colleagues and during the supervision and we tried to be mindful of these during our work. These included; verifying - in traditional research terms, this means determining reliability (how consistent the findings are), validity (whether the study really investigates what you intended to investigate), and generalizability. In qualitative studies, one important way of verifying findings or establishing validity is to actually take transcripts or analysed results back to some of the interview participants, and ask them if this is really what they meant. We sent the written scripts to the psychologists as well as a copy of initial findings to participants. Summary of findings was also given to a few psychologists to see how much they agreed with what had been said.

The very personal, conversational nature of interview situations highlighted many of the basic ethical issues of any research or evaluation method (Patton, 1990) which we tried to be mindful of while conducting this study.

1) Confidentiality - Because respondents shared very personal information, it was important that I inform the participants that although their names and institutes would not be reported I would report the name of the city. However Lahore is a big city with many psychiatry departments and the participants had no problems with this.

2) Informed consent – I obtained both verbal and written consent from the respondents. I also informed them that the interviews would be read by the research team in the UK.

3) Risk assessment – there were no major risks identified in this case. However, the names of the participants would not be disclosed.

4) Promises and reciprocity – I discussed with the participants and those who agreed their names would be mentioned in our project and relevant publications

5) Interviewees' mental health – I was aware of issues arising due to patients' mental health. I was particularly careful not to bring into discussions anything which could have affected their mental health. The research protocol had a strategy for dealing with these issues in detail.

7.6.6 Ethical approval

The study received ethical approval from Lahore Mental Health Association, Fountain House, Lower Mall, Lahore, Pakistan

CHAPTER 8 INTERVIEWS WITH PSYCHOLOGISTS

8.1 Background

Based on my conversations with both psychologists and psychiatrists I realized that experienced professionals already modify therapy for the individual needs of patients in Pakistan taking into considerations cultural and religious factors, like elsewhere. For example, it has been pointed out that the psychologists working in Pakistan use religious practices as part of the therapy (Murray, 2002). I thought that talking to psychologists to ask about their experience of providing therapy might be a good start.

Published literature from Pakistan indicates that the cost of medicines might inhibit effective treatment availability (Taj, 2005). Due to the low cost of available human resources, psychological help may be less costly to provide with additional therapeutic benefits and as an alternative to medication. Most patients have to buy medicines privately in Pakistan, where the price of the cheapest SSRI is Rs. 20 (0.25 USD) per tablet. The cost of a session of therapy by a psychology graduate is approximately Rs. 100 (1.28 USD) (based on a salary of 10,000 Pakistani Rupees per month for a psychology graduate).

Most universities in Pakistan, whether private or state run, have a psychology department (Twelve such courses are being run only in Lahore, capital of the province of Punjab). There are approximately 60 state run universities in Pakistan and a higher number of universities within the private sector (Pakrang, 2009). Psychology is a popular subject and most universities offer both bachelor (BSc) and masters (MSc) programmes. However, to practice as a psychologist, it is necessary to do a university

based postgraduate diploma. There are currently five institutes that provide postgraduate diplomas in Pakistan. The training is provided using an eclectic approach. While students have access to local hospital patients, some institutes also have their own counselling centres, which are mainly attended by the students. There is no uniform national system for accreditation or registration. Psychologists gather under two professional bodies in Pakistan. The Pakistan Psychological Society has a membership of nearly 500, while the Pakistan Association of Clinical Psychologists has a membership of nearly 50. However there is no regulating body, for accreditation of training and for setting up standards. Most psychologists join Non Government Organisations after postgraduate qualifications; however, a small number also joins the psychiatry departments of state-run hospitals. These departments have a very limited number of posts for psychologists. None of the hospitals in Pakistan has an established psychology department: psychologists work as part of the medical team. Not all of these psychologists have post graduate qualifications. Psychologists also work as generic mental health workers in psychiatry departments where they are involved with history taking and assessments in the outpatient clinics. Outpatient clinics in Pakistan are like drop-in centres in the UK, and any patient from any part of the country can present himself to the outpatient department for assessment.

This chapter reports the qualitative findings and implications of the information received through the psychologists' interviews. The study looked into identifying the factors which might need modification or consideration in the use of CBT in Pakistan through eliciting the experiences, perceptions and expertise of the local psychologists.

8.2 Methods

Interviews were considered to be more effective in gaining information rather than a survey, because this was an unexplored area and the aim was to engage in a meaningful dialogue which could help to explore difficult or contentious issues (e.g. do patients in Pakistan present with a different picture and how this is taken into consideration when applying techniques from the Western psychotherapy? and clarify any ambiguities or language nuances).

8.2.1 Aims and purpose

The aims of this study were to;

(1) Elicit psychologists' experience of therapy (particularly CBT) and/or their experiences of clients with depressive illness for whom CBT might be an appropriate therapy; and
(2) Identify factors that should be taken into account when developing therapy and the

accompanying training manual for use in Pakistan.

The purpose of the interviews was to;

(1) Ascertain how the psychologists help their patients with depressive illness
(2) Gain an comprehensive understanding as to the kinds of therapy (including CBT) techniques therapists use that are acceptable to their patients
(3) Discover whether the therapists employed any techniques that had been developed from local traditions.

8.2.2 Areas explored

Drawing on the literature review, the lead author's (FN) experiences as a practitioner in Pakistan and data from other countries, a list of important issues to be focused was prepared, which consisted of the following;

1. Background of the psychologist (name, age, training, years of experience, area of training)
2. Their area of work (adult/child, individual/group etc.)
3. Their typical patient load and the proportion of patients who suffer from depressive illness
4. What are the other problems with which patients present
5. How many sessions are usually provided to patients in routine therapy
6. The attendance and attrition rate from therapy sessions
7. Whether they find it easy to understand Western psychotherapy techniques especially those from cognitive therapy
8. Which techniques are used more often
9. Whether patients find some techniques unhelpful

10. The techniques patients prefer

11. Patients' expectations of therapists

12. Elements of therapy, e.g. the role of the family and community

13. Distinctions in presentation of depressive illness and anxiety

14. Whether there is a need to modify CBT techniques for use in Pakistan and if so, how?

8.2.3 Sample & settings

The intended population of psychologists was those working in the psychiatry departments of the teaching hospitals in Lahore. Psychologists were sought who preferably practiced CBT. However, it was soon apparent that they were only trained in Rational Emotive Behaviour Therapy. Since there are some similarities (but also notable differences) between CBT and REBT (Ellis, 1980), we decided to proceed with the interviews. Psychologists also reported that they were aware of the basic concepts of the CBT. An intermediary provided a list of all the psychologists from Lahore who were approached by telephone. All those who were contacted agreed to participate. The final interview sample was drawn from those who provided consent. It was estimated that the sample size was likely to be in the region of 5-10 participants or until data saturation was reached and no new themes emerged. In effect, after 5 interviews and through discussion with the qualitative research supervisor I found that no new themes were being generated and the data was saturated. The reason for this could be that all the psychologists received their postgraduate qualifications from the same institute and had similar clinical experiences and were working in large city teaching hospitals in the state run health service.

8.2.4 Design and conduct of study

An interview guide that incorporated the areas of our interest was developed to ensure consistency of approach. Psychologists were asked about their experience of therapy with patients, focusing upon those with depressive illness attending the state run health service. However, it became apparent that therapists also referred to patients in the private sector and data concerning this was also gathered when appropriate. The study was conducted in two parts. In the first part in depth interviews were conducted with a sample of the psychologists (N=5). All the psychologists were interviewed (by FN) in their hospitals. The audio-recorded interviews lasted between 30 to 60 minutes using the interview

guide, commencing with details about the psychologist and their practice. The interviews were conducted in English since English is widely spoken by the health professionals in Pakistan. Anonymity and confidentiality were assured. The interviews were conducted between February and April 2007. During the second part of the study, following transcription, the interview scripts were returned to the psychologists for comment, verification and for clarity with respect to queries that arose from the analysis stage. In addition, some individuals were contacted by phone to clarify points and emergent themes that arose from the initial transcriptions or analysis. The verbatim interviews were analysed by FN, MG and MA for emerging themes. The themes were then converted into codes. In the final analysis these were built into categories. Transcripts were sent again to the psychologists and they were asked to point out any point they did not agree with or wanted to comment on. In an attempt to triangulate and judge the generalizability of the data, the interview transcripts were reviewed by seven (7) psychologists from the original list working in Lahore, Pakistan (different from those who were initially interviewed). Their comments and observations were noted if different from the previous ones. However, no major differences emerged and this confirmed that the data were saturated with respect to the research aims.

8.2.5 Data Analysis

Interviews were analyzed using thematic content analysis. Transcription of interviews started as soon as the process of the interviews started. The interviews were transcribed by the researcher (FN). The interviewees were ascribed numbers (for example I_5 for fifth Interviewee) which were used in the transcription and writing the results. Three of the research team (FN, MG and MA) closely read transcriptions as and when they became available, identifying topics of interest (open codes) whether because they already existed in literature (for example, somatic presentation of illness) or they were important because of the areas the study wanted to explore (for example, effect of services structures on therapy or literal translation of the concepts of therapy). The authors worked on this separately and exchanged notes through email and during the meetings. MG provided supervision and support through telephone and email throughout the study. Regular meetings were held in which emerging themes, concepts and conflicts were discussed. These separate readings were compared and discussed in details throughout the period of study. This helped to construct a synthetic set of codes to guide not only the next interview but also the analysis of the transcripts. This process was repeated, thus modifying the working codebook till a final set of codes was obtained. The process stopped when saturation point was reached and the authors realized that no new themes were emerging. Finally the

data were reorganized into wider themes (for example hurdles in therapy) and categories (for example homework) and written for this chapter.

8.3 Ethical issues

All the patients gave consent both in writing and verbally. For those patients who were not educated consent was confirmed through the relative who was accompanying the patient. Approval had been granted by the local ethics committee.

8.4 Results

The five psychologists who were interviewed were all females. This is due to the fact that psychologists are mostly females in Pakistan. All of them were trained in Rational Emotive Behaviour Therapy (REBT), although they reported being aware of other CBT techniques. While they all worked mainly in the state run health service, three also worked in the private sector in the evenings. They all worked with male and female adult patients. Their experience ranged between 3 to 15 years. They all had a postgraduate diploma.

Psychologists reported that patients come with psychiatric problems as well as emotional and social problems. The common diagnoses with which patients present include anxiety and depressive illness (nearly 60-70% of the patients have a mixture of anxiety and depressive illness). Patients also present with conversion disorder, family conflicts, broken love affairs, bereavement, and OCD.

8.4.1 Hurdles in therapy

8.4.1.1 Service issues

The health service is poorly structured and specialist services are only limited to the big cities. In addition to seeing patients in the outpatient services, psychologists also receive referrals from psychiatrists, through Accident &Emergency departments in the hospital and ‘self referrals’ from patients. Patients attending the state run health service are usually poor, not well educated and come from remote places (e.g. one patient who travelled from Kashmir to Lahore for treatment took two days to arrive). According to one psychologist, majority (70-80%) of the patients came from outside the city of Lahore. Some of the patients who see psychiatrists or psychologists in private practices might be well educated and not very poor. However it appeared in later discussions that the outcome

of the therapy for those who live locally, are educated and come from an affluent background is not entirely different from the rest. One psychologist thus described the service structure,

> *(We) cater our services to poor people who come from different areas of (the province of) Punjab. They are usually illiterate and belong to the (lower) or lower middle (social) class. So, how can you give them therapy? In my private practice I (sometimes) deal with educated people (I_1). But they are also not keen on therapy. And there is no referral system. And we have to see patients in outpatient department for screening.*

Due to the small number of psychiatry departments, the patient load is very high. The number of psychologists working in health system is even smaller than the psychiatrists. This obviously means even psychologists have to see a higher than usual number of patients for therapy. One psychologist told us that,

> *In the Out Patient Department we usually see around 20 to 30 patients (per day) (I_1).*

Another said that

> *For psychological therapies I see 6 or 7 patients per day (I_2)*

We should keep in mind that an average working day consists of 5 hours. So it is hard to imagine how much time each patient gets and how so many patients are managed. It is not surprising that a session can be as short as 15 minutes.

Only a small proportion of patients (less than a third according to most psychologists) come back for follow up. Even these patients drop out after one or two sessions. Most psychologists said the number of patients who turn up for follow up is very small and most patients come for 2 to 3 sessions. The drop outs are understandably higher for those coming from outside Lahore; however, they also described other factors responsible for high drop outs,

For illiterate patient coming from outside Lahore therapy lasts over hardly one or two sessions (I_2)Apart from distance, socioeconomic status, female gender and patient not being psychological minded are other reasons for drop outs (I_3). Patients stop coming as soon as they are symptom free (I_4). Doctors also don't refer them properly, Psychiatrists usually say to patients "go to the Psychologist and they will give you relaxation therapy" they do not even know anything about cognitive therapy (I_2)

8.4.1.2 Dealing with somatic complaints

Patients present with different diagnoses, but mostly present with physical symptoms. We wanted to know how do therapists deal with these somatic complaints, however, none of the psychologists were able to elicit this further.

Sometimes it's depressive illness due to for example, some type of family problem, marital conflict, broken love affair or the death of a loved one (I_3). But almost all our patients present with somatic complaints. It is difficult to tell them that they have no physical problem but only psychological problem, which can be helped by psychotherapy.

8.4.1.3 Pills and psychotherapy

It was typically mentioned that patients always receive psychological help in combination with medical treatment. One psychologist said:

We are a pill oriented society (I_1),

while others talking on the same subject said:

As far as the psychological sessions are concerned, they are always accompanied by the medical treatment (I_3). I think that the patients are more interested in medicines because "they feel good with medicines (I_4).

8.4.1.4 Homework

One important aspect of CBT is its emphasis on homework. Therapists working in the west find adherence can be a problem. However, this is particularly a difficult area in Pakistan. Some psychologists said that it might be due to illiteracy. However, psychologists working in the private setup with educated patients also said that patients are not keen on doing the homework. According to one psychologist:

Not all the patients follow home work assignments, may be only up to 40% do (I_3).

Only one third patients do the homework, and they also don't do it for all the sessions (I_2)

8.4.1.5 Patient's expectations from the mental health system

Patients knowledge of, and their expectations from, the mental health system are pivotal in their help-seeking behaviours, engagement, compliance and follow-up with the therapy. As some of the psychologists said, it is possible that people probably do not expect psychological therapies in the medical system,

Maybe they are not expecting this kind of therapy. They are expecting only medicines from here (I_5) And when we talk to them, they feel it is only chatting although we are very purposeful. They feel that this is like a Gup Shup (chit chat). And they are not able to perceive the underline meanings, although we are very meaningful. (I_5)

8.4.1.6 Literal translation does not work

Psychologists said they find it difficult to explain the cognitive errors. They said they give long descriptions to explain cognitive errors and use literal translations of the cognitive errors. For example most psychologists translated black and white errors into its literal Urdu or Punjabi translation, which does not translate into a phrase which is readily understandable. Although when you say black and white thinking to an English speaking person he will have a good idea of what it means. Literal translations of terminology can pose additional problems, such as,

Sometime people do not understand the cognitive errors. When I use the term negative thinking they will say, "No, no, we have no negative thoughts". I think this is because they don't know what the negative thoughts are. They think negative thoughts are very bad. It is something evil (I_2)

8.4.1.7 Beliefs about illness

Involvement of non-medical healers was described to be a hurdle in therapy. Being aware of patient's beliefs about the cause of the problem can be helpful. It appears that some patients believe in non-medical causes like magic and they seek help from faith healers or religious healers. One psychologist tried to clarify the difference between faith healers and religious healers and said,

Patients usually go to see the religious healers. They also go to see the spiritual healers, but mostly they see religious healers. The reason they see the religious healers is because they believe their illness is due to Jadu (Magic) (I_1)

8.4.2 Issues related to therapy

8.4.2.1 Assessment

The process of assessment does not seem to be very different from that used in the west. Most psychologists said that they include the family in assessment. Assessment consists of history taking and formulating a management plan. Sometimes assessment includes psychometric testing. They focus on the patient's problems and later on problems are addressed on a cognitive level and emotional level. However, the first step in therapy remains a careful assessment, as one psychologist said;

Patients tell us about their problems and they usually have a diagnosis of depressive illness or anxiety and they mostly present with physical complaints or with conversion, so the first step is to assess them (I_1). We look into the problems and sometimes make a list of patient's problems or complaints (I_5)

8.4.2.2 Commonly used techniques

Psychologists described frequent use of common Cognitive Therapy and Problem Solving Therapy techniques. They said,

We commonly use CBT techniques such as, identifying and teaching on cognitive errors, monitoring mood, cognitive restructuring, use of diaries to identify and change thoughts and working on irrational beliefs(I_3). Monitoring mood is a very good technique (I_4). We also provide coping statements and for certain problems build a list of problems. We also use problem solving, social skills training, building coping strategies, activity plans and assertiveness training (I_5)

8.4.2.3 Structure and content of sessions

The number and length of sessions varies from patient to patient. We have already mentioned low rates of engagement and high rates of drop outs. Most psychologists said they usually plan 12 sessions. They said it is not always possible to follow a structured session. Describing the process of therapy they said

A therapy session can last between 15 minutes to an hour or even more (I_5). As you can imagine it is not always possible to discuss the formulation with the patients (I_1).

8.4.2.4 Normalizing techniques

Judicious use of humour can facilitate therapeutic process and improve rapport. This can be quite useful when sharing a personal experience or to normalize an experience.

Sometimes we use humour with them. Let me give one example, one of my patients said that she had been scolded by mother in law and I said every mother in law is like that, you are not on your own (I_1)

8.4.3 Techniques which patients find helpful

8.4.3.1 Behavioural techniques

A typical statement was that at the start patients find behavioural techniques easier to follow. Similarly building strength and difficulties and using prompt cards are easy to use by the patient. As one psychologist said,

On a behavioural level_ if a person is depressed I will help him to improve his activities by using behavioural techniques (I_1) "for a patient who comes with anxiety I use relaxation exercise to help him or her. Most patients only need relaxation techniques (I_3) when they come with problems, I always use problem solving and they find it very helpful (I_4)

8.4.3.2 Style of therapy

Psychologists said that the style of therapy in Pakistan is more instructional than collaborative. This could be due to the fact that the patients ask for direct advice and they like suggestions. Our first interviewee said,

Our patients like us to advise them on different issues. They typically come and say "Doctor please tell me what should I do now". This is what they expect from us (I_1)

8.4.3.3 Involvement of the family

In the absence of a health system family and friends is the only network of support patients can access in Pakistan. However there are problems involved with family as well, as most psychologists described, exemplified by this,

In Pakistan the family is too much involved with the patients, and sometimes it can be a big problem. However, family can also be very helpful in different ways (I_2). I usually go for independent session with the family as well, and sometimes family does not want to disclose anything about the patient (I_3)

8.4.4 Modifications in therapy

Psychologists try to tackle the hurdles by doing whatever they feel is suitable. However, it was difficult to get any coherent information regarding the changes that have been made and are widely used or are acceptable in the use of therapy. One psychologist talked about her experience of homework,

We focus on homework and discuss the importance of home work with our patients. But they do not do it. So I give them homework during the therapy session and this will be a kind of punishment (I_2) I usually take the patient's educational and the personal background in mind when giving therapy (I_4) We arrange sessions variably. The gap between two sessions can vary between 2 to 4 weeks (I-1).

Conducting the interviews, the lead author tried to explore this part of the interviews in detail, as exploring modifications in techniques was a major interest. Although it was not possible to identify any common trends or obvious changes in techniques, all of them agreed that the therapy in its current form is not applicable and that changes need to be made in therapy to suit the needs of the patients in Pakistan. They all said that they have to change therapeutic techniques according to the personal requirement of the individual. However, it was not possible to get more information on how it is done.

8.5 Discussion

This is the first study to explore psychologists' experiences with the use of psychotherapy and in particular CBT, from a non Western developing country. Since psychologists in Pakistan are not trained in CBT (although they reported using CBT techniques during the interviews), it was necessary to interview psychologists who were trained in REBT. It soon became clear that this was a difficult task to carry out. Participants gave the impression of not being very comfortable when admitting to lack of knowledge on some subject. This has obvious implications for interview studies in Pakistan. However, some information was obtained regarding their experiences of psychotherapy, and an understanding was gained of how the psychological services work.

The investigation began by focusing on the content and style of therapy. It was soon evident that the broader service and resource issues heavily impinge on the style and content of the therapy. The issues are service structure, delivery and organization (distance, finance, knowledge, and referral path), biological orientation of mental health services and patients' beliefs about mental health and the health system. As far as I am aware no previous attempts have been made at institutional level in

Pakistan to adapt therapy or to improve access to psychological interventions. It seems like the therapy is more of a ritual rather than an attempt to change the situation.

Mental health facilities are limited to only a few big cities in Pakistan. Patients come from far off places to see the mental health professionals in these centres. Most of the patients refer themselves to the specialist services. Patients have to travel for long distances and often they come as a family and might even bring friends with them. The mental health system is very biological in its treating approach. There are no written protocols about the referral process. Psychologists also help the psychiatrists in their clinics as generic mental health workers. The number of patients seen by psychiatrists varies from day to day and across the country. Sometimes the number reaches more than 100 per day.

While everyone knows that most patients come from far off places there is no mechanism in place and no strategies in practice to make a decision as to who should be seen for psychotherapy and who should not be seen and how should patients coming from a distance be helped psychologically. It is understandable that most people coming from distant places might not be able to attend regular sessions of therapy. It is therefore not surprising that most patients do not turn up for follow up. However, psychologists said that even those who come from the same city drop out after a few sessions.

Women are more likely to drop out than men. It has been reported that more men than women patients attend traditional healers in Pakistan (Farooqi, 2006). Does this apply to psychotherapy as well? Women are dependent on men to be brought to the hospitals. They at least have to seek permission from men. Men on the other hand can travel more, are in control of finances and are more educated than women. In the end it could be possible that men are more prone to therapy because psychologists are usually female. Poverty, illiteracy and poor referrals were described as other possible reasons for poor follow up. The observation that patients stop attending therapy as soon as they are symptom-free has a logical appeal. The state does not help the diseased or the disabled and people have to return to their work as soon as they can to earn their livings. Some psychologists arrange follow up at longer gaps to allow patients coming from distant places to be able to come back. However, lack of a mechanism to support them between the two appointments and no written, audio or video material and lack of interest in homework all possibly minimize the impact of this useful strategy.

Psychologists see high number of patients for therapy. It is hard to imagine how they manage this number along with other duties. This certainly can have an effect on the quality of the therapy patients receive, as well as cause stress for the therapists. The typical session starts with assessment and if we take into consideration the high rates of dropout, it possibly ends with the assessment too. A structured format is not followed and formulation is possibly not always drawn.

Psychiatric patients in Pakistan present with somatic complaints. The high prevalence of somatic symptoms in Asian cultures is widely known. Somatic presentation possibly explains why pills are more acceptable and the pill prescriber is seen in high esteem. But it is not a straightforward issue. One study from Karachi, Pakistan has reported that patients with physical complaints (musculo-skeletal problems, headache, high blood pressure & angina, headaches, fever, jaundice, diabetes mellitus, epilepsy, gastro-intestinal problems, eye diseases, asthma and pneumonia, sexual problem) go to spiritual healers who do not prescribe them medicines (Farooqi, 2006). At the end of the day a psychiatric patient presenting with physical symptoms and being treated with medicines might also mean less stigma attached. However, all it means in terms of a trial of cognitive therapy is that we should keep in mind that taking medicines has certain implications which are beyond the boundaries of psychopharmacology. These are traditional, cultural, economic, organizational, political and even financial possibly for the patient but definitely for the prescriber.

Seeing spiritual and faith healers was also described to be a problem. It was said that patients see them because of beliefs about magic etc. Some of these beliefs, for example; belief in jadu (magic), saya (possession) and religious or spiritual causes of illness are common. The fact remains that most patients attend faith healers, spiritual healers and traditional healers (Saeed & Mubasshir, 2000; Qidwai, 2003). Knowledge of the patient's knowledge about and expectations from the mental health system are important considerations. Interestingly, people follow faith healers for life. They ask them to make major changes in life style, read verses or many other things in between the meetings. This is similar to homework. The question remains: why don't people go back to mental health practitioners?

Although problems with "homework" are frequently reported by therapists in the west, it seems to be one of the biggest problems in Pakistan. Some therapists said illiteracy is a possible reason, others said even educated patients don't like to do written homework. What did they mean by literacy? Homework involves writing. However, I have observed that people in general do not like to read and write in Pakistan. Verbal commitments are still respected. This is seen commonly when people are getting into a contract, for example, dealing with a shopkeeper, a mechanic or a tailor.

Language is the main tool which is used to deliver psychotherapy. Bibliographical material in the English language is provided to patients during therapy. English is the official language of Pakistan. Urdu is the national language of Pakistan. Although, nearly 80% of people can speak Urdu in Pakistan, the majority of people don't speak this language as their mother tongue. The languages distinctively spoken in Pakistan include Punjabi (45%) (with 8 distinct dialects), Sindhi (15%), Pashto (15%) Siraiki (10%) Balochi (4%) and Other languages (11%), which include Burushaski, Shina, Khowar, Kalash and Wakhi (Wikipedia, 2008). Even the very educated may not be able to understand psychological terminology in English or even Urdu. This leads to yet another important issue. While translation of medical or psychiatric information for patients might not pose many difficulties, literal translation of psychotherapeutic concepts for use in a non Western culture might cause certain problems. One such example is the translation of the term "negative thoughts", which psychologists reported people don't like. Similarly, literal translations of cognitive errors were also described to be important hurdles in therapy.

Therapists claimed that for those who stay in therapy it works. But the number of those who stay in therapy is very small and there is no systematic evidence for this. As far as the process of the therapy is concerned overall there were no major differences, at least in theory. The overall style of therapy is directive rather than collaborative in Pakistan. Therapy involves a lot of suggestions, advice and support. This could be due to the culturally ingrained value of seeing a person in authority as the source of advice, support and enlightenment. This is in line with Laungani's (2004) suggestion that social hierarchies influence the process of the therapy, as well as Iwamasa's (1993) observation that "Asian patients like a directive style of therapy". However we have to keep in mind that collaboration does not necessarily mean following strictly a Western model of equality of therapist and clients. At the end of the day every therapy uses techniques which rely on a teacher-student-like relationship, like educating the patient and use of Socratic dialogue. Similarly, mindfulness-based therapy also employs a teacher-student model of therapy.

Therapists said that behavioural techniques are used commonly and yield good results. This impression could be either due to termination of therapy before the therapist moves on to more sophisticated techniques, or just because the patient wants to get back to work. Probably patients feel less stigmatized and endorsement by the therapist that they can continue to work might make them feel less disabled. The fact that relaxation techniques are found to be helpful only highlight the predominance of anxiety symptoms among patients. Problem-solving and building on coping

strategies are other helpful techniques, and this makes perfect sense since the majority of the patients present with social or relationship problems. A vast body of literature from Pakistan indicates that depressive illness and anxiety is associated with social and relationship problems in Pakistan (Hussain et al., 2000; Shaikh & Hatcher, 2005).

The family is not only a part of the assessment but also a part of the therapy. Involvement of the family brings certain strengths but also difficulties into the therapy. Shah et al (Hussain et al., 2004) reported that women living with husbands' extended families were more depressed and anxious than those living in nuclear families. Living with the extended family not only means sharing resources but also the problems. The family can be helpful in improving compliance and follow up as well as in helping the patient in therapeutic work at home.

All the psychologists agreed that psychological help can be useful for patients with psychiatric problems, but the therapy needs to be modified. Unfortunately we were unable to elicit changes being made. However, this study gives us some ideas regarding the strengths and weaknesses in applying therapy in Pakistan.

8.6 Limitations of study

This study has a number of limitations. Only psychologists working in psychiatry departments from one big city were approached. They were all trained from the same institute. The interviews focused on issues which had previously been decided. This might have prevented discussion of useful information that was not included in our list of ideas to be explored. However, care was taken in our interviews to not ignore any useful cues as they emerged. In order to increase the reliability of the information the interviewees were not only contacted on the phone to clarify any issues which arose during the analyses, but the transcribed interviews were also sent to a number of other psychologists to see their level of agreement. It was not possible to interview psychologists with training in CBT. Therapists were trained in REBT. Although there are similarities between CBT and REBT, there are also differences between the two. We also had a small sample size however; interviews stopped only when it was felt that new themes were not emerging.

8.7 Conclusions

This is the first study to explore psychologists' experience of providing cognitive therapy to patients. Four major themes emerged on analyses. These were; hurdles in therapy, therapy related issues, involvement of the family and modification in therapy. Psychologists pointed out that therapy

needs to be modified to be applied effectively in Pakistan. However, it was not possible to get further information regarding changes that need to be made for therapy to be effective. Factors related to service structure and delivery, the patient's knowledge and beliefs about health and the therapy itself were found to have an effect on therapy. This study has numerous limitations and this work needs to be repeated with improved methodology and with bigger sample size.

In summary from our study's point of view, the most obvious thing was that therapy needs to be adapted. It also emerged from the study that any work to adapt should take into consideration the following wider areas; patients' beliefs (what do they think of CBT?), cultural needs of the patients (presentation of symptoms, religion and spirituality) and limitations posed by the system of health and support, as well as individual differences particular to the Pakistani culture (for example, training in CBT, lack of mental health facilities and therefore distance people have to travel to see mental health professionals, number of patients seen by psychologists and gender differences in accessing the service).

CHAPTER 9 INTERVIEWS WITH DEPRESSED PATIENTS

9.1 Background

The next step in my enquiry was to explore patients' ideas about their illness and its treatment, especially psychological treatment. It has been suggested that depressive illness has significant cultural variation in clinical presentation (Manson, 1995), although, the core symptoms of depressive illness might be similar across cultures (WHO, 1983). Research so far seems to have focused on presenting complaints, diagnosis and prevalence of depressive illness in these cultures (Kleinman, 1977; Noppon, 1986; Zheng, 1988; Radford, 1989; Nakane, 1991; Gupta, 1991). Patients' help-seeking behaviours are influenced by their knowledge of illness and their beliefs about its treatment (Kleinman, 1980; Brown, 2001) . In order to develop effective strategies for the treatment of depressive illness, we need to understand a patient's frame of reference. For example, a study from the US (Cooper, 2003) reported that African Americans are less likely than white persons to find antidepressant medication acceptable. Hispanics are less likely to find antidepressant medication acceptable and more likely to find counselling acceptable than white persons (Cooper, 2003). The authors also reported that although racial and ethnic differences in beliefs about treatment modalities were found, they did not explain differences in the acceptability of depressive illness treatment.

There are a few qualitative studies of depressive illness from the developing world which have described the essence of the depressed patients experience. One such study of depressed patients' conceptualization of illness and its impact on help-seeking, reported that somatisation of emotional problems, variations in causal attribution between patients and their significant others, the nature of the available health care system and burden of infectious disease complicate access to care (Elialilia, 2007). A study from Brazil focusing on depressed women found that depressive illness was inextricably woven into their violent and downtrodden daily lives, as well as with other sources of suffering. The local community identified two types of depressive illness: 'true' and 'false,'

suggesting a concept enmeshed with morality (Martin, 2007). Similarly, a qualitative study from Dubai using focus groups reported that the key symptoms of depressive illness were: social withdrawal, feeling afraid, irritability, loss of sleep, loss of appetite, sadness, crying, excessive thinking, feeling bored and loss of interest in sex, the causes of depressive illness included; stresses in the family and in the society, relationships, lack of support, marital conflicts, and problems with children and the most effective coping strategy identified was that of going to religious places and talking to religious professionals (Sulaiman, 2001).

Although very high rates of depressive illness have been reported in Pakistan (Mirza, 2004), very little is known about patients' views of depressive illness and their knowledge about treatment of depressive illness. In our literature search we found no qualitative studies from Pakistan of patients' knowledge and their perception of depressive illness. The lead author's previous work in Pakistan has revealed that only a small number of doctors, medical and non medical students in a university in Lahore had some knowledge of depressive illness (Naeem, 2005; Javed, Naeem et al., 2006; Naeem, Ayub et al., 2006). This first study in which we interviewed psychologists in Pakistan also highlighted the importance of exploring the concepts of the patients. It was therefore decided to explore patients' knowledge and beliefs using qualitative methods. This chapter describes findings from our study in which we interviewed patients to see what they think about their illness, its causes, its treatment and specially psychotherapy.

9.2 Methods

9.2.1 Aims and purpose

1. To ascertain patients knowledge concerning mental illnesses, especially depressive illness

2. To establish their knowledge and their expectations concerning the health system, and to ascertain their perceptions of the treatment they have received, especially non-pharmacological treatments

9.2.2 Areas explored

We focused on the following topics during the interviews;

1. What are the common symptoms and duration of the illness in Pakistan?

2. What do patients understand about depressive illness and the mental illnesses in Pakistan?

3. What they know/understand about treatment of their condition?

4. Whether they had seen any faith healers and what had been their experience with them?

5.What are their common beliefs about causes of their illness?

6. What are their beliefs about treatment or cure?

7. What do they see as the role of the mental health professionals?

8. What do they expect from psychiatrists/doctors?

9. What do they know about psychologists and their role?

10. What do they know about psychotherapy and its effect?

11. What do they think about medicines?

9.1.3 Sample and settings

I selected a purposive sample (in this method of sampling the researcher chooses the sample based on who they think would be appropriate for the study) with the aim of identifying informants who would enable exploration relevant to the study. The sample was drawn from the outpatient service of Sheikh Zayed Hospital. Psychiatrists running the outpatient clinic were asked to refer patients who fulfilled inclusion criteria (i.e., a diagnosis of depressive illness, being 18 years and older, and absence of symptoms of psychosis, drug or alcohol abuse and mental retardation). Once referred these patients were given information regarding the study. Those who consented were included in this study. None of the patients declined to participate, with consent being taken in both the verbal and written form. They were interviewed again using International Classification of Diseases, 10th Edition, Research Diagnostic Criteria (WHO, 1992) to confirm the diagnoses by FN, who carried out all the interviews. To enable us to understand their experience of mental health services, I selected patients who had attended at least 3 outpatient appointments. Interviews were conducted on two days each week, with one interview per day. I asked my colleagues to refer the first patient they saw with depressive illness that day and then every third patient afterwards.

9.2.4 Design and conduct of study

I interviewed patients from the psychiatry outpatient clinic of a teaching hospital in Rahim Yar Khan, Pakistan. Rahim Yar Khan is a famous city in the South of Punjab in Pakistan. Rahim Yar Khan is the district headquarters of Rahim Yar Khan District (The Districts of Pakistan are the third order of administrative divisions, below provinces and divisions. Currently there are 106 districts in Pakistan). The city itself is administratively subdivided into 9 Union Councils (the union council is the smallest administrative unit in Pakistan). It has been renamed customarily over the last 5000 years, first available (on record) name was AROR or ALOR, and then it became City of Pattan, PhulWada, Noshehra and now Rahim Yar Khan. The area of Rahim Yar Khan City is about 22 square kilometres. According to the January 2007 census, the population of the city is around 330,000 (Wikipedia, 2009). Rahim Yar Khan is located at the meeting point of three provinces (Punjab, Sindh and Baluchistan) of Pakistan. The city has a university campus, medical college and numerous private and public sector colleges. Patients from adjacent districts of the three provinces come to the local teaching hospital (Sheikh Zayed Hospital attached with Medical College of the same name). Rahim Yar Khan is accessible through road, train and air routes. People can speak Urdu, Punjabi and Saraiki languages. Most people are trilingual. Although majority of people are Muslims, a significant minority of Christians and Hindus also live in Rahim Yar Khan.

I conducted this qualitative study with the aim of developing an understanding of depressive illness from the patients' point of view by exploring how people diagnosed with depressive illness in Pakistan conceptualize their illness and what they know about its management, especially their knowledge of non-pharmacological treatments. A qualitative research design was chosen because I had no prior knowledge of this subject. Although the central question was "what do patients know about (and if they do, what do they think about) non-pharmacological interventions for depressive illness (especially CBT)?" It was felt that it is essential to explore their knowledge of depressive illness, its causes and its treatment in general terms, before specific questions could be asked about non-pharmacological treatments. Furthermore the patients might not respond well to a written survey. Initially I tried in-depth open interviews with patients. However, it turned out to be a difficult task

because all the 4 patients who were interviewed had no or very little knowledge of the mental illness and its treatment, and responded very briefly with apparently little to say. This might be due to the local cultural values, because my impression is that generally patients are not encouraged to ask questions or express themselves and do not have confidence to give their views I therefore decided to prepare an interview schedule with mostly open ended questions to increase our sample size and to ensure that I have explored the important issues. I was successful in interviewing 9 patients. Interviews were carried out until new themes stopped emerging and the data were saturated.

9.2.5Data Analysis

Interviews took place over a period of 16 weeks between October 2007 and January 2008. All the interviews were tape recorded. Interviews were conducted in Urdu. Interview notes were hand written for analysis by FN. The interviews lasted for between 30 to 60 minutes and were undertaken in the psychiatry outpatient clinic. All the interviews were translated into English. I performed data collection and analysis concurrently, and I ceased recruitment of participants once no new information relevant to the main purpose of this analysis emerged. I read the transcripts repeatedly to develop codes and identify main themes relating to the aims of the study. I completed analysis of the interviews using a qualitative descriptive design (Sandelowski, 2000), which involved the use of thematic content analysis methods to develop codes based on the comparison of data from each interview and subsequent grouping of these codes to represent main themes. As implied by this design, the analysis was intended to be descriptive and involved minimal interpretation of the data. To ensure credibility in the analysis, MG & MA independently coded the transcripts, and I compared these codes with those identified by myself. No alterations of or additions to the main themes originally identified were considered necessary. I have presented statements that illustrate the main themes in the results.

9.3 Ethical issues

All the patients gave consent both in writing and verbally. For those patients who were not educated consent was confirmed through the relative who was accompanying the patient. Approval had been granted by the local ethics committee.

9.4 Results

Of the 9 respondents, only three patients were male. Their ages ranged between 18 to

60 years. One patient had fourteen years of education, three patients had no formal schooling (all women with ages 22, 35 and 60 years). Among the educated patients, two had five years of education while three had ten years or more of education. All of them were married except one. Four lived in rural areas while the rest were from urban areas. Four of them were local residents while the rest came from other cities. The history of illness ranged between 15 days to 3 years, but for two who had 6 and 10 years of illness. Six patients had one prior episode of the illness. Only three said they had been treated for depressive illness in the past. All were treated by the doctors (in primary or secondary care). All the patients who met criteria for depressive illness according to the ICD10, RDC, also suffered with significant anxiety symptoms.

I gathered information regarding depressive illness as well as mental illnesses in general. The results are described in part 1 (depressive illness) and part 2 (mental illnesses). The Findings from part 1 are presented in four themes: (1) Their perception of depressive illness and its impact on their lives (2) their model of causes of the depressive illness (3) their model of referral and (4) the treatment of depressive illness.

In the second part of this chapter which describes the results of interviews pertaining to general knowledge about mental illnesses, two broad themes were identified: (1) their knowledge and perception of mental illnesses and (2) their treatments.

9.4.1 Depressive illness

9.4.1.1 Patients' perception of their illness and its effect on their lives

Patients mostly complained of physical symptoms. For example, headache, pains in the body, sleep disturbances, vertigo, weakness, numbness of arms, breathlessness, palpitations, restlessness, tiredness were the complaints that led them to seek treatment. Other complaints included, crying, anger and sadness. Three patients didn't describe sadness as a complaint. Only one patient described sadness as the first complaint. Headache was the commonest complaint and most often the first complaint as typified by this patient,

I get headache and vertigo. I also feel weak, my arms feel numb. I feel tired but I cant sleep properly at night or during the day (I2)

When patients were asked what kind of illness they had, they invariably described it to be "some sort of physical illness". They typically used expressions like 'weakness of brain or illness of brain', 'physical illness', 'illness of suffocation', 'illness of poor sleep' and 'tension'. Interestingly, patients didn't use any specific name for their illness. When directly asked if they knew anything

about depressive illness (in Urdu, for example, "udasi ki bimiari" or "gham ki bimari" etc.) no one recognized it as an illness.

However when patients were asked whether they had a physical illness or mental illness, most (6) replied that it was a mental illness. Only one patient thought he suffered from a physical illness. Two believed they had both physical and mental illness. One patient said,

This is a mental illness which affects my thinking (I9)

However this question was not open ended. When open ended questions were used prior to the closed question, only two patients said that they had a mental illness.

Depressive illness can be a disabling disease. All the patients admitted that the illness has affected their lives. However, they kept performing their specified roles in lives. They believed that it had affected their ability to work. But none of them reported stopping his or her duties or responsibilities. No other areas like quality of life etc were described to be affected, as one remarked;

I feel weak all the time. It is difficult to do household chores. But I have to do it. If I do not look after my children and husband who else will (I3)

9.4.1.2 A psycho-social model of causes of the depressive illness

The patient's ideas about the cause of depressive illness are important, since they have important implications in treatment and follow up. Three of them didn't know the reason for their illness. The rest described problems at home, at work and social problems to be the cause of the illness. One woman said she acquired these symptoms post natal, while another reported she had the symptoms due to the life events,

I have this illness due to the problems in my life. I think I had so many problems in my life that now I feel like this all the time. (I4)

9.4.1.3 Referral to the psychiatrist

Three patients referred themselves to the service. Five were referred by a relative. Only one of these referrers had experience of mental illness. None of the referrers had a link with the medical profession. Only one patient was referred by a gynaecologist (This was the patient who developed post partum depressive illness). Those who referred themselves to the clinic could not offer an explanation as to why did they decide to come to this particular clinic. This is probably the most confusing finding in this study, namely to ascertain how these patients decide to come to psychiatric clinics, especially

when their major complaints are those of physical symptoms and they think that the illness is due to a physical diseases. On further enquiry only one patient, who was referred by a relative said, "someone else with similar symptoms had benefited from the service and we thought I will also benefit from this treatment."

9.4.1.4 Treatment of depressive illness

The main aim of our enquiry was to ascertain patients' ideas about treatment of depressive illness. Nearly all of them (N=7) believed that they can get better with medicines. One didn't know, what treatment can help him. Two of them said they should also get good tests for the brain, like these patients who said,

> *I should get good quality medicines. I should get good tests of my brain (Q. what do you mean by good quality medicines*). *Good quality medicines are the one which are not necessarily expensive but can cure the illness) (I9), and whatever doctor tells me or the tests he suggests or the good quality medicines he prescribes. That will be the treatment. But I need some treatment that eradicates illness at its roots (I1)"*

We were particularly interested in their knowledge of non medical treatments. When asked about treatment apart from medical treatment, they all said that they have not seen any other healers (faith healer, religious healer, hakim, magicians or homeopath). Only one person who said she was using some other treatment said,

> *I have been prescribed medicines only by a doctor and that's all. However, I read soora rehman (a verse from Quran) and do dum (blowing air on one's self) on myself… and I say my prayers more regularly now (I9)*

It is possible that patients felt that they should not disclose their contact with the healers outside the medical system rather than having no faith in alternative methods of healing. When asked directly about non pharmacological treatments for depressive illness (talking therapy/counselling) only one patient admitted that he has heard about it.

9.4.2 Mental illnesses

We decided to get patients' ideas about mental illnesses in general. This was to make sure that we didn't miss some knowledge that might be related to their illness and its management.

9.4.1.5 Patients' knowledge and their perception of mental illnesses

While three patients said they don't know anything about mental illness, others defined them as "illnesses due to tensions and trauma, problems in the environment, thinking too much and worries". Their definitions of mental illness were based on psychosocial causes of mental illnesses, for example this patient said,

Mental illnesses are the illnesses which are due to worries and trauma (I9)

The most striking thing was absence of names for mental illnesses. Most patients could name only one term, i.e., tension, other names included mental worry (zehni preshani), illness of seizures (doron ki bimari) and worries (preshanian). Only one patient used the term "tension and depressive illness". When directly asked if they had heard the name of an illness called depressive illness (udasi ki bimari), 8 of them said they don't know anything about it.

When asked if there are different types of illnesses**,** all but one said they knew nothing about the types of mental illness. The only patient who described a classification of mental illnesses said, there are two types of illnesses; esabi bemari (neurotic illnesses) and janoon (madness). Problems at work and home, thinking too much, difficult circumstances were the commonly described causes of mental illnesses. One person said trauma can cause mental illness. One patient also said mental illnesses can be due to genetic causes (moroosi). Typical statements included;

Mental illnesses are due to problems at home and at work. problems which make you worry. Or other problems which make you worry (I1), or due to worries or due to thinking too much (I2)

9.4.1.6 Treatment of mental illness

Apart from one patient everyone believed that mental illnesses are treated by medicines. Only one patient had heard of psychotherapy. They all believed that only doctors can treat mental illnesses. One person said "yes" on direct question, regarding psychotherapy as a treatment (psychotherapy, ya nafsiati ilaj, ya dawai kay baghair ilaj), although had said previously that mental illnesses are treated with medicines only. They all said doctors and nobody else can treat mental illnesses.

Most of them knew that psychiatrists are doctors. They were not aware of any other professionals involved in the care of mentally ill (for example psychologists). Only one of them had

heard the name of psychologists as a profession. They all seemed to have strong faith in the abilities of doctors, as typified by this patient;

Only the doctor can give the best advice as to what type of treatment I should receive (I5)

9.5 Discussion

I conducted interviews with patients attending the outpatient clinic of a psychiatric service in a teaching hospital in the south of Punjab, Pakistan. I initially had difficulty in getting information from the patients. I tried to assure them that these interviews will have no impact on their management and I only want to have some understanding of their illness and its treatment. People, however, were either reluctant to express their views or had no knowledge of mental health problems especially depressive illness. Patients answered in monosyllables, yes or no. These findings are in line with our previous work in Pakistan in which we surveyed medical and non medical university students and university teachers and doctors from Lahore, Pakistan. More than half of the participants said they had not heard of an illness called depressive illness (Naeem, 2005). Patients were especially careful when answering the questions regarding treatment. They were particularly guarded when talking about non medical treatments. My guess is that they did not want to say something to annoy the doctors. Since I was not very successful in interviewing in depth I decided to prepare a list of open ended questions. I also prepared closed ended questions and cue questions in a structured interview schedule. This enabled me to interview 9 patients in the second round.

Most patients in my study presented with somatic complaints. Somatic symptoms as presenting complaints have been frequently reported in literature, even core symptoms such as depressed mood or loss of interest may not be prominent in many cultures (Ustan, 2004). Although sadness of mood was described by a significant majority of patients, only one patient described it the reason for presentation. Headache seemed to be the main presenting complaint. Patients called their illness "illness of tension" (tension ki bimari). A few patients said it's a physical problem and possibly a brain disease. The word "tension" is commonly used by both Urdu and Punjabi speakers. Even the less educated or uneducated people use this term. Mood is also commonly used word both among the educated and the uneducated. However, mood is used in slightly different meaning, e.g; "he has a mood" means he has a labile mood. One patient called his illness, the "illness of suffocation" (dam ghutnay ki bimari). It was obvious that patients focused more on anxiety symptoms (and their associated somatic complaints) rather than the symptoms of depressive illness. Although on closed ended questions most of the patients said it is a mental illness, they did not use this word when the

concept was being explored through open ended questions. It is possible that people do not want to use the term "mental illness" due to the strong stigma attached? But it is equally possible that they did not think that they were suffering with a mental illness and came merely to see the doctors with their physical complaints.

All of them said that depressive illness was affecting their lives. However, they all carried on with their routine chores in lives. This could be due to Pakistan not being a welfare state. People have to perform their roles simply to survive. Similarly, women have to perform the duties imposed upon them through their roles within the family. One patient said she increased her prayers during her depressive episode. A combination of increased religious activities and continuation of daily routine might play a beneficial role in reducing the severity of depressive illness. During our informal discussions with clinicians it appeared that patients mostly demand medicines which make them feel better quickly, so that they can return to their routine. This also confirms what psychologists had said in their interviews, i.e; patients stop coming for therapy as soon as they are symptom free. Psychologists also reported that patients want only medicines.

Patients also used the terms "good medicines" and "good brain tests". Although, a desire to have brain tests done because of a belief that they suffer with a physical illness affecting the brain is understandable, it is difficult to understand what the good medicines are. Or what this means, this requires further investigation and was beyond the remit of this project. Are these only medicines which can cure the illness forever, or are these medicines which are not out of date or substandard (There are no checks on quality of medicines and newspapers often describe stories of drug companies producing poor quality medicines. It is possible that patients refer to this when they talk about good quality medicines). The idea of cure or illness being eradicated at its root has important implications. It simply means a patient and his family might look for a cure until and unless he is educated about the possible nature of illness. Due to the high number of patients attending outpatients (50-150 patients per clinic), however, this might not be practically possible. This possibly explains (at least in parts) why there are such high drop outs from psychiatric services in Pakistan. Interestingly, at least one person thought that there are two broad categories of mental illness, i.e., neurotic and psychotic.

But there are many pieces which do not fit in this jigsaw. Although patients want medicines and brain tests, they describe their depressive illness to be due to psychosocial problems, mainly problems at work, at home and due to some trauma or loss. In Pakistan people generally have too

many social and financial problems affecting their lives (for example, unemployment, social inequality and injustice, numerous national traumas etc) and therefore a psycho-social model of understanding of stress and depressive illness is comprehensible. But why do patients ask for medicines for problems caused by psychosocial stressors? Similarly, we were unable to ascertain how the process of referral works (in Pakistan any one can present himself to any hospital, in any part of the country). Why did patients (or in case of referral by a relative or friend) refer themselves to a psychiatric clinic, even though they had no previous knowledge of mental illness and did not know that their illness is a mental illness? It seems they are simply guided by the presence or absence of somatic complaints.

I expanded our interviews to include patient's views on mental illness in general. I believed that this might add to our understanding of patient's beliefs and perception of their mental health problems. Although I did not get any additional information, I was able to confirm that patient's perception of mental illnesses extended to their perception of depressive illness. Patients believed that mental illnesses are due to stress and trauma and that the commonest cause of the mental illnesses is tension. Again a psycho-social model of the understanding of the mental illness appeared and patients believed that these mental illnesses can be treated by medicines only.

I was especially interested in seeing if patients are aware of psychotherapy as a possible treatment of mental illness. In my interviews with the psychologists I found that patients have poor follow-up rates, they only think that medicines can treat their illnesses and possibly don't know much about psychotherapy. In our interviews with patients we found that patients are only aware of the doctor's role in treating mental illnesses. They were not aware of the psychologists. Doctors were described as the ultimate authority and the only professionals who can give the right advice. However, this leads to the question, why patients do not even follow psychiatrists and why there are high drop-out rates from psychiatric clinics.

I was unable to get a clearer picture of how depressed patients perceived their illness. However, the finding that patients in Pakistan probably knew very little about their illness is important in itself. This can have an impact on their actions to seek help. This also means that patients need to be educated about the illness and a shared understanding of symptoms should be developed. It is possible that depressed patients who experience somatic symptoms present to the medical services, while those experiencing less or no somatic symptoms seek help from traditional healers. In this way, somatic symptoms not only serve the function of medicalising the mental illness (and thus reducing the

attached stigma), but also lead their bearers to the medical system. Patient's unawareness of non-pharmacological methods of treatment should be taken into consideration when referring them to psychologists. Sharing a formulation which uses a bio-psycho-social model of illness might be useful when delivering psychological therapy to such patients. Patient's concepts about mental illness were similar to their concepts about depressive illness. Similarly, some of the ideas in this study confirmed the findings from our interviews with psychologists in Pakistan.

9.6 Limitations of the study

I interviewed patients attending a secondary care service from a medium sized city in the south Punjab, in Pakistan. It is possible that patients in community or those attending in other parts of the country might have different opinions. The study also involved a smaller number of patients. Future studies similarly, talking to patient's families and general public could have given us a more thorough understanding of the issues around understanding of depressive illness and its treatment. I should also point out that these are the patients who have come forward to seek treatment. They are likely to be different from people who suffer from the same problem and either seek help from other health professionals or even seek health from outside the traditional health system or do not seek help.

9.7 Conclusions

Depressed patients in Pakistan have very little knowledge of depressive illness or mental illnesses. They also don't know very much about non medical treatments of mental illnesses. Although they believed that mental illnesses are caused by psycho-social stressors, they felt that their somatic symptoms need investigating and should be treated with medicines. The study also confirmed and triangulated some of our earlier findings when we interviewed psychologists (for example somatic presentation, patients not being aware of non-psychopharmacological treatments etc.). This study highlighted the need to educate the patients and discuss with them treatment options and inform them of the role played by psychological interventions in the treatment of depressive illness and allow them to choose from these options. The study again highlighted the three areas which we need to focus on in order to modify therapy in Pakistan, i.e., cultural considerations (for example patients' use of non-traditional healing methods), capacity of the system and the individuals (for example pathways to care

including the process of referral) and patients' cognitions and beliefs (their model of illness, what they think about the treatment of depressive illness).

CHAPTER 10 GROUP DISCUSSION WITH STUDENTS

This study consisted of two parts, i.e., exploration of the students beliefs about CBT and related concepts and, the translation of terminology into Urdu involving group discussions with students. The two parts of this study are presented in one chapter because they were conducted at the same time and with the same group of students.

10.1 University students' views about the compatibility of cognitive behaviour therapy (CBT) with their personal, family, social, cultural and religious values

10.1. 2 Background

I realized early in my literature search and initial discussions with colleagues in Pakistan and the UK that psychotherapies have a philosophical basis which is mostly Western in origin (for example, as mentioned already, the principles of CBT were derived from the writings of Greek stoic philosophers and have evolved mainly in Western cultures). Psychotherapies developed in the west are therefore understandably not only influenced by Western values but probably promote Western values too (for example assertiveness training for better communication or helping the person to live independently rather than live in harmony with their family). Western psychiatry and psychotherapy also work closely with the systems of health and social support which have developed over the years. Unsurprisingly, therefore, it has been argued that most counselling theories reflect a white Western male perspective and so inherently are in conflict with the cultural values and beliefs of third world or minority individuals (Scorzelli, 1994). A significant amount of literature highlights difficulties or potential difficulties in the application of psychotherapies developed in the West to other cultures (Patel, 2000). In essence, Western psychotherapies may have ingrained within them socio-cultural and individual as well as family values but also religio-spiritual values based on Christianity as it is practiced in the west. We should however, keep in mind the fact that these therapies have evolved over

time as the Western culture changed, especially during the last century. In other words these psychological interventions have the capacity to evolve within the Western cultures. But we should also remember that Western psychotherapies have incorporated principles and techniques from Eastern therapies successfully (for example relaxation, yoga, breathing exercises and more recently mindfulness from Buddhism) (Brotto, 2008; Hanstede, 2008; Kozasa, 2008; Lundgren, 2008; Nyklicek, 2008; Atkinson, 2009; Ong, 2009). However, this issue has not been explored in detail.

The availability of CBT is limited in the developing world (Rahman, 2008). Service and training issues, in addition to availability of culturally acceptable forms of therapy might be some of the barriers (Rahman, 2007). There are differences between the Asian and the Western cultures which might need consideration before an attempt is made to provide therapy to Asian patients (Pande, 1968; Iwamasa, 1993; Sue, 2000; Laungani, 2004). In order to adapt CBT for use in non-Western cultures, it might be useful to investigate "how consistent the concepts underpinning therapy are with the way people view themselves, their world and people they live with". One study of psychology students which looked into this important issue in India found that 82% students felt that the cognitive approaches to therapy were in conflict with their values and beliefs, 46% reported that therapy was in conflict with their cultural and/or family values and 40% described these as conflicting with their religious beliefs (Scorzelli, 1994). The main reasons for this incompatibility were described to be religious beliefs that human destiny is controlled by supernatural powers and influenced by the deeds committed in a previous cycle of life. Students believed that the individual must abide by the rules and the values of their family or community to have a meaningful and conflict-free life and that the females will always need support from a stronger individual. Pakistani culture shares some concepts with Indian culture but also is influenced by Islamic religious and cultural heritage. The same authors described different results in a similar study conducted in Thailand a few years later (Reinke-Scorzelli, 2001). In this study, they found that 54 (93.1%) of the participants felt that the cognitive approaches did not conflict with their values and beliefs. The participants said that ''Buddhism emphasized the present and focused on an awareness of one's identify and behaviour'' and that ''the mind is the major cause of suffering.'' The differences between these studies highlight the fact that there might be wide variations among Asian cultures in terms of acceptability of cognitive therapy.

Therefore the decision was taken explore this concept further in Pakistan. In the attempt to expand as well as modify the work that had already been carried out in India and Thailand, a more structured questionnaire was developed. This chapter reports on the results of group discussions with university

students in Pakistan. In these groups, students' views were explored regarding about the compatibility of the concepts underlying the CBT with their personal, family, cultural and religious values.

10.1. 3 Methods

10.1.3.1 Aims and purpose

The aim of the study was to explore the participants' views about compatibility of CBT with their values. Avisual analogue scale was used to measure them. This was to make sure that the full range of compatibility or otherwise with these concepts was captured. The values in four different domains, that is, personal, family, social and cultural and religious were examined.

10.1.3.4 Areas explored

Three concept areas were identified for exploration. This was decided on the basis of clinical practice, field observations and past literature. These included:

10.1.3.4.1 Concepts discussed in Session 1

The first session discussed the basic concepts of CBT. The questions discussed included;
What is psychotherapy?
What is CBT?
Which mental health problems are treated by CBT?
What is the style of therapy and philosophical concepts?
Are we responsible for our own actions?
Is man the master of his own destiny?
What is individualism?
How does it relate to the concept of social and family life in local culture?
What is a collaborative style of working?
Can therapist and patient be equal?
Socratic dialogue was used as an example to illustrate the style of therapeutic work in CBT with clients.

10.1.3.4.2 Concepts discussed in Session 2

The focus here was on communication styles. The questions addressed in this session were;

What is passive behaviour?
What is aggressive behaviour?
What is manipulative behaviour?
What is assertive behaviour?
What does assertiveness mean in talking to an elder or a senior person?
What are the basic rights of the individual and how can they come in conflict with the wider social and cultural values?

10.1.3.4.3 Concepts discussed in Session 3

The details of the cognitive model of psychopathology were discussed. The main questions debated were;
What is the cognitive model?
What is the link between events, thoughts, emotions, behaviour and physical symptoms? What is a cognitive triad?
How to change thoughts?
What is meta cognition?
What are cognitive errors?
How to find them and then change them?
How to challenge the dysfunctional thoughts?

10.1.3.2 Sample and settings

Three university departments (Masters in English, Economics and Political Science) in a local university campus in the city of Rahim Yar Khan were contacted. The purpose of the study was explained to the respective head of the departments. When they agreed, they were requested to give the names of the first 15 students from attendance registers. For the discussion and cross sectional survey, 34 of the selected 45 students attended.

10.1.3.3 Design and conduct of study

The students were given information on the study and its purpose. Those who agreed were invited to the discussion groups. Students participated in three facilitated discussions about psychotherapy, CBT and different concepts around CBT. Discussions were held in Urdu in an interactive format where students had a chance to discuss and clarify the ideas. Each session lasted for one hour. At the

end of each discussion, students were asked to report whether the ideas discussed in the session were compatible with their personal, family, social and cultural and religious values. They had to record their responses on visual analogue scales between 0 and 10. A 0 meant that the relevant concept was not compatible with the values while 10 meant that the concept was perfectly compatible. In the scale, there were separate variables for personal values, family values, social and cultural values and religious values. Space was left for students' comments or explanations. The reason for using the visual analogue scale instead of a binary variable (yes or no) was to study the degrees of variation in beliefs.

10.1.5 Analyses of the interviews

Numerical scores produces from the scales were analysed using SPSSv 16. Data from visual analogue scales was converted into three categories to get a more meaningful picture. Zero to three was re-coded as 1, 4 to 7 as 2 and scores of 8 to 10 as 3. Further analyses were performed on recoded variables.

Both parametric and non-parametric tests were performed. Mean age was measured using explore command in SPSS, gender differences were measured using frequency. Chi square tests were used to measure the difference between two genders in terms of their recoded beliefs.

10.1.4 Ethical approval

Ethical approval was obtained for the study from relevant institutes.

10.1.6 Results

A total of 34 students participated. Three were removed because of too much missing data. The details are: Males 16 (57.1%), females 12 (42.9%) (3 missing), age in years (N 31), mean 21.8 (range 20–24). The number of students from the three departments was as follows: Political science 9 (29%), English language 8 (25.8%) and economics 14 (45.2%). All the students were Muslims by religion.

Table 2 shows the responses of students on a visual analogue scale to cover four possible aspects of their values related to different concepts around CBT, after recoding. For the first concept, which included an introduction to CBT and its philosophical basis, there was moderate to high agreement among students on these concepts not conflicting with their personal values. However, students thought that the concepts were in conflict with the other dimensions of value systems; for social and cultural values 3.2%, family values 9.7% and religious values 25.8%. In Pakistan, people are more deferential, and expressing one's opinion, when talking to a senior or an elder, until and unless one is in agreement, is not seen as a positive value. Our second discussion therefore was based upon communication and social skills. Again, perception of conflict increased as we moved from personal to religious domains, that is, conflict on personal level was 3.2%, while both for social and cultural values it was 9.7% and for religious values, 32.2%. During the third discussion, we explained cognitive errors and how they can be recognised and changed. In this domain the perceived conflict in all the domains was less than 6.5%. There were no statistically significant differences between two genders except for the first concept. For this concept for social and cultural values, women saw less conflict than men and for family values men saw less conflict. Table 3 shows gender differences in their response (P values from X^2 test show statistical differences).

Table 3. Gender differences in values held by the students about the concepts related to CBT

Concept		Level of agreement	Males N(%)	Females N(%)	P
Concept 1	Personal values	0-3			
		4-7	8 (50.0%)	6(50.0%)	0.863
		8-10	7(43.8%)	6(50.0%)	
	Social &cultural values	0-3			
		4-7	10(66.7%)	3(25.0%)	0.031
		8-10	5(33.3%)	9(75.0%)	
	Family values	0-3	2(13.3%)		
		4-7	7(46.7%)	11(91.7%)	0.045
		8-10	6(40%)	1(8.3%)	
	Religious values	0-3	2(12.5%)	5(41.7%)	
		4-7	7(43.8%)	5(41.7%)	0.189
		8-10	6(37.5%)	2(16.7%)	
Concept 2	Personal values	0-3	1(6.2%)		
		4-7	2(12.5%)	2(16.7%)	
		8-10	12(75.0%)	10(83.3%)	0.651
	Social &cultural values	0-3	2(12.5%)		
		4-7	5(31.2%)	4(33.3%)	
		8-10	8(50.0%)	8(66.7%)	0.407
	Family values	0-3	2(12.5%)	1(8.3%)	
		4-7	8(50.0%)	7(58.3%)	
		8-10	5(31.2%)	4(33.3%)	0.914
	Religious values	0-3	2(12.5%)	5(41.7%)	
		4-7	6(37.5%)	5(41.7%)	0.141
		8-10	7(43.8%)	2(16.7%)	
Concept 3	Personal values	0-3			
		4-7	8(50.0%)	3(25.0%)	
		8-10	7(43.8%)	9(75.0%)	0.137
	Social &cultural values	0-3	1(6.2%)	1(8.3%)	
		4-7	8(50.0%)	8(66.7%)	0.710
		8-10	6(37.5%)	3(25.0%)	
	Family values	0-3		1(8.3%)	
		4-7	9(56.2%)	9(75.0%)	0.259
		8-10	6(37.5%)	2(16.7%)	
	Religious values	0-3		2(16.7%)	
		4-7	8(50.0%)	4(33.3%)	0.211
		8-10	7(43.8%)	6(50.0%)	

10.1.7 Discussion

This study was conducted to find out whether university students find the different concepts related to CBT consistent with their personal, socio-cultural, family and religious values. This was an exploratory study and the students were selected as a convenient sample. Pakistan is a country with 160 million people, numerous languages and local dialects and great racial and cultural diversity. For a study of this size it would not be possible to capture that diversity. We are encouraged by the responses of the students who do not see CBT in conflict with their personal values. One of the concerns can be that these responses were influenced by the students' desire to be seen in a positive light by people conducting the study. To address that issue we had informed the participants that there was no right or wrong answer to these questions and that they should rate the visual analogue scale according to the first thought they had in response to the issues raised during the discussion. In addition, the responses were anonymous.

The first discussion introduced the concepts embedded in Western psychotherapy, like fate, individualism and how a person is related to the people around him. One-third of the students thought that these concepts were not compatible with their religious values. This percentage is closer to the percentage in the Indian study where 40% of the students thought that the concepts of psychotherapy were in conflict with their religious beliefs (Scorzelli, 1994). In Thailand, the participants did not think that the values of CBT were in conflict with their religious values (Reinke-Scorzelli, 2001). Al-Qadr is one of the fundamental beliefs in Islam. It is about God's control of the creation and destiny of everything in universe. In terms of human beings it means that their creation and all their acts are controlled by God. For centuries there has been a debate among Muslim scholars about the interpretation of this basic tenet of the religion. At one end, the scholars with rational outlook believed that human being had full freedom of action and they will see the consequences in the life after death. On the other side of the argument the interpretation emphasized predetermination of the destiny of human beings. Muslims hold opinions of different shades between these two views (Watt, 1946; Thomson, 1950).

The second concept that was debated during our sessions was of assertive communication. A high degree of disagreement was expected on this concept, because it specifically discussed assertiveness in terms of expressing one's views to an elder or a senior. One-third of the students thought that assertiveness is in conflict with religion. One can speculate that the students' values are in transition from the traditional ones to something more like the Western outlook. In the process it is

likely that the personal, family and social values have changed more than the religious values. We should keep in mind, however, that religion and culture affect each other and a culturally appropriate interpretation of religion might help build a symbiotic relationship between the two in any given culture (for example a blond, blue eyed Jesus Christ in the West). It is possible that interpretation of religion is mediated by the culture. If you travel through the Middle East and South Asia it becomes apparent that communication patterns in Pakistan are (and understandably so) closer to India and not to the Middle East.

The results of the third discussion were interesting. This discussion described cognitive errors, the cognitive triad, thinking about thinking, the emphasis on finding unhelpful ways of thinking and trying to change them by finding the evidence and finally arriving at a balanced view. Apart from a small proportion of students this was not seen in conflict with any set of values.

The presence of clear trends among participants in their agreement on a personal level is encouraging. It is likely that the students' values are similar to those of people in the West. The media has a strong influence on the attitudes and beliefs of people in the modern world. Not only are Western TV channels watched throughout Pakistan, especially by young people, but the Pakistani media also promotes Western values. It is also possible that at least some of the values of Pakistani people are similar to Western cultures because of the influence exerted by monotheistic religions. I believe this could be due to the common origin of, and many beliefs shared by, Islam, Christianity and Judaism. A small proportion of the total population (less than 5%) go to University in Pakistan (World Bank 2009). In socioeconomic terms they are not likely to be representative of all the sections of society. It is possible that their values might not be representative of the wider community. But it gives an idea about certain trends.

The differences in views between India, Thailand and our sample highlight the diversity within the developing world. Any form of therapy needs to be individualised and should take into consideration the patient's view of the world, his belief and value system and his particular way of thinking. As described initially, a major concern has been that psychological therapies developed in the Western world – although often drawing elements from Eastern traditions – may be incompatible with Eastern values. This initial study examining a specific therapy, CBT and a specific group, students in Pakistan, does not suggest that this is the case.

In summary, psychotherapies developed in the West have evolved over a long time period. They are influenced by, if not derived fully from, the existing value systems in the West; i.e., individual, family, socio-cultural and religious. In order for therapies to be adapted for non-Western cultures, it is essential that we try to understand the value systems of the given country and take these into consideration during the adaptation process.

10.2 Translation of terminology

10.2.1 Background

During my initial therapy work I realized that translation and adaptation of terminology is an important part of the overall process of the adaptation of CBT. This was confirmed by psychologists who suggested that literal translations of terminology might be a hindrance in providing therapy in Pakistan. Drawing on our previous work in Pakistan which included translation of a number of measurement instruments (Mufti, Naeem et al., 2005; Naeem, Mufti et al., 2005; Naeem, Irfan et al., 2008; Ayub, Irfan et al., 2009) and translation and adaptation of the International Classification of Diseases, 10th edition, Research Diagnostic Criteria (ICD 10, RDC) (WHO 1992), we were aware of the problems and difficulties in this area (Naeem et al., Accepted for Publication).

Pakistan is a culturally diverse country with different languages spoken by people from different parts of Pakistan. The languages distinctively spoken in Pakistan include Punjabi (45%) (with 8 distinct dialects), Sindhi (15%), Pashto (15%) Siraiki (10%) Balochi (4%) and Other languages (11%), which include Burushaski, Shina, Khowar, Kalash and Wakhi. However a distinct Pakistani dialect has evolved which is spoken in most parts of Pakistan. It is the national language of Pakistan (although it is not the native language of any native groups) as well as some states of India. Urdu is an Indo-Aryan language of the Indo-Iranian branch, belonging to the Indo-European family of languages. It developed under Persian and to a lesser degree Arabic and Turkic influence on apabhramshas (a group of local Indian languages) during the Delhi Sultanate and the Mughal Empire in South Asia (1526–1858 AD). In general, the term "Urdu" can encompass dialects of Hindustani other than the standardised versions. Standard Urdu is 19th in world languages ranking. Present day Urdu borrows words from English and some European languages, notably when it comes to scientific terminology, but it has also absorbed words from the local languages in Pakistan and as well as from Hindi (mostly through the Indian media). The Pakistani dialect of Urdu has also evolved in such a way that the

Arabic and Persian words are less often in use now. Nearly 80% people in Pakistan can speak Urdu (Wikipedia 2008). We therefore decided to choose Urdu as the language in which we were going to translate our work. However, we kept in mind the linguistic diversity and tried to choose terminology which was widely used and easily understood.

The use of words and associated grammatical rules from different languages makes Urdu a difficult language to translate into. It is therefore not surprising that there is a paucity of literature on psychological and psychiatric topics in Urdu. Many writers have described methods and principles of translation in psychiatric literature (Sartorius, 1994; Simonsen, 1990; Sartorius, 1994; Gaite, 1997; Hutchinson, 1997), albeit limited to measurement scales. One important issue here is, "who can translate". Our previous experience of translating mental health information and scales into Urdu suggests that the role of the professional translators might be limited in this regard. Translation of psychiatric terminology is different from literary terminology and some understanding (or experience) of both cultures might be helpful in this regard. It has been suggested that it is crucial that translators understand both languages (original and target), and know about the cultural understanding of mental distress and disorder (Bhui, 2003)). Some have recommended choosing translators who have learnt the language of the original version as a second language, in preference to those who use the source language as their dominant language (Edwards, 1994). Others have stressed the importance of translators being highly qualified; having good technical knowledge of both the source and the target languages and full emotional understanding of the source and target languages; being deeply involved in the cultures in question; knowing about the cultural problems related to the concepts and terms used in the questionnaire (so as, for example, to avoid the use of stigmatising concepts); and having integrated knowledge of the area and domains explored in the questionnaire (Knudsen, 2000). Surprisingly, however, none of the published studies on this subject advocate the involvement of the end users in the translation process.

In my search of the literature I found no information on translating "specific terminology" used in psychiatry or psychotherapy into colloquial language. I felt this is an important part of the work I was planning. Local idioms and phrases are easy to understand and remember (note the use of "black and white thinking" rather than "dichotomous thinking" in the UK, which is a concept most lay persons need no further explanation to understand). A technique was therefore adopted which we had already used in our previous work, which we termed "suggest the title" (Naeem et al., Accepted for Publication). In this simple technique we described a concept to the participants in Urdu and asked the

participants of the group to name it. We used the same technique to find out locally accepted and known equivalents of terminology (for example cognitive errors & dysfunctional beliefs). Since this study was conducted with students after the three discussions, only relevant details from methodology are being described.

10.2.2 Methods

10.2.2.1 Aims and purpose

The aim of this part of the study was to find culturally relevant CBT terminology.

10.2.2.2 Areas explored

For this study we mainly focused on cognitive errors.

10.2.2.3Design and conduct of the study

The "suggest the title" technique was used with the same group of students who participated in the first study. Once the first three discussions had taken place, students were informed about the purpose of the study, i.e., finding out local terminology for the concepts represented by some of the terms used in CBT. They were never told the English term. Each term was explained with examples and then a short discussion ensued. At the end of the discussion we had several alternatives. Students were then asked to choose the one term which they considered most appropriate. The process was repeated for the rest of the terms. Here we will describe the alternatives we found for cognitive errors only. I am describing the terminology suggested by the group along with the final term (in bold and underlined).

10.2.2. 4 Results

The following words or terms were offered as possible terms which could represent cognitive errors.

1. Black and white thinking: shaitan or farishta (angel or devil), intaha pasandi kay khayalat (extreme thinking), do intahai soch (thinking on two extremes), aar ya paar (either side of the river), dooba ya sokha (wet or dry), takhat ya takhta (throne or execution)

2. Jumping to conclusions: ghalat fehmi ki soch (thinking style of misunderstanding), wehmi soch (thinking style of someone with delusion), shakki soch (thinking style of a suspicious person), jaldbazi ka nateeja (conclusion in a hurry) or jaldbaz ki soch (thinking of a person in a hurry), jazbati daleel (logic based on emotions), najoomi ki ghalti (fortune teller's mistake)

3. Overgeneralization: na insafi (injustice), tassub (prejudice), thappay lagana (putting stamps or labels), tang nazri ki soch (narrow mindedness)

4. Selective abstraction: soi atak jana (being stuck on something), tang nazri (narrow minded), manfi soch (negative thinking)

5. Magnification and minimization: choti bat ko bara karna (to make a big thing out of a small one), baat ka batangar (creating a big dialogue out of a small one), rai ka pahar or pahar ki rai (making a mountain out of a mole and a mole out of a mountain), hassas soch (sensitive thinking).

6. Personalization: har bat apni jan pay lena (taking everything on your life), zati masla banana, (to make everything a personal issue), urta teer baghal men lena (to catch a flying arrow in your armpit), khud ilzami ya khud malamti ki soch (blaming yourself)

10.2.2.5 Discussion

Initial discussions revealed that one of the barriers in therapy is unavailability of properly translated reading material and terminology in local languages. Psychologists found it difficult to convey their messages using literal translations of the terminology in English. It was felt that for terminology to be effective, it should be grounded in locally used idioms and expressions. The "suggest the title" technique proved to be useful in finding alternatives for cognitive errors in this study. When this terminology was used with patients they found it easy to understand and to remember.

10.2.2.6 Conclusions

The "suggest the title" technique can be used in finding local alternative in a non western culture. It can be used in small group discussions and does not need a lot of resources.

10.2.2.7 Limitations

Students might be using different terminology than the rest of the population. However, when terminology was used with patients they were comfortable with these and found them easy to understand and remember.

CHAPTER 11 SOUTHAMPTON ADAPTATION FRAMEWORK FOR CBT (SAF-CBT)

Once the small scale studies had been completed and analysed (interviews with psychologists and patients and group discussions with students), the stage was set for the next stage of our project, i.e., to develop guidelines which could help us in adapting our manual for the local needs in Pakistan. Based on this work, three broad themes emerged: culture and related issues, the capacity of the individual and the system, and the cognitions and beliefs of patients and professionals. Each theme had seven categories within it. In this chapter the results of this work are described (Southampton Adaptation Framework for CBT, SAF_CBT) and the process used is briefly mentioned.

11.1 Background

The move towards improving therapists' competence in addressing ethnic issues has gained momentum during the last few years. Some therapists living and practising in the USA have tried to modify CBT for their ethnic minority clients in the West. In our literature search we found only one paper describing the process of adaptation of a Cognitive behaviour Therapy based intervention from outside the West (Rahman, 2007).

Some US therapists working with ethnic minority patients have developed guidelines for adaptation of therapy. One such author for example 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 counselling 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 (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, 2004) 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 defence 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, no such effort has been made in non Western cultures to systematically address the issue of the adaptation of CBT taking into consideration the local needs. Although the experience of therapists in the West working with ethnic minorities and frameworks developed as a result are a good starting point, they might not be very useful for a variety of reasons. The minority clients might be different from the patients in their country of origin. They might be more ambitious and better skilled in coping with changes, although we can not rule out the possibility that some of them might have moved due to mental illness or its consequences. In the end the trauma of migration and adjusting to a foreign culture mean additional stress. Similarly, a significant proportion of the migrants might have left their countries due to war or other traumatic experiences (for example, migration of Jews during the World War, Palestinians due to ongoing conflicts in Palestine and Afghans during the period of the Russian invasion of Afghanistan). There

are other important variables like, being familiar with Western concepts (especially the second generation individuals) of health, illness, causes of illness and its treatment as well as the wider health system, stigma and financial resource issues, which might have an impact on therapy. There are even wider cultural and sub-cultural variations in Asian countries. Rapid Westernization of the non-Western countries only adds to the complexity of the issues. In the end we are not aware if any one of these guidelines was derived from structured observations and later was used to guide the development and adaptation of therapy which was field tested. It is important that frameworks for adaptation of therapy are developed in a given culture and then tested locally. I am describing the guidelines which I developed based on my qualitative work.

11.2 Methods

11.2.1 Aims & Objectives

To develop guidelines for adaptation of CBT in Pakistan

11.2.2 Design

It was decided to analyse the information that had been gathered so far. So far three small scale studies (psychologists, patients and students) had been conducted. In addition to this, information had been gathered through therapy sessions, field observations and discussions with colleagues in Pakistan (field notes) (Please see appendix 1, Extracts from the fieldwork diary"). This part of the project essentially involved analysis of data from previous studies. Table 4 shows some examples of categories which were used to develop the framework.

11.2.3 Analysis

All the interviews were re-read many times, including their results and the filed notes. The process described in early chapters was used, and the original codes from all the available work were used to develop categories and then themes (this was done in two steps, sub-themes were first developed and then themes) to develop these guidelines. Sub-themes from different studies were also compared with each other for reliability. It was a difficult task and lasted for nearly 6 months. Once all the data had been organized into sub-themes and themes, a literature search on this topic was undertaken . Sub-themes and themes were then revisited. In describing these results (unlike the previous studies) the author has relied on thematic analysis more than a simple content analysis, hence, the themes are to some extent discussed during the results section. Table 4 gives a few examples of some of the

categories which were the basis of our sub-themes. At first 28 sub-themes were developed, which were reduced to 21 during the next step of analysis which was carried out after the literature review. These sub-themes were grouped into three major themes.

Table, 4. Examples of categories used to develop framework

Psychologists study	Patients study	Field observations
• People come from different areas, they are usually illiterate and belong to the lower social class • They usually have a diagnosis of depression or anxiety and present with physical complaints or with conversion • If a person is depressed I will help him to improve his activities by using behavioural techniques • As soon as a patient becomes symptoms free he stops seeing us • For illiterate patient coming from outside Lahore therapy lasts over hardly one or two sessions • Women are more likely to drop out of therapy than men • In Pakistan the family is too much involved with the patients and sometimes it can be a big problem • Patients like direct advise • Patients find it difficult to understand some concepts, for example, cognitive errors • Patients are more interested in medicines. May be they are not expecting this kind of therapy. They are expecting only medicines from here	• I get headache and dizziness. I also feel weak, my arms feel numb. • I can not stop working. I have to look after my family • I don't know the name of my illness • It is "some sort of physical illness", 'illness of poor sleep' and 'tension' • I have this illness due to the problems in my life • I don't know about psychologists • Only a doctor can treat my illness • Whatever doctor tells me or the tests he suggests or the good quality medicines he prescribes will be good for me. That will be the treatment • I have not heard of psychotherapy or treatment without medicines • Mental illnesses are the illnesses which are due to worries and trauma • Mental illnesses are due to problems at home and at work • Nearly all the patients were referred by themselves or by a friend or a family member	• I have a ball of gas in my stomach which rises to my head and then I start feeling dizzy (a patient with anxiety) • Patients come from far off places. It might take upto two days for a patient who is travelling to a big city. • Mental illnesses are due to sins (One medical colleague) • My son got married few months ago. His attitude has changed. My daughter in law has put magic spell on him (a depressed patient) • How can she be depressed? She has got everything she can imagine (husband of a depressed patient who was informed she as depression) • When I refer patients to see a psychiatrist they usually refuse because of the stigma. So i have to treat them myself (a cardiologist) • The health service is poorly structured and specialist services are only limited to the big cities. There is no referral system. Patients mostly refer themselves • Patients like instructions rather than a collaborative approach

11.3 Results

The three main themes derived from our work were: culture, capacity and cognitions. There follows a description of each theme and the subthemes from which it was derived.

11.3.1 Culture & related issues

The first theme that we are going to consider in adapting CBT is culture and issues related to culture. As mentioned in our previous discussion, this is the area which has been highlighted most in the literature on this topic. There are seven sub-themes in this culture theme which should be considered:

- culture, religion and spirituality
- family
- communication and language
- rules of engagement
- symptoms and expression of distress
- focus of therapy
- traditional healing practices

11.3.1.1 Culture, religion and spirituality

It is widely accepted that culture, religion and spirituality influence expression of mental health problems. However, not a lot of information is available on the role of these factors in delivering CBT. Religion and spirituality are important parts of peoples' lives in many Asian cultures (however, we should not deal with all Asian cultures as a single entity). These factors influence the belief systems of people, especially those related to health, well-being, illness and help-seeking in time of distress. Culture, religion and spirituality also give rise to myths and stigmas attached to an illness. For example, during informal discussions with colleagues it emerged that many people in Pakistan believe that not following religion can make people depressed. The idea is based on misperception of some verses of Holy Quran. However, this knowledge can be used to help patients by using examples from

Quran and Hadis (sayings and actions of Muhammad). Therapists should be aware of these beliefs and educating patients on depressive illness and its treatment becomes really important in this context.

11.3.1.2 Family

It is still common for people to live within an extended family setup. Family can be a cause of conflict and stress as well as a valuable resource to help and support the patients. Sometimes patients talk freely only when they are seen on their own and may not express themselves when a family member is around. Some of the psychologists said they involve the family members in the second or third meeting. We involved family from the start and when diagnosis, treatment options and cognitive therapy are being discussed. It is especially important to discuss the future involvement of the family and in particular which member of the family is going to attend the sessions in the future along with the patient. This is a highly sensitive area and the therapist should be very careful in dealing with the family. Due to the hierarchical system, there is usually one decision-maker in each family. The therapist should find out early in therapy who is the family's decision-maker. Approaching the decision-maker can ensure cooperation and future follow-up. It is important to keep in mind the family secrets within families. It is important to maintain the patient's privacy, dignity and confidentiality. They should be consulted at the start of therapy as to what they would like and what they would not like to share with the family members.

The family can especially assist in following areas;

- Information gathering
- Therapy (by being a co therapist)
- Supporting the patient (there is no support system after office hours)
- Bringing the patient back for follow-up

11.3.1.3 Communication and Language

Patients with depressive illness and anxiety often need help with communication and social skills. Their inability to manage conflicts at home and at work can be a possible source of anxiety and distress. It is therefore helpful for the patients and their families if they receive at least some information and advice on communication and social skills and simple tips on how to manage conflicts within their relationships, if this is a problem area. People generally do not take much interest

in writing. This is evident when you are getting into a contract (for example, a tailor, electrician or a plumber). This certainly has implications in terms of homework. Respect is an important part of Asian cultures. Respect can also mean that a son cannot disagree with his father or that an employee cannot express his opinion when the boss is around. This as a result leads to a "triangulated approach" to communication, although this can lead to more conflicts. When there is no option, or there is limited time, then we have advised patients to use this technique as well, i.e. finding a senior relative or a senior employee to convey the message.

I observed that good communicators in Pakistan use a strategy which I call "apology technique". In this technique the person begins the sentence with, "with a big apology, I would like to seek your permission to disagree", "if you allow me to express myself", "with due respect I would like to say that my opinion is". People using this technique not only say this, but they also look humble, especially lowering their eyes. I have used this technique effectively. The patient may need some practice using role plays. Similarly, making a list of excuses rather than straight refusal as a starting point for learning to say 'no' can be helpful. Another technique which is less confrontational is writing a letter to the person.

Although, Urdu is the national language of Pakistan (with 80% of people being able to speak in Urdu), it is not the native language of any native groups (Wikipedia, 2008) . This only adds to the complexities of psychotherapy in Pakistan. Psychological concepts are difficult to translate in non-Western languages. Psychologists said patients find it difficult to understand concepts of therapy, for example, cognitive errors. The first step in providing therapy in a non-English speaking culture, therefore, should be translation of concepts into colloquial expressions and translation of reading material into that language.

11.3.1.4 Rules of engagement

The therapist-patient relationship is that foundation on which the building of therapy is built. This becomes even more important in the context of the Asian cultures, where people go to see healers because of faith rather than reason. I experienced many occasions when a patient who had benefited from psychotherapy brought a neighbour or friend who suffered a physical illness. It was very difficult to convince them that psychiatrists can not deal with an orthopaedic or cardiac problem. This issue needs to be tackled carefully. Once the patient or his family is convinced that the therapist has

"healing powers", follow-up becomes an easy task. Patients are not very different from their Western counterparts in Pakistan and demand courtesy, careful listening, warmth and genuineness. Patients prefer advice from the therapist. Cognitive therapy can be adapted to suit patients' needs and can be delivered in a counselling style. Sometimes patients might not disagree with therapist (although they might not turn up for the next appointment) due to respect. It is the duty of the therapist to pay attention to patients' body language and subtle changes in language and expression.

11.3.1.5 Expression of distress & symptoms

Many patients with anxiety or depressive illness present with physical complaints. Some patients with anxiety might say "I have a ball of gas in my stomach which rises to my head, and then I start feeling dizzy". It is very important that we address patients' concerns – i.e. their physical symptoms - instead of using therapy in a 'mechanical' way.

Cognitive therapy emphasises formulating the case and sharing the formulation with the patient. Formulation can include linking the somatic complaints with thoughts, emotions and behaviours. The therapist should not expect that the patient will change his mind regarding the causes of his symptoms in the first meeting, and should be ready to talk about this a few times. A careful discussion should be built on neutral grounds where you initially don't agree or refute the patient's ideas of illness strongly. The therapist should be ready to "agree to disagree" with the patient. This is a particularly useful strategy, for example, when dealing with patients who are convinced that their somatic symptoms are due to a physical illness.

11.3.1.6 Focus of therapy

CBT puts great emphasis on structuring sessions around patients' needs. This probably does not cause problems in the Western cultures, where therapy techniques are well developed and, at least for depressive illness and anxiety, therapist and patient might share their concerns. However, this can be an issue in non-Western cultures where patients come with unusual presentations - especially since techniques to address somatic or dissociative symptoms are not well developed. A therapist who is trained in only Western therapy techniques might find himself out of his depth here. Trainee therapists might be in a hurry to try therapy techniques. Without sufficient preparatory work this might cause a

patient lose faith in the therapist's abilities. It is the responsibility of the therapist to address the patient's concerns, engage him and move on to therapy issues which he feels need addressing. The two-stage rule we use can be described as "focus and connect". In the first stage, the therapist should "focus" on the patient's concern (which might be somatic complaints) and during the second stage, the therapist "connects" the patient's concern with his concern (depressive illness, anxiety or suicidal thoughts) and promotes the therapy agenda. The above discussion does not only apply to somatic symptoms, but also to other issues which are on the patient's mind like multiple problems, communication or social problems or relationship difficulties.

11.3.1.7 Traditional healing practices

The psychologists felt that seeing traditional healers (faith healers for example) causes hindrances in therapy. Interestingly, we were not able to confirm this in our interviews with the patients. None of the patients admitted to seeing a traditional healer. However, this could be due to their fear that doctors do not want to hear about traditional healers, rather than a lack of contact. Our impression based on informal discussions with the colleagues is that mental health professionals do not like the involvement of traditional healers. While there are stories of abuse of patients by the traditional healers, there are more success stories. Our discussions also revealed that people follow traditional healers faithfully (in the literal sense of the words) for lives. The fact remains that the number of mental health professionals is too small to cope with psychiatric problems if the faith healers stop working (Naeem, 2005). It seems that at the moment the two systems are operating parallel to each other. The question "how does the traditional system of mental health support, compete with or complement the medical system?" begs a detailed enquiry.

11.3.2 Capacity & Circumstances

- *Sub-themes:* gender and age
- educational status
- coping strategies
- capacity of the health system
- availability of mental health professionals

- pathways to care & help seeking behaviour

Although some of the areas in this domain are not entirely new, they are probably different in their significance. Issues in this area have been described as on an individual level and on a system level. By the system is meant not only the medical or traditional health system, but also the wider system of support of which the health system is a part.

Individual level

11.3.2.1 Gender

Psychologists reported that women are more likely to drop out of therapy than men. Women are dependent on men to be brought to the hospitals. They also have to seek permission from the man in the house. In our study of domestic abuse among women in Pakistan we found that a common problem reported by women was that men control finances (Naeem et al., in press). Men, on the other hand can travel more, are in control of finances and are more educated than women. Women are more likely to suffer from depressive illness and anxiety. Depressive illness among women not only has negative effects on children but also the while family. Including the accompanying person during the assessment and thereafter talking to him on how the mental health of the woman can have an effect on the health of the family and especially children might be useful in this regard.

11.3.2.2 Age

The age of the patient can be an important variable in therapy. In our experience younger patients are more likely to benefit from therapy. Being educated and having access to electronic and print media and internet might be contributory factors. But younger patients are also more likely to have shorter duration of illness and more insight into their problems. It might also be possible that younger patients are more aware of Western concepts of mental illness and its treatment.

11.3.2.2 Educational level

A major part of 'traditional' CBT involves reading informational material or writing for various homework assignments, which require reasonably good reading and writing skills. As mentioned above, patients in the younger age group are mostly educated. Even many older patients are also educated at least in reading the Quran or at least can have basic literacy skills. But it is still common to

come across patients, especially female patients, who are not literate. This needs to be sensitively assessed so that alternative methods can be used, e.g., audio tapes and audio diaries (as cassette recorders are widely available) beads, counters or symbols for writing diaries. Patients can be provided with audiotapes of therapy session, information or assignments. Beads and counters are commonly used in Pakistan for repeating religious verses or words. Counters can be used to count thoughts. Involving a family member as a co-therapist can be useful in this regard. During the pilot project we were able to use this strategy effectively.

11.3.2.3 Coping strategies

The ultimate aim of the therapy is to help the individual to adjust to a difficult situation in life. Psychologists said that their initial work consists of enhancing or sometimes even building new coping skills. Common examples of coping skills include; talking to a friend, going out for a walk, saying prayers, going to mosque or reading a book. The range of successful coping skills varies widely. Coping skills can be; behavioural (going for a walk), cognitive (listening to a song), spiritual or religious (saying prayers or another religious or spiritual activity) or emotional (eating, smoking or drinking). Advising coping skills which are compatible with the cultural, religious or spiritual background of the patient can enhance the therapeutic relationship and can improve the overall well-being of the patient. For example, advising patients to say their prayers just like they did before (that is if they did and now they find it difficult because of lack of motivation) they became depressed, raises their hope, increases activity level, interrupts the cycle of negative thinking and improves their spiritual well-being. Similarly, advising patients to see their friends (men in semi-urban and rural areas still gather in the evenings) can be helpful.

System level

11.3.2.4 Capacity of the health system

There is no established referral system in Pakistan for patients. Patients can present to any health facility and in any city. Practically this means that many patients who present to the health facilities come from distant areas. The first step is to discuss with the patient and his family whether they might be able to come back regularly for therapy. The interval between sessions can then be adjusted accordingly. Longer sessions with appropriate breaks or even two sessions on the same day may be a

possible alternative. Self-help material in written, audio or video format can be given to such patients. One other option is to give intensive therapy to patients as inpatients. Mobile phones are fairly common in Pakistan and we can use mobile phones to keep in touch with the patients, to remind them of the future appointments or homework. We contacted patients using mobile phones in our pilot project with good effects (including the illiterate patients)

But distance from the health facility and number of patients are not the only aspects of the health system that have impact on therapy. When developing interventions in developing countries it is important to consider the overall capacity of the health system, i.e; resources, both human and financial, systems' ability to absorb and adopt new ideas and interventions and political will and stability.

11.3.2.5 Mental health professionals

There are nearly 300 psychiatrists in Pakistan (for a population of 160 million). The number of psychologists working in the public sector is also very small. This is possibly the most important single limiting factor in the provision of therapy. This is in spite of the fact that there are many universities, both in the public and the private sector, which run BSc and MSc in Psychology courses in Pakistan. There are nearly 60 institutes running MSC psychology programmes only in the Province of Punjab. However, we should keep in mind that in Pakistan psychiatry is very biological in orientation, and we can not move on without accepting this reality and addressing the concerns of the prescribers in therapy manuals in such settings.

11.3.2.6 Pathways to care & help-seeking behaviours

Interviews with patients revealed poor knowledge on the part of patients regarding the care available, and raised many questions as to the decision-making model on the basis of which they seek help. Knowledge of pathways to care and help-seeking behaviours is important in this regard, and anyone attempting to modify a therapy manual for a developing world country should study these. The pathways to care and help-seeking behaviours, however, in turn are related to multiple factors, e.g. socio-demographic factors, social structures, level of education, cultural beliefs and practices, gender discrimination, status of women, economic and political systems environmental conditions and the disease patterns and the health system itself (Shaikh et al., 2004).

11.3.3 Cognitions & Beliefs

Sub-themes:

- Beliefs about health and illness
- Beliefs about causes of illness
- Beliefs about treatment
- Beliefs about the health system,
- Beliefs about healing and the healer
- Beliefs about psychotherapy
- Cognitive errors and dysfunctional beliefs

Cognitive therapy aims to help people think rationally. Working on cognitions and dysfunctional beliefs is the main strategy in therapy. However, in this area we also need to consider cognitions and beliefs related to well-being, illness and its treatment, which essentially influence therapy.

11.3.3.1 Beliefs about health and illness

It is important to explore the patient's beliefs about his concept of health and illness. Patients' ideas of good and bad health might be different from our ideas. For example, the patient who believes that feeling tense and depressed is normal because of circumstances (even though the therapist has diagnosed him with a depressive illness) is less likely to seek help for depressive illness or anxiety. Similarly, it is possible that people think of normal health as comprising of only physical health. It is obvious that only a small number of depressed or anxious patients present to the medical system. Is this because these are the people who have somatic symptoms, and those with only psychological symptoms go to faith healers or spiritual healers? All these concepts need to be explored and be addressed where necessary.

11.3.3.2 Beliefs about causes of illness

A patient, who believes that his depressive illness is caused by his sins, or even due to psycho-social stresses, is less likely to see a doctor. Colleagues working in Pakistan have pointed out how some family members find it difficult to understand that a patient has depressive illness "because he or she has everything in the world". Patients in our study believed in a psycho-social model of illness rather than a physical illness. However, probably because of their somatic symptoms they presented to the doctors. On the other hand the label of physical illness can avoid negative stigma. When specifically asked about their own illnesses, patients were unable to explain what was wrong with them. This needs to be tackled in a sensitive manner without being too challenging.

11.3.3.3 Beliefs about treatment

Beliefs about causation of illness can influence our decision about choice of treatment. Asking the patient about his expectations from treatment is important. All the patients in our study said they will benefit from good tests and quality medicines. They also said that only doctors can treat their depressive illness with medicines. Talking to patients about their concept of illness and its treatment can be helpful in our understanding of their belief system and this can guide us in delivering therapy. Patients who come to see psychologists are always on medicines. It is difficult to say as to whether they are always on medicines because of their choice or that of the treating doctor. However, this can be used in favour of therapy. Educating a patient on the side effects, indications and limitations of medicines can result in increased confidence in a therapist's abilities and possibly improvement in engagement. This also helps in monitoring the effects, side effects and dosage of the medicine and adherence to treatment.

11.3.3.4 Beliefs about the health system

Patients' knowledge of the health system, available treatments and their likely outcomes are important factors in service utilization and engagement. The above knowledge can also have an effect on patients' expectations from the health system. It is possible that, currently, patients do not expect any treatment other than pills when they come to a psychiatry department. On the other hand, psychiatrists in Pakistan often talk about patients who demand treatment without medicines.

One other variable in this area is patients' trust in the health system. It is common for patients to go to doctors whom they can trust. Seeking help from a doctor who belongs to a patient's village, city, sectarian, religious or linguistic group are examples of how trust is an important factor and how this reflects the patient's lack of trust in the health system. Colleagues in Pakistan often talk about patients coming to their private practices bringing a letter of reference or trying to relate to them, although they are willing to pay the full consultation fee.

11.3.3.5 Beliefs about healing and the healer

When a patient was asked "Can you tell me what is wrong with you?", the reply was, "You tell me what is wrong with me, you are the doctor". What the patient thinks about healing and the healer is very important. Does he think that a good doctor should give him a diagnosis just by looking at him? What does he think the doctor can do for him? What are his limitations? Does he think that sadness cannot be treated by a medical doctor? It is very important for the therapist to explore the patients' beliefs about healing which potentially lead to perception of aetiology, attitudes towards treatment and health-seeking behaviour. If the therapist is not respectful to the patient's beliefs about healing and his faith in other healing systems, he might risk offending the patient or even losing the patient's faith in him.

11.3.3.6 Beliefs about psychotherapy

We also need to explore patients' knowledge and their beliefs about psychotherapy. Many people in Pakistan, when they know I am a psychiatrist, ask me about psychoanalysis. Lack of awareness of psychiatric problems and their treatments is very common in Pakistan. In my interviews with the patients I found that no one knew about psychotherapy. However, these interviews were not conducted in a big city like Lahore or Karachi. It is possible that patients in bigger cities are more aware of psychological interventions.

11.3.3.7 Cognitive errors and dysfunctional beliefs

As was mentioned in our discussion of CBT and culture, some well known cognitive therapy writers believe that dysfunctional beliefs and cognitive errors might vary from culture to culture. During my therapy work I found that some of the beliefs which are not considered healthy in the West are probably widespread in Pakistan. For example, beliefs related to dependence on others, enmeshment, need to please people around, need to submit to demands of elders or loved ones, and scarifying one's needs for the sake of family are fairly common in Pakistan. Commonly used inventories to assess cognitive errors and dysfunctional beliefs can be used to gather normative data in this regard.

11.4 Discussion

As far as I am aware this is the first framework for the adaptation of a psychological intervention which is based on systematic observations, which was used to adapt a CBT manual that was later tested in a pilot project. Previously published frameworks were developed mainly in the West for adapting therapies for ethnic minority patients in the West. I followed the existing guidelines for adapting CBT in Pakistan. I can confirm some of the suggestions described in earlier frameworks for example, focusing on communication, cultural issues, orienting clients to therapy, cultural beliefs about mental illness, its causes and treatment, therapeutic relationship, religion and spirituality, age and gender and expression of distress. However, the major limitation of these frameworks was in their emphasis on therapy factors and ignoring or undermining factors related to health and health system. This is however understandable when one considers the fact that therapists working in the West are working in well-established health systems. In the context of developing countries, issues related to health and social support system, as well as resources are equally important.

CHAPTER 12 THE PILOT PROJECT: CBT FOR DEPRESSIVE ILLNESS

12.1 Background

Once a culturally adapted CBT manual for depressive illness had been developed, it was decided to put it to the test through a small pilot project. I found only few non-Western studies of effectiveness of CBT for depressive illness published literature. In the first study effectiveness of cognitive behaviour therapy was assessed in reducing depressive symptoms and negative thoughts in neurotic depressives. CBT was provided to a sample consisting of 25 clients for 25 sessions. The analysis of data of pre and post assessment on some measures revealed that therapy was significantly effective in reducing depressive symptoms as well as negative thoughts (Nalini, 1996). Another study of CBT for depressive illness among women with physical problems found that women receiving CBT showed improvement in mean scores on the factors of dependency, self criticism and depression (Dixit, 2001). However, I did not find any published randomized controlled trials of CBT for depressive illness when I started working on this project. The first published trial of CBT for depressive illness came out recently from Hongkong for treatment of chronic depressive illness against a waiting list in a group setting (Wong, 2008). The therapy was provided in ten sessions with each session lasting for 2.5 hours. All technical terms were translated into colloquial expressions, worksheets were designed in Chinese and therapists emphasized exploration and modification of the dysfunctional rules relating to the family and interpersonal relationships. The group leaders were particularly active in delivering therapy and delivered mini lectures throughout the therapy. However, this paper described only the trial of the intervention and not the process of translation of the CBT and its modification.

There are two other non-Western studies which used CBT as part of the intervention. In one study of the CBT for medically unexplained symptoms in Srilanka (Sumathipala, 2008), CBT was compared with structured care. CBT was provided by primary care physicians after short term training. Each patient received three mandatory sessions of CBT. Three more sessions were optional; however uptake

of the optional session was low, according to the authors. There was no difference between the two groups. Even if therapy was more effective than the structured care group, it would have been very difficult for the primary care physicians to provide CBT in other developing countries due to heavy costs involved. One recently published study from Pakistan used CBT as part of the intervention (CBT based psychological intervention) for depressed mothers and their infants (Rahman, 2007; Rahman, 2008). Although the intervention was aimed towards helping the infants, CBT was found to be effective for depressed mothers. Therapy was provided by the lady health workers. They were trained for 2 days to deliver intervention and received monthly supervision in groups. Therapy was delivered in 16 sessions organized in 5 modules (4 weekly sessions in the last month of pregnancy, 3 fortnightly sessions in the first postnatal month, 9 monthly sessions thereafter). Thus the total period of delivery of intervention was 11 months. The authors describe the lack of the involvement of a cognitive therapist to be a problem. They also highlight the problems of sustainability and feasibility of such programmes. Lady health workers working even in other areas might not be motivated enough to take on the extra work of delivering psychological interventions to women and their infants.

This chapter describes our pilot study

12.2 Aims

The aim of this study was to evaluate the efficacy of the culturally adapted CBT and to judge our ability to train therapists, deliver the intervention and collect outcome data to calculate sample size for a later definitive trial.

12.3 Objectives

The primary objective of the study was to see whether CBT adapted culturally and given using a manual is effective in reducing symptoms of depressive illness

12.4 Methodology

12.4.1 Design

The trial was conducted in Rahim Yar Khan, a large town in South Punjab, Pakistan between January and May 2008. I arranged meetings with the local primary care physicians and explained to them the project. A consecutive sample of primary care attendees referred by primary care physicians in a conveniently located cluster of 3 practices were invited to participate. Written consent was sought prior to randomisation. The treatment arm received CBT with antidepressants and the control arm

received antidepressants alone. Baseline and outcome assessments were carried out at 0 and 3 months by raters blind to the type of intervention.

12.4.2 Inclusion/exclusion criteria

Patients with a an ICD10 (International Classification of Diseases) RDC (Research Diagnostic Criteria) diagnosis of depressive illness and with Hospital Anxiety and Depressive illness Scale (HADS) Depressive illness subscale score of more than 8 and living locally within an hour's walking distance from the family practices were included. Those with severe physical illness, intellectual disability and severe mental illness were excluded from the trial.

12.4.3 CBT Intervention

CBT was provided by a psychiatrist (FN) and two psychology graduates who received extensive training and ongoing supervision in use of this manualized CBT by FN. DK provided supervision throughout the project over phone and through regular meetings. Out of the planned 9 sessions, the initial 6 sessions could be delivered twice a week and then subsequently on a weekly basis. The two trainees saw 6 patients each while FN saw 5 patients.

I tried to address the barriers in therapy which were described by the psychologists and which I observed during our initial work. For example, to improve the follow up rates, we asked the primary care physicians to talk to the patients they referred and stressed the importance of regular attendance. All patients were prompted to attend their sessions a day earlier via mobile phones. We encouraged patients to attend even if they were unable to complete their homework. One patient attended only one session. Three patients attended between 3 to 4 sessions. The rest (13) attended 6 to 9 sessions. During the therapy sessions a member of the family accompanied all patients and helped the patient with homework where required.

The manual was developed at the start of the study by FN and DK. The process of the adaptation continued throughout the project. My work started in 2007 and I was able to finalize the manual on the basis of above framework in 2008. The process of adaptation of the manual consisted of the following stages;

1. Writing a manual for CBT which was based on the Western model
2. Translation of the manual into Urdu
3. Working with clients using CBT while carrying out qualitative studies

4. Information gathering on the basis of qualitative studies, experience of therapy using CBT and other information from the field observations (including discussions with colleagues)
5. Translation of the terminology into colloquial expressions, using focus groups
6. Development of an "adaptation framework" on the basis of qualitative work and field observations
7. Adaptation of the manual
8. Testing the manual in a pilot project
9. Further refinements in the light of the pilot project

The manual consists of details of therapy in 16 short chapters. In the end I have described instructions on 9-12 sessions. The manual is accompanied by detailed patient information leaflets for each session. Appendices also contain samples of thought diaries and behaviour activity charts. I have included examples from real life therapy in the manual on each section. One important aspect is the provision of relevant questions for each technique to make things easy for the new therapist.

12.4.3.1 Arrangement of sessions

Session 1

Introduction, assessment and formulation

Session 2

Information regarding depressive illness and anxiety as well as anxiety management if anxiety symptoms are prominent

Session 3

Use of behavioural methods for example, activity scheduling

Session 4

Problem solving

Session 5

Thought, mood, behaviour, physical symptoms

Talking about thoughts and moods

Identifying thoughts, moods and physical symptoms

Session 7

Teaching on cognitive errors

Discussions of thoughts identified

Session 8

Challenging negative automatic thoughts (evidence that supports the thoughts and the evidence that does not support the thoughts)

Session 9

Creating alternative thoughts

Closure work

12.4.4 Prescription of antidepressants

Primary care physicians trained in the management of depressive illness prescribed Paroxetine or Fluoxetine to every patient in both arms of the trial and followed up the patient every 4 weeks.

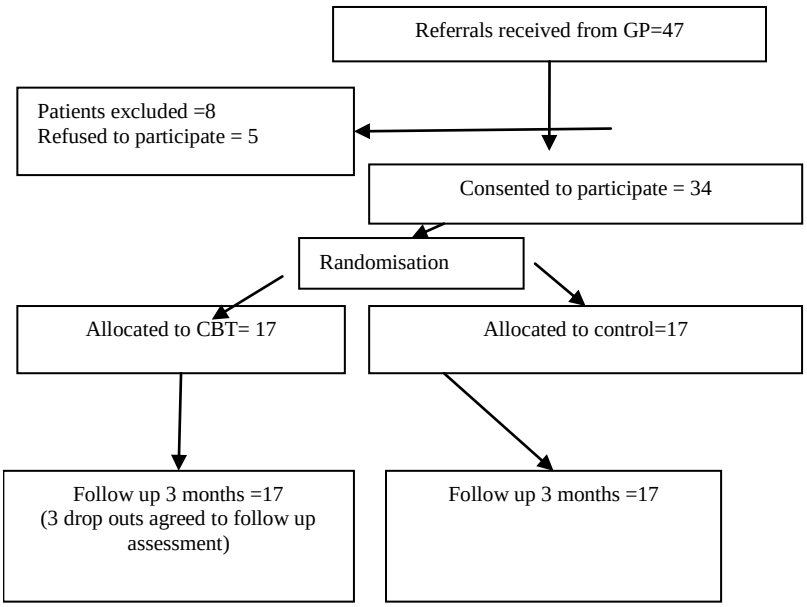
12.4.5 Outcomes and Assessments

Assessments were carried out at baseline and 3 months. Depressive illness was rated by validated Urdu versions of Hospital Anxiety and Depressive illness Scale (HADS) consisting of 7 items subscales each for depressive illness and anxiety. This scale has been extensively used in Pakistan. Scores of 11 or more on either subscale are considered to be a case and Bradford Somatic Inventory (BSI) consisting of 45 items. Scores above 21 indicate depressive illness.

12.4.6 Recruitment

Between January and May 2008 consecutive referrals from 3 primary care clinics were assessed for ICD 10 depressive illness and those meeting the inclusion criteria and giving written consent were included in the trial. The randomisation to the treatment and control arm was done remotely in the University of Southampton by using www.randomization.com. We generated 8 blocks of 4 and one block of 2 for this purpose. The treatment arm received CBT combined with antidepressants and the control arm received antidepressants alone.

Fig 1 CONSORT Flow diagram of CBT Pilot Trial



12.5 Statistical analysis

I followed the CONSORT guidelines for randomised controlled trials (Moher, 2001). The analysis was carried out on intention to treat basis using SPSS version 16.0. Initial analyses to compare the two groups were carried out using t test and x^2 test (to compare gender, marital status, financial status, employment and education) and t test (age). A linear regression analysis was used,

with end of therapy as the dependent variable and group allocation, financial status and baseline differences scores as independent variables. Figure 1 shows the consort flow diagram.

12.6 Ethics approval

Ethics approval was received from the Ethics committee of Sheikh Zayed Medical College, Rahim Yar Khan.

12.7 Results

Seventeen patients were assigned to each arm of the trial. There were no statistical differences between the two groups at baseline; age [therapy= 32.35 (SD 8.9), control= 33.64 (SD 1.0), p=0.965], gender (female) [therapy 14(82%), control 11(65%), x2=0.244], education (5 to 10 years of education) [therapy 8(47%), control 9(52%), x2= 0.732], family system (nuclear family living) [therapy 8 (47%), control 8 (47%), x2= 0.607],employment status (unemployment) [therapy 10(59%) control 9(53%) x2= 0.399] marital status (married) [therapy 13(76%) control 13(76%) x2 = 1.0], except for financial status: more people were in the lower monthly income group in the CBT group compared to control (i.e. ; those earning up to Rs10000) [therapy 10(59%), control 16(94%), x2 =0.015]. table 5, shows differences in demographic factors between the two groups at the baseline. Fourteen (82%) patients attended at least 6 or more CBT sessions. The remaining three patients attended 1, 3 and 4 sessions respectively. When comparisons were made of therapy and control group at the end of 3 months for compliance with anti depressants, subjects in the therapy group were more compliant (65%) compared with those in the control group (35%), x2=10.7, p=0.001.

Table 6 and figure 2 show the difference between therapy and control group at the end of the therapy controlled for the baseline differences in BSI and HADS scores. Final outcome assessment at 3 months showed a statistically significant reduction in BSI and HADS scores in therapy group as compared to the control group. Since baseline differences were observed in financial status between the two the two groups, further analyses were carried out to account for these differences. However, the differences remained statistically significant.

Power of the study and sample size for future trial

The effect size reached by the study was 0.61. We calculated sample size for larger trial based on comparison between groups in terms of the change in the HADS Depression scores. A difference of 2 units between groups would be of clinical importance. Pilot data suggests that the within group

standard deviation of the change in values over time is 3 units. With a 5% significance level and 90% power it is calculated that 48 subjects per group are required, 96 in total. It is expected that up to 50% of patients will drop out of the study. To allow for this it is planned to recruit 192 subjects into the study.

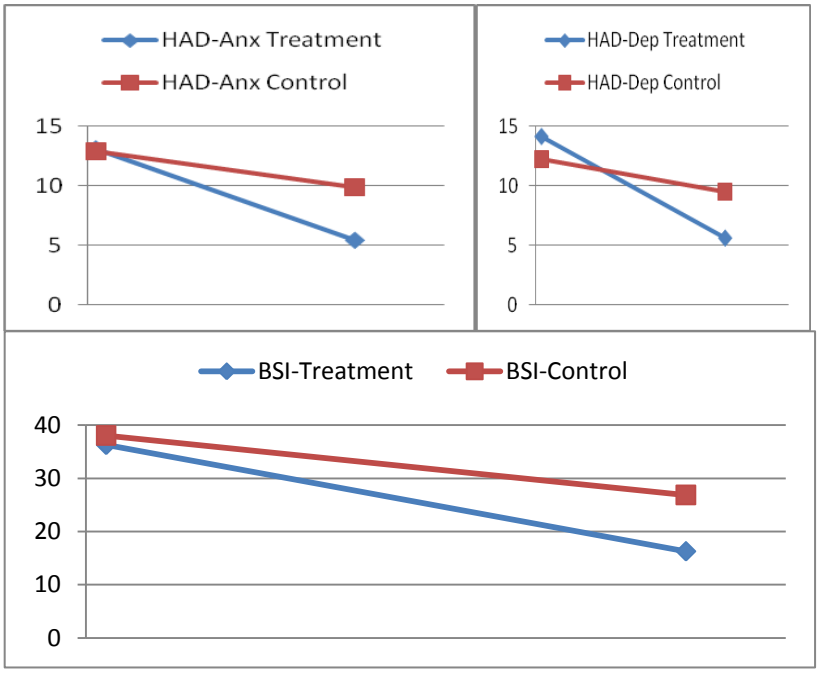
Table 5 Demographic differences between the control and therapy group

		Therapy	Control	P
Age in years		17(32.3) (8.9)	17(32.4) (10.8)	0.975
Education	Upto 5 years	8 (47.1%)	9 (52.9%)	0.732
	More than 5years	9 (52.9%)	8 (47.1%)	
Gender	Female	14 (82.4%)	11 (64.7%)	0.244
	Male	3 (17.6%)	6 (35.3%)	
Family system	Nuclear family	8 (47.1%)	8 (47.1%)	
	Extended family	2 (11.8%)	4 (23.5%)	0.607
	Joint family	7 (41.2%)	5 (29.4%)	
Financial status	Less than 5000	10 (58.8%)	16(94.1%)_	
	More than 5000	7 (41.2%)	1 (5.9%)	0.015
Employment Status	unemployed/house wife	10 (58.8%)	9 (52.9%)	0.399
	self employed	5 (29.4%)	3 (17.6%)	
	employed	2 (11.8%)	5 (29.4%)	
Marital status	Married	13 (76.5%)	11 (64.7%)	
	Unmarried	3 (17.6%)	3 (17.6%)	0.558
	Divorced/widower/ widower	1 (5.9%)	3 (17.6%)	

Table 6. Differences between the treatment and control groups, both uncontrolled and controlled for intial differences as well as financial status. Analyses were carried out using a linear regression

	Differences uncontrolled				Differences controlled for baseline score & financial status	
	Therapy N=17 (Mean) SD	Control N=17 (Mean) SD	Mean difference (95% CI)	P	Mean difference (95% CI)	P
BSI	16.3(7.3)	26.8(12.7)	10.6 (3.3-17.8)	0.006	9.8(2.7-17.0)	0.008
HAD_A	5.4(3.8)	9.8(3.8)	4.5(1.6-7.3)	0.003	4.8(2.3-7.4)	0.001
HAD_D	5.6(2.7)	9.5(2.9)	3.8(1.8-5.8)	0.000	4.6(2.4-6.9)	0.000

Figure 2, Scores on Hospital Anxiety And Depression Scale(HADS) subscales and Bradford Somatic Inventory (BSI) at baseline and at 3 months. HAD-Anx is Hospital Anxiety and Depression Scale Anxiety Subscale, HAD-Dep is Hospital Anxiety and Depression Scale Depression Subscale andBSI is Bradford Somatic Inventory Scores



12.8 Discussion

Increasing awareness and improving recognition of depressive illness in resource-poor countries like Pakistan will not be beneficial unless it is also accompanied by specific treatments that overcome the socio-cultural and health system barriers faced by these populations. Our culturally sensitive intervention is based on CBT as used in Western society but we successfully undertook necessary conceptual, format and delivery modifications that improved compliance with therapy and thus symptom reduction. A high rate of dropouts from the treatment was cited as a major barrier in our preliminary qualitative studies. More subjects in our therapy group were still taking antidepressants at the end of the therapy as compared to the control group. It is certainly possible that this disparity in medication use has contributed to better outcomes in the therapy group.

Appropriate intervention began with a prior understanding of socio-cultural nuances, discussion and exploration of therapy with indigenous therapists and patients and development of informal networks within primary care that helps in bringing the subjects and health providers together.

Interviews with the psychologists revealed that patients come from long distances and probably this is the biggest hurdle in providing therapy. They present mainly with somatic symptoms and drop out of therapy as soon as they start feeling a little better. Patients also like a directive style and probably don't feel comfortable when a collaborative style is used. They also felt family involvement can be a hurdle if not dealt with carefully. Patients like medicines and are not even aware of psychologist's role or psychotherapy. Seeing faith healers and lack of explanation given by the psychiatrists at the time of referral were described to be other major problems. Interviews with the patients confirmed some of these themes (for example, they were not aware of the role of psychotherapy and, they presented mainly with somatic symptoms and believed that only doctors can treat their illnesses). Patients had very limited knowledge of the illness. However, they believed that in general mental illnesses are due to due to social or psychological causes. They said they cannot stop performing their roles and wanted to get better as soon as possible. Interestingly almost all the patients in our study referred themselves to the psychiatry departments.

The study with the students revealed that although concepts underpinning CBT were not in conflict with their personal, family and social values, they might be in some conflict with their religious values. Field observations and experience of therapy were very helpful in developing insights into cultural issues too. For example as mentioned in chapter 11, one patient with anxiety said "I have a ball of gas in my stomach which rises to my head and then I start feeling dizzy". Another patient when asked, "What is wrong with you and how can I help you?", replied, "You are the doctor, you tell me what is wrong with me". Some traditional healers can diagnose patients by just looking at them. The patients' expectations are determined by their experience with those healers. Discussions with colleagues in Pakistan revealed that patients think mental illnesses are due to religious causes (for example sins) or even material deprivation. Magic spells, evil eye and bad luck can be described as the cause of an event or even an illness. A therapist needs to be careful when working with dysfunctional beliefs, for example dependence on others, seeking the approval of others, especially parents, sacrificing in favour of a family member might all be seen as positive values in Pakistani culture. Patients might not feel comfortable with commonly used therapy techniques like "Socratic dialogue". Similarly assertiveness can be considered as rudeness and I therefore used some modifications to deal with this issue.

In this preliminary trial, depressive illness and somatic symptoms only were measured. Future research needs to assess cost-effectiveness, quality of life, disability, and changes in cognitive errors and beliefs.

In conclusion, therapists, trainee psychologists and psychiatrists, trained in the use of a culturally adapted CBT manual, were successful in reducing anxiety and depressive illness along with somatic symptoms in patients referred from primary care in Pakistan.

12.9 Limitations

This was only a pilot project and many answers including variables which could potentially influence therapy were not studied and detailed analyses were not carried out due to the small number. For example, close contact with therapists and increased compliance with medication in the therapy group might have led to this improved compliance.

CHAPTER 13 SUMMARY & DISCUSSION

I have discussed the main findings of each study at the end of each chapter. I will therefore only summarize the project here, highlighting the parts of the project, results and relevant points from the discussion as well as the points that were not covered during discussion of the individual chapters. As this is a new area in psychotherapy there are many questions unanswered. I became acutely aware of this as I went through the content of this thesis. I hope that it could be the start of a new area in psychotherapy. I tentatively call it study of CBT across cultures or "ethno-CBT".

I set out to adapt CBT, a psychological intervention, which was developed in the West, just like many other treatments, for example the pharmacological 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, infrastructure etc) can be easily controlled. However, to adapt psychological therapies additional cultural barriers including language need to be overcome.

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. It is therefore important that we study not only their explanatory models of the disease, but also study attitudes of health professionals as well as related issues in society. On the other hand non Western cultures have developed their own ways of managing emotional problems over the centuries. This is also a major limitation of this study in that we were not able to explore the local practices of dealing with mental health problems. Cultural diversity is another area that needs consideration here. The diversity of cultures and languages might not be impossible to manage in the Western world. Even the language might be more homogenous in European countries. There is, however, more diversity of cultures and associated languages in Asia and Africa and therefore simple translations might not work.

There were two aims of this project, first to adapt CBT, and the second to draw some general principles for a methodology. Although it seemed a very difficult task at the beginning, it proved to be possible in the end. I have focused on process throughout the thesis. I have also described the prudent issues throughout. Here I will summarize and describe some of the generalized points and the lessons learned;

1. The process of the adaptation should involve all the stake holders (providers and recipients of the therapy). A greater emphasis on understanding the health systems.
2. I started with a loose framework. I was willing to learn as I went along
3. Mixed methods research can be a powerful tool when developing interventions in areas where no such work has been done
4. Initial work helped me to develop questions rather than answers, for example, what do patients think about psychotherapy, what do professionals think are the issues in providing therapy and what do people think about CBT
5. Adaptation can be done through a series of small scale studies and does not need to be a time-consuming and costly affair

Some examples of the adjustments in therapy included;

1 Focus on somatic symptoms, included in first thought diary
2. Developing a strategy for translation which involved members of the general public
3. Family involvement
4. Culturally sensitive communication styles and power issues
5. Strategies to engage patients (for example involving a family member in therapy)

13.1 Prevalence of depressive illness

Depressive illness is a common mental disorder with a heavy disease burden. It has been estimated that by the year 2020 depressive illness will be the second most cause of disability after heart disease (Murray & Lopez, 1997; Ustun, Ayuso-Mateos et al., 2004). Although the prevalence has been studied more systematically in the developed world it is still rather poorly studied in the developing world. Review of the literature suggests that the annual prevalence rate of depressive illness in Western Europe is nearly 5%, with higher prevalence in women, the middle-aged, less privileged groups and those experiencing social adversity (Paykel, Brugha et al., 2005). Available information from different

parts of the world suggests that the prevalence rates of depressive illness vary across the world (Sartorius, 1983; Sartorius, Ustun et al., 1996; Weissman, Bland et al., 1996). It is however difficult to be certain if these differences are due to actual differences in prevalence and incidence rates or merely reflect problems with recording methods, unreliable diagnostic instruments, differences in presentations and concepts of depressive illness and the mental illnesses, or even simply reflecting the way people in a society view and cope with distress, emotional pain and anguish. In spite of the differences in prevalence rates it appears that women across the world seem to have higher rates of depressive illness than men. Whether this represents women being able to express themselves more, being more disadvantaged and less empowered in some developing countries or is simply due to the gender differences remains a question. Findings from across the world also highlight that depressive illness is the most common mental illness in primary care (Sartorius, Ustun et al., 1996). We should keep in mind however that, as I already mentioned, most of the studies from the developing world have used measures of depressive illness developed in the Western world and therefore the findings might not be accurate in other settings

13.2 Diagnostic issues

A depressive episode is characterized by psychological and physical symptoms as well as disturbances in functioning level. A depressive episode may be classified according to severity into mild, moderate or severe (WHO, 1992). We should keep in mind, however, that these criteria are only for guidance, and clinical judgment remains an important tool in diagnosing depressive illness. There are important issues in diagnosing depressive illness, for example, the emotional response of a person who has experienced a life event can mimic depressive illness. Although we diagnose a person with depressive illness once he has suffered with the symptoms for two weeks or more, it is rather an arbitrary cut-off period and some "normal" people might take longer than others in recovering from the aftermath of a mishap. Similarly, impairment of ability to function is also considered as an important diagnostic criterion. However, in our qualitative interviews we found that patients were depressed but refused to take rest because they "had to look after" their family members. We use behavioural activation for the treatment of depressive illness (Veale, 2008). Does this pressure to keep working act like behavioural activation, or does it further enhance the sense of helplessness at not being able to control the environment in a person, or increase guilt because the patient feels she is unable to look after her family like she used to? Depressive illness can not only have an effect on personal and social functioning, but it can also lead to suicide in a significant number of patients (Chachamovich, 2009). In addition to this, depressive illness costs a lot of financial burden to the

individual, the family and the society (Ustan, 2004; Sobocki, 2006), not only in terms of treatment costs, but also the impact it can have on the working life of the individual, for example missing days from work. Effects of depressive illness among women on their family and particularly among children have been well reported.

In spite of the presence of some core symptoms which are common in most cultures (Bhugra & Mastrogianni, 2004), it is widely agreed that presentation of depressive illness is influenced by cultural factors and therefore varies across the world (Desjarlais, 1995). It was thought that patients from non-Western countries are more likely to present with somatic symptoms. However, more recently this view has been challenged on the basis of findings from research studies (Bhatt, Tomenson et al., 1989; Simon, VonKorff et al., 1999; Bhugra & Mastrogianni, 2004). This evidence suggests that although, the rates of somatic symptoms among patients in the non-Western cultures might be higher than their counterparts from Western cultures, patients in the West also seem to complain of somatic complaints. It might be after all not as dichotomous an issue as previously thought. But somatic presentation is not only common among depressed patients, and patients with other psychiatric problems also present with somatic problems. Researchers and phenomenologists have offered different explanations for these variations over the years. For example it has been suggested that mind-body dualism, which is possibly underpinned by Western philosophical tradition might be a possible explanation and could offer an explanation of why patients from Eastern cultures are relatively more inclined to present with somatic complaints (Kirmayer & Young, 1998). Whatever the explanation might be, these variations in depressive illness certainly pose difficulties not only in screening and therefore diagnosis of depressive illness, but also in managing depressive illness, especially using psychological approaches, as we learned in our project later.

13.3 Causes of depressive illness

In spite of many years of research, our knowledge and understanding of the causes of depressive illness is still limited. Currently a bio-psycho-social model is used to understand the causes of depressive illness. In its very simple form it implies that interplay of biological and psycho-social factors causes and maintains depressive illness. Research on biological factors has focused mainly on genetic, hormonal and neurotransmitter disturbances (Rockville 1998) (Thase, 1995; Mitchell, 1998; Rush, 1998). The monoamine hypothesis of aetiology of depressive illness has gained enormous support among clinicians and proposes that depressive illness might be caused by disturbances in

serotonin and the three principal Catecholamines (Dopamine, Norepinephrine and Epinephrine). Although the theory has many loop-holes, there is sufficient indirect evidence to support it. The argument against monoamine theory is strong too. However, it is not only the theory that drives sciences. Probably our training in medical system also forces us to think of biological causes more than psycho-social factors. A biological hypothesis has even further advantages, for example it reduces the burden of responsibility that exists if we had to have a purely psycho-social model of depressive illness. Hormonal disturbances and their association with stress are well studied in relation with depressive illness. However, this might work through mediating factors which might be of psycho-social nature. Life events, personality traits, traumatic experiences, thinking styles and belief systems might all be responsible in this regard. In the end, whatever the cause of depressive illness, psycho-social measures seem to have an effect. Even if we don't take into consideration existing literature and the clinical experience that suggests the role played by psycho-social factors, probably an argument similar to monoamine theory can be used in suggesting a psychological origin of depressive illness based on the impact of such interventions on alleviating depressive illness.

13.4 Management of depressive illness

It follows that the first step in successfully managing depressive illness is a thorough assessment using the bio-psycho-social model. The assessment usually consists of a thorough history, mental state examination, relevant physical examination and appropriate laboratory investigations. Management can be divided into short term and long term. In the short term a clinician needs to decide whether the patient should be admitted into hospital or treated in the community. This is based on assessment of the severity of depressive illness and exploring the suicide risk as well as exploring the protective and perpetuating factors in the patient's environment. Physical treatments consist of ECT and antidepressant medicines, while commonly used psycho-social interventions include education and support, supportive therapy, cognitive therapy and interpersonal therapy. Severity of depressive illness is one of the factors which help the clinician in choosing appropriate treatment. National guidelines in the UK suggest that a period of watchful waiting and psycho-social interventions might be helpful in treating mild depressive illness. Moderate to severe depressive illness might be treated with either drugs or psychotherapy. Drugs commonly used for treating depressive illness include, Tricyclic antidepressants, SSRIs, MAOIs, and the newer antidepressants. Most patients respond to drug treatment in nearly 4 weeks. Antidepressant medication should be continued until and unless all the symptoms have been treated. Twelve to thirty six months of maintenance treatment reduces the risk of relapse in a significant number of patients. ECT is usually reserved for patients who have

severe major depressive illness with psychotic features, psychomotor retardation, or are medication resistant. How many people stick to these treatment guidelines, and how often, is an unanswered question. I am not aware of any audit of NICE guidelines for depressive illness being carried out in the UK.

Both in the US & the UK, National Guidelines (APA, 2000; NICE, 2007) recommend considering psychotherapy for every patient. While medicines aim at mending neurotransmitter abnormalities, psychotherapy goes beyond the symptomatic improvement and tries not only to help patients with current symptoms, but also tries to help them deal with their environment, both internal and external, more effectively by learning techniques which might reduce the rate of future relapse. There is a large body of research which indicates that CBT is better than other therapies for the treatment of depressive illness. CBT has been shown to be as effective as drugs in treating depressive illness, but has the added advantage of reduced rates of relapse in comparison with drugs. It can be given both individually and in group formats and has been shown to be effective in a self-help format for relatively milder cases. Cognitive behaviour therapy has been shown to be more cost-effective than drugs in the long term. However, we should keep in mind that even in the developed world, provision of CBT is limited by many factors, the most important of which is availability of therapists.

13.5 CBT

CBT combines the principles of cognitive therapy as well as behaviour therapy in its application. The basic idea in CBT is very simple; it is not what happens in our surroundings that makes us happy or sad, but what we think of what is happening. CBT is an active, directive, time-limited, structured approach towards treating mental illnesses. The patient usually meets with a therapist for between 8 to 12 sessions. The sessions are usually arranged weekly. Each session might last for nearly an hour. Therapy involves regular feedback from patients and gives patients control of the direction it might take. CBT uses a collaborative approach and aims to test the patient's misconceptions by looking at the evidence for and against his thinking patterns. A Socratic dialogue is used to develop new insights.

The cognitive model which is the back bone of the cognitive therapy postulates three specific concepts to explain the psychological basis of depressive illness; (a) the cognitive triad, (b) cognitive errors and (c) the schemas. The cognitive triad explains how a patient perceives his world, internally (views about self) and externally (views about others and about the future). Cognitive errors or thinking errors are the most obvious anomaly in depressed patients. We all make cognitive errors

however, and the difference between depressed or anxious patients and normal subjects is quantitative not qualitative. The commonly described cognitive errors include: black and white thinking, personalization, minimization and magnification, jumping to conclusions, over-generalization and selective abstraction. The third concept of schemas tries to explain why depressed patients maintain their thinking patterns in spite of obvious evidence against their thinking patterns. According to the cognitive model, our beliefs are the building blocks of our personality. These beliefs are the outcome of our childhood experiences and long term development and are influenced by the social, cultural, religious and family values. A dysfunctional attitude is a belief which is not adaptive and will become activated only when a person faces certain situations. This in turn leads to cognitive errors, which might cause depressive symptoms.

We should point out however that in the real world, at least in the developed world, a pure CBT model is hardly used. Psychotherapists from both psychology and psychiatry backgrounds use an eclectic approach. Modern CBT is not a monolithic structure, but a broad movement that is still developing, and is full of controversies. The newer ideas in CBT such as third wave therapies are exciting developments and highlight the evolving nature of CBT. The examples of third wave therapies include mindfulness and acceptance commitment therapies.

13.6 CBT & culture

Psychotherapies are derived from philosophical tradition and are thus heavily influenced by the values of the cultures in which these therapies developed. But what is culture? The term culture is both difficult to describe and define (Triandis, 1980). Whatever the current debates on culture, one can suggest that people living in a culture or sub-culture might have some beliefs which are specific to that group. Psychotherapies develop from psycho-social, cultural and philosophical traditions within a culture. Difficulties in providing therapy to ethnic minority patients living in the West might highlight issues (although not all of these might be related to cultural differences). Published literature highlights some of the relevant areas in this regard. Some people see Western and Indian cultures on opposing dichotomies (Laungani, 2004). It has been suggested for example that individualism-communalism, cognitivism-emotionalism, free will-determinism and materialism-spiritualism are some of the dimensions. One concept that needs consideration in this regard is that of Fate. While Western people might believe less in Fate, Indians see Fate as a fixed destiny. The Islamic concept of faith, however, lies somewhere in between. The most famous example is that given by Ali, the fourth caliph and a philosopher. When a person asked him about the fate, he asked him to raise one leg, when

he rose, he asked him to raise the other leg, which he could not. Ali said, this is how much control we have over Fate. At least in Pakistan, however, both Islam and Hinduism have influenced each other. Similarly, different sects of Islam interpret the concept of Fate differently. People in most developing countries, especially in Asia and Africa, live in families (sometimes an entire village consists of a members of an extended family). This not only has numerous material advantages, for example sharing resources, but also offers a system of emotional support. However, this also means a greater degree of interdependence. While dependence on others is not a trait highly regarded in the West, being independent might be considered selfish in the East. But the writers in this area have probably made too many assumptions. For example it has been suggested that Western societies are work-oriented, Eastern societies are relationship-oriented (Pande, 1968). What about Japanese society, where both remain important?, and what about China? Shops and markets in Pakistan are open till midnight - the focus of life for many people seems to be work, but they have to equally focus on their relationships too. We are living in the age of globalization and the internet and media has probably blurred the boundaries across cultures. It is possible that different cultures probably share some values or at least have some understanding of the basic values of other cultures.

Shame, anger and guilt are commonly experienced emotions, however, their interpretation, use in power and control issues and even perception might vary across cultures. The study of cultural norms is really important in this regard. While some cultures might see shame and guilt as negative values, others might see these as positive and even commendable. One example of how values can be contrasting and contradicting in different cultures is that of queuing. So, queuing in the West is a highly valuable ritual, but queues are not common in some of the Asian countries I visited. However, people in some of these countries don't resist when an elderly person, a child or a woman jumps the queue. Similarly, it is common in some non Western cultures to offer an elderly person or a woman a seat in a bus or a train. While shame and guilt might be seen as pathological emotions by some in the West, they certainly have some positive values attached to them, for example, shame and guilt can be effective in bringing some order in a society. It has been suggested that Asian patients look for cures (Laungani, 2004). It is not clear however, whether this is also true for psychotherapies. Our experience suggests that this might be the case. Probably what makes it even more possible is the fact that there is no referral system in Pakistan and patients can present themselves to anywhere. The Asian concept of a guru for life is probably not followed in the psychiatric setup at least in Pakistan. Is it possible that the model for the medical system is different than their model of a spiritual system of healing? But Asian countries have different cultures from each other. Even within the same country, the variety of

cultures can be astonishing. Then there is the mixture of religious values. Pakistani culture has borrowed values from central Asian, Hindu, Middle Eastern and Persian cultures. This variety of cultures is reflected in the variety of languages in Pakistan.

Cognitive behaviour therapy not only evolved from psychological and philosophical doctrine but also has at its roots Western values of the social system (for example democratic values represent themselves as a collaborative approach). Scorzelli's work is important in this regard (Scorzelli, 1994; Reinke-Scorzelli, 2001). It highlights the differences within the Asian cultures. Similarly there is at least some research evidence to suggest that patients have different dysfunctional beliefs, some of which might be specific to their cultures. There are some aspects of the Asian cultures which might be helpful while giving CBT. for example, it has been suggested that Asian patients prefer a more structured and directive approach (Iwamasa, 2006) and that Asian clients might find it useful if the presenting problem is addressed directly and some progress is evident in the first session. We can confirm through our work this last observation.

13.7 Why CBT?

One important choice I had to make at the start of the study was between CBT & Interpersonal therapy. It was thought that IPT might be more suitable due to its focus on relationships, and as discussed above relationships might be a cause of depressive illness in Pakistan. However, after long discussions I decided to opt for CBT, since it was felt that CBT also focuses on relationships (two sessions in the manual were specially devoted to improving relationships as well as communication. Family was also involved in therapy later), and due to our background training in CBT. Similarly, I had to decide whether I should adapt the Beckian model, or CBT in its current form, especially because our prior discussion, literature review and understanding of culture had suggested that a model of therapy based on Sufism/mindfulness might be more culturally appropriate in Pakistan. However, the main issue was that unlike the West where mindfulness techniques are introduced in therapy without any religious affiliation, in the East these techniques might be difficult to be applied without such affiliation; would a therapist have the same level of acceptance or legitimacy as a faith healer practising such techniques. As it turned out later, none of the psychologists admitted to using any of the techniques from mindfulness in their work.

13.8 Depressive illness in Pakistan

There is no concept of depressive illness as an illness in Pakistan, although there are words for sadness. I have noticed that generally people don't talk about attaining happiness as they do, in my experience, in the West. My understanding is that this could be because Islam emphasises a state of "contentment and acceptance" rather than happiness. This certainly has implications in terms of patients' acceptance of being sad in mood and admitting to these symptoms to others.

Research from Pakistan has shown that the rates of depressive illness among the general public are very high (Mirza, 2004). It is difficult to guess how many of these go to the medical system or to traditional healers. However, we should keep in mind that these surveys used translated screening measures (with the exception of a limited number of surveys which used locally developed instruments, for example BSI and AKUADS). Social problems are common among depressed patients (Naeem, 1992; Husain, 2004; Niaz, 2005) . Whether depressive illness is caused by social problems or causes social problems is difficult to make out. It has been reported that suicide rates are on the increase in Pakistan (Khan, 2000). However it has been considered an underestimate and the real situation might be worse. But this is a difficult area to study in Pakistan; for all we know, it might not be that suicide rates are on the rise but that more cases are being reported. Most of the research conducted in Pakistan has focused on prevalence surveys. Interventions studies can be counted on fingers. Generally, psychiatry is biological in its approach; there are only two published trials on psychological treatment of depressive illness (Rahman, Mubbashar et al., 1998; Ali, Rahbar et al., 2003). There are a limited number of studies which looked into the knowledge and stigma attached to mental illnesses and especially depressive illness (Naeem, 2005; Javed, Naeem et al., 2006; Naeem, Ayub et al., 2006; Ansari, 2008). In our studies, not only were medical students and doctors generally not much aware of depressive illness and mental illnesses, but they also had negative views of patients with psychiatric problems. One study of patients has described that nearly half of them felt stigmatised.

13.9 Mental health in Pakistan

Pakistan is a country of more than 150 million people, a history full of national traumas, army rule, ongoing violence, wars, natural disasters, many financial crises; it is a country of causalities, conflicts and contrasts. Pakistan has diverse and sometimes complex linguistic, racial and cultural groups. Pakistan spends less than 1% of GDP on its health budget. Healthcare is provided by three types of hospitals, public, private and charity. The health system is distributed in a way that the public health facilities in primary care are mainly provided in rural areas (secondary care hospitals) and big

hospitals (supposed to provide secondary care) are located mainly in cities. In other words, the public sector provides primary care in cities mainly. There is no referral system. Practically it means every one is free to go where they like. This not only leaves the choice of choosing where to go and who to see to the general public, but this also means many people present to specialists with problems which are not severe enough. Basic health services in rural areas are poorly resourced and staffed. However, the charity sector plays a vital role in providing healthcare. According to the Guinness World Records, Edhi Foundation, a charity organization, runs the largest private ambulance service network in the world (Wikipedia, 2008). However, in spite of this generous contribution from the private sector, healthcare is far from satisfactory.

I am not aware of a national survey of mental health problems from Pakistan. The available figures are merely estimates. One such estimate states that 10-16% of the population of Pakistan suffers with mild to moderate mental health problems, while, 1% suffers with severe mental health problems. There are four mental health hospitals in Pakistan. Most districts in Pakistan have medical colleges and attached psychiatric units. Bigger cities have more than one medical college and attached units. Currently there are 12 medical colleges in Lahore city only. However the total number of psychiatrists in Pakistan remains very small. Similarly, the number of psychologists is also small, in spite of the fact that most universities run psychology programs (bachelors and masters). But to practice as a psychologist one needs to have a post graduate diploma, and there are only limited numbers of universities which run diploma programs. Similarly, there are limited jobs for psychologists in Pakistan. The attitudes of professionals and public, as well as their knowledge, might be contributory factors in this regard. The situation with nurses and social workers is even worse.

My guess is that most of psychiatric care is provided by alternative healers. These can be broadly divided into those using biological treatments (healers using, old Indian, Greek or Islamic medicine) and those using non-biological treatments (faith healers, spiritual healers, magicians, fortune tellers etc.). There is a reason why I make this assumption. If I take into consideration only the high rates of depressive illness in Pakistan, only 300 psychiatrists and a limited number of psychiatry departments wouldn't be able to cope with this number. There is some research which indicates that a significant number of people attending faith healers have mental health problems (Saeed, 2000). We need to remember that people also contact them for physical health problems. People want medical healers to be spiritual people and want spirituality to be a part of healing system. This raises many questions from the point of view of our study. Can we learn anything from faith healers in providing therapy?

Have psychologists and psychiatrists already learned something from faith healers in Pakistan? And finally how much the mental health professionals are integrated with the people's value systems.

13.10 Developing culturally sensitive CBT in Pakistan

When we decided to culturally adapt CBT in Pakistan nearly 4 years ago, very limited information was available on adapting CBT in non-Western cultures, at least in published literature. There was no published trial of CBT for depressive illness from the non-Western world. There was some guidance available based on the experience of CBT therapists in the West working with ethnic minorities. We also had consultations in meetings and conferences, personal communication with Beck and discussions with Pakistani colleagues working in psychiatry and psychology. We found three guidelines which were relevant (MRC, 2000 2006; Rounsaville, 2001; Barrera, 2006). The first guidelines talk about developing complex interventions, the second talk about developing psychological therapies in novel situations and the third guidelines, which were more relevant to our work, described the process of adaptation of psychotherapies in the West for ethnic minority clients. We did not find any guidelines which might be useful in adapting CBT for non-Western cultures.

We were also faced with another dilemma, the choice of therapy. We had to choose between CBT and Interpersonal Therapy. In the end we decided that we should choose CBT. This is due to the fact that there is more evidence in favour of CBT, CBT takes into consideration interpersonal factors, interpersonal factors might not be the only factors which need addressing in depressed patients in the non-Western world, and our personal experience of using CBT. Our aim was to adapt CBT for depressive illness in Pakistan.

13.11 Guidelines for adaptation of CBT in non Western cultures

Taking into consideration the guidelines and framework for cultural adaptation of therapy available (Sue, 1990; Bernal, 1995; Hays, 2006; Hwang, 2006; Iwamasa, 2006) as well as the brain-storming session, we decided that a simple straightforward approach might be to gather information from colleagues working in Pakistan using psychotherapies to help depressed patients, talking to depressed patients and finally getting the view point of the general public as regards to their perception of the principle of CBT. We also planned to talk to faith healers in Pakistan, since it appeared reasonable in the light of the above discussion. However, we had to give up on this. The first few faith healers we contacted were not very keen on talking to us. This is a major limitation of the study. We

felt that adaptation work might consist of the following phases, (1) gathering information (2) developing a framework which might provide guidelines for adaptation (3) adaptation of a CBT manual (4) testing of a manual in a pilot trial (5) further refinement of the manual (6) testing of the manual in a large RCT. The methodology we proposed was only tentative and we felt that we might change it as we went along through iterative self-evaluation and reflection. We did envisage, however, that most of our work would consist of qualitative studies. The project consisted of two broad stages. The first stage of the project comprised development [(drawing on the experience in the design of manuals by the applicants and the relevant literature (Duncan, 2004)] and adaptation of a CBT manual (evidence base, new knowledge generated through a series of studies; interviews with psychologists, patients and university students, therapy with patients and field observations, all of these lead to the development of a theory in the form of an adaptation framework, which guided our manual). In the second stage a pilot project was carried out.

We used a mixed methods design for this study. We used in-depth interviews, using an interview guide flexibly, with psychologists. We tried to use the same strategy with patients but it did not work. We therefore had to use a more structured approach with patients. We used thematic content analyses to analyze our data. We planned to use focus groups with students. We had a plan of ideas to discuss and we decided to measure students' ideas using a visual analogue scale.

13.12 Psychologists study

The literature search suggested that psychologists in Pakistan adapt therapy for clients taking into consideration religious factors (Murray, 2002). However, this happens on a personal level and not on an institutional level. This was not only the most important, but also the most interesting and in some ways challenging part of our project. We thought that talking to professionals would give us initial information as well as guidelines for our further work. We simply wanted to see what their experience of treating clients with depressive illness was, and how we could learn from that in order to adapt therapy in Pakistan. Their information would help us to focus on what works in therapy and what does not, as well as the process of the therapy. We made a list of topics and conducted interviews to gather information in those areas. There was however one big problem: as we realized, psychologists are not trained in CBT, although some of them are trained in REBT. We contacted psychologists working in a big city in Pakistan. Interviews were conducted with psychologists in their own departments. Generalizablilty is an issue with qualitative studies. We decided to send the transcripts back to the psychologists for validity. We also sent the findings to a group of psychologists who had agreed to the

interviews but were not involved. The idea was to get consensus from as many psychologists as possible, who were working in psychiatry departments and who had experience of treating depressed patients. Our findings can be described under the following headings: hurdles**,** service issues, somatic symptoms, use of medication, homework, patients' expectations from the health system, use of literal translations, beliefs about illness, therapy related issues, assessment, common techniques, structure and content of sessions, normalizing techniques, helpful techniques, style of therapy, family involvement, modification in therapy**,** need for adaptation of therapy. Service and training issues in addition to availability of culturally acceptable forms of therapy might be some of the barriers. Service issues being barriers in therapy was suggested by other researchers working in Pakistan (Rahman, 2007).

We realized that adaptation in Pakistan can be broadly divided into two parts, service issues and therapy issues. Previously mentioned adaptation frameworks have only focused on therapy issues. This is understandable since they were presented for therapists working in Western cultures. In developing countries the situation might be very different, however, and a wider perspective needs to be taken into account. Some of the findings are similar to those of work with faith healers, for example predominance of men attending the psychological services (Farooqi, 2006).

The referral process seems to be a major hurdle in therapy. Broadly two categories of patients present to the psychiatric services, those who are local and an even a bigger number who come from far-off places. How to give therapy to these? I observed that there is no selection process for patients. We were told that women are more likely to drop out of therapy. We overcame this by engaging the family members and by informing them of the effects of depressive illness in women on the family. An important part of the CBT is to empower patients; this can be helpful for women in paternalistic societies. Somatic complaints were described to be another problem; we therefore emphasised focusing on somatic complaints at the start of therapy, as well as on advising on symptomatic management. Therapists said that therapy needs to be modified, but nothing as to how. Therapists did not recognize the role of traditional healing practices: for example we advised patients to use an extended head massage for headache; it is a routine practice in Pakistan and patients were comfortable with this. Problems in homework and writing were overcome by involving an educated member of the family. Using behavioural techniques at the start of therapy was mentioned, which we found very useful. The role of the family in providing therapy is more crucial than has possibly been suggested in the literature. I remember one of the first clinics (Traditionally many patients were seen in one big

room, and there was no privacy. It was a big struggle for me to change this) when a woman who wanted to talk to me in private asked her husband to leave the room and then described everything in front of the rest of the crowd. I was probably the only one who was not comfortable in that room. Confidentiality has probably different meanings there.

13.13 Interviews with depressed patients

We believed that understanding patients' perspective (what do they think about their illness, its causes, its treatment and specially psychotherapy) is really important in this regard. Interviews with psychologists had raised some interesting points in this regards, for example, patients probably are not aware of psychological therapies, they only expect pills, etc. it was only natural that we extended our inquiry to patients.

We planned a study similar to the psychologists, i.e. in depth interviews with the help of a checklist of topics which we thought were relevant to our study. However, this proved to be a difficult task and we had to make our interview more structured in the light of experiences drawn from the first few interviews. This helped us in getting information from a slightly larger sample. My impression was that when a controversial topic was discussed (for example about help from faith healers) patients were guarded and tried to give an answer which they felt was the answer we want to hear. We studied patients attending secondary care psychiatric services in a medium sized city in south of Punjab. Four main themes emerged from the analysis of data; (1) their perception of depressive illness and its impact on their lives (2) their model of causes of the depressive illness (3) their model of referral and (4) the treatment of depressive illness. Since patients were not very forthcoming we also asked them about mental health in general. The categories derived from this part could be divided into two broad themes (1) their knowledge and perception of mental illnesses and (2) their treatments.

Psychologists reported that most patients present with somatic symptoms. Most patients were not aware of the names of the illnesses (please note that we had chosen patients who were not new to the service. It is therefore possible that nobody had discussed the diagnosis). They used various expressions to describe their illnesses. They had to work to survive. They referred themselves to the mental health services (mostly with somatic complaints). As far as the treatment was concerned their focus was mainly on physical investigation and treatments; they were not aware of psychological therapies or even the role of psychologists. Only one patient admitted to using some religious healing techniques. Patients believed that mental illnesses are due to bio-psycho-social causes. They did not know much about depressive illness, even though we had selected patients who were already attending

services. Patients appeared guarded when talking about treatments, especially non-medical treatments. These interviews confirmed some of the things which psychologists had said.

13.14 Students study

We wanted to get some idea of the compatibility of CBT with the belief system of the general public. We felt that talking to students in this regard might be helpful. We also felt that we might be able to compare the results with studies carried out in India and Thailand (Scorzelli, 1994; Reinke-Scorzelli, 2001). The final study we conducted involved group discussion with university students regarding their views about the compatibility of cognitive behaviour therapy (CBT) with their personal, family, social, cultural and religious values. We have already discussed that psychotherapies are underpinned by the value system of a society in which they are developed. In our literature search we found that the views of the general public in India and Thailand were different. In India students felt that the concepts of CBT are not compatible with their value system, while in Thailand they had a more favourable view of these concepts. It is however difficult to compare our work with this work due to the difference in the way these studies were conducted. We simply explained the concepts and asked students to rate their views in these domains according to their value system.

In addition to CBT we also discussed concepts around assertive communication. This was simply because we had observed that communication patterns in Pakistan are different from those used in the West. Most students were comfortable with these concepts in terms of their personal values; however as we moved towards religious values, through family and social values the disagreement increased, with maximum conflict in religious values. We also utilized this group setting to culturally adapt the terminology. This is a strategy we had used in our previous work.

It is possible that students do not reflect views held by wider societies. This study highlighted that CBT might be compatible with the value systems of the students in Pakistan. Generalizability is an important issue with qualitative study, and this is certainly a limitation of our work due to small numbers. Not having carried out this part of the study with members of the general public is a major limitation of this study.

13.15 Adaptation framework

Once these different studies had been analysed we put all the available information together as well as notes from the field and therapy. This analysis yielded 3 major themes, culture, capacity and

cognitions. These were organized into 21 sub-themes, with seven in each major theme. We used this guideline to adapt the therapy. While this guideline confirmed some of the factors which appear in the literature as needing consideration for adaptation of the therapy, we realised that there are other factors, especially related to services, which need consideration.

13.16 Pilot project

Once the modified therapy was developed, we decided to test it in a small pilot study. I trained two psychology graduates to see if therapy could be given by them after a short period of time. This trial was conducted in a medium sized city in the South of Punjab. Therapy was provided to patients attending primary care and compared with care as usual. Patients in both arms of the trial were on antidepressants. We used lessons from our project to not only adapt the therapy but also in delivering therapy. For example, we involved GPs, who explained the therapy and advised patients to see their therapists. Clients were contacted through phone to remind them of appointments etc., similarly, we only involved clients who lived within travelling distance of the clinic. Most patients attended 5 or more sessions. Therapy focused on dealing with anxiety and somatic complaints, symptomatic management and behavioural methods at the start, finding and dealing with cognitive errors, problem solving, relationship difficulties, communication etc. We measured both depressive illness and somatic symptoms. Patients in the therapy arm showed more improvement on both of these measures compared with those in the control arm. Patients in the treatment arm were also more compliant with medication.

13.17 Lessons learnt

Our project aimed at adapting CBT for a non-Western culture in Pakistan. The methodology we adopted was successful in developing an adapted version of CBT. A small pilot project found the therapy to be effective, when delivered by psychology graduates after a short period of training. We had no funding for this project. Our project consisted of a series of small studies. The main point that our work highlights is that involving therapists and the patients in the process of adaptation of the therapy is essential, and should be preferred in comparison with attempts to adapt CBT in a given culture. This adaptation process can be easily carried out through small scale qualitative studies which focus relevant populations. The process of adaptation can be divided into these steps (1) gathering information (2) developing a framework which might provide guidelines for adaptation (3) adaptation

of a CBT manual (4) testing of a manual in a pilot trial (5) further refinement of the manual (6) testing of the manual in a large RCT.

13.18 Limitations

The major limitation of this study is that we were unable to talk to faith healers. This could offer valuable insights into the model of explanation of illnesses, their techniques and their perception of the concepts of mental illnesses in modern psychiatry. We could also gather information related to Sufism, which could help us further adapt therapy. Although generalizability is probably not an issue at the core of qualitative studies, we could still broaden the scope of our studies by talking to patients and psychologists from two or three other cities, to capture the cultural diversity. Similarly, extending the student study to other university students and maybe even to members of the general public could give more generalizable results.

There are wider issues which might have affected our results, for example our impression was that patients were guarded about issues which were controversial. It is therefore possible that we might have not gained a clear picture.

13.19 Future directions

Similar studies are required in Pakistan to adapt therapy for other disorders. The therapy we adapted needs to be tested in a bigger trial and further modifications made if required. Similarly, adaptation work in other countries will also give us more insights into cultural differences and their impact on therapy and its adaptation.

13.20 Impact

I presented work in different conferences both in Pakistan and internationally. This work raised a lot of interest in Pakistan. I was asked to conduct workshops in different psychiatry departments across Pakistan. Nearly 300 mental health professionals were trained in these workshops in using adapted manual for CBT for depression. We started a Google discussion group for those who had received training. As a result of this, the Pakistan Association for Cognitive Therapy came into being. Currently we are working on developing therapy manuals for psychosis, Post Traumatic Stress Disorder (PTSD) and conversion disorders, using the methodology that we developed. The adapted manual is being used in some universities as part of their curriculum. We also successfully negotiated an online CBT certificate with the Oxford Cognitive Therapy Centre, Oxford, UK at a reduced subscription for

Pakistan. Sixty three participants have registered so far. The manual is being translated into Sindhi and Pashto languages. We are also working with two universities on starting a Diploma in CBT.

APPENDICES

1. Extracts from the fieldwork diary
2. Scales used in pilot project
    a. Hospital Anxiety and Depression Scale (HADS)
    b. Bradford Somatic Inventory (BSI)
3. Consent forms
    a. Consent form for patients
    b. Consent form for professionals
    c. Consent form for students

Appendix 1. Extracts from the fieldwork diary

These extracts are from field work diary. They are reflections, but some of them are related to observations from clients work. Although the diary is dated, these are not dated for the reason of anonymity.

- A depressed woman believed that her young son was under the magic spell of her daughter-in-law. It turned out that her son had married 6 month ago and appearing to be paying more attention to his wife had made his mother feel upset because she concluded that her son was ignoring her. She began to feel depressed thinking that the change in her son's behaviour was due to a magic spell
- Mrs SA was a school teacher who presented with symptoms of anxiety and depression. She had two children and was currently living with her older sister. She was married to a university lecturer but had left her husband because he shouted and scolded the children, was controlling, and emotionally abused her. He made decisions for everything in the family, did not give her sufficient money to run the house (he had made her leave her job soon after marriage) and did not allow her to meet with her parents. After 9 years of marriage Mrs SA decided to leave him after he threatened the family with a knife. She had left him on two occasions in the past, but their families had intervened and she had to go back. As any improvement in her husband's behaviour had been short term in the past, she was now determined not to go back to him, although her husband was still in contact which was a source of constant conflict and anxiety. Our initial work focused on helping her with anxiety, low mood and decision making. By the fourth session she had decided to give her husband a last chance provided he fulfilled certain conditions (being allowed to visit her parents regularly, joining a school job and continuing her in therapy for six sessions).The aim of the joint sessions was to help the couple addressing domestic abuse. The therapist further explored the husband's ideas about dealing with his family in detail. Soon after joint therapy started it became obvious that Mr A felt it was his right and privilege to deal with his wife and family in this way, because this is allowed in Islam. The therapist talked to a local religious leader, who informed him that this was a misperception and that was there was plenty of evidence in the Quran to suggest that it was not the case. During the next session Mr A was given the homework assignment of writing out evidence for and against "treating his wife and children with cruelty", from the Quran and Hadis (sayings of Prophet Muhammad). The results were amazing when the couple returned next time. He had a long list of verses and Ahadis which contradicted his assumption. The couple stayed in therapy for another 4 weeks and worked on conflict management and social and communication skills. Wife then returned to husbands home. The couple came back for follow up after 6 months when they brought a huge basket of sweets
- Mr AH was a 32 years old man who lived with his parents and younger brother. He had an engineering degree but had been working for 2 years as a project manager in a small firm. He presented with constant headache, anxiety, low mood and disturbed sleep. He had been seen by two psychiatrists but, in spite of being prescribed antidepressants, anxiolytics, mood stabilizers and a small dose of antipsychotics, there was no change in his symptoms over 6 months. During the assessment sessions it emerged that Mr AH was not happy with his job. He felt that his job

was not up to his standard and that it could not help him to achieve his full potential. He had no friends in his home town and wanted to return to the city where attended university where he may have more opportunities to work as an engineer and improve hi social life. When he tried to talk to his father, who was a strict and powerful man, about returning to the big city two years ago, he had dismissed the idea. The therapist helped the patient in dealing with the symptoms of anxiety, and further explored the patient's conflicting views about going to the big city. Assertiveness training failed since the patient was not ready to try any techniques. He felt guilty because his father had told him that leaving the family home was against not only their religion but also his family and cultural values, and would bring shame to his parents. The therapist worked on AH's feelings of shame and guilt related to cultural and family values, before referring the young man to a local faith healer (he was a retired teacher who the therapist had met a few times before and with whom he had discussed the issue in detail). Meeting with the religious leader was helpful in clarifying AH's mind: he was told that a man is allowed to express his opinion and disagree with his parents, so long as he is not rude to them; he was also told that he had duties as well as rights as a son. Finally AH was able to discuss the issue with his father and in the end they both agreed that it would be better for the patient to move out

- It is not common for people to write down things when they are entering a contract. For example, when i gave my clothes to a tailor, he didn't write down anything. Similarly, plumber, electric technician didn't write anything down when something went wrong. It was very frustrated initially for me, however, after sometime i realized not writing does not cause any problems and they are doing the job properly.
- People don't like to ask questions about the illness. They commonest questions people asked me when i saw a patient was "is he going to be ok? How long would it take?. But not a lot of question about the nature of problem and treatment options.
- I read with interest a newspaper column by Ajmal Niazi in daily Jang newspaper, on 30th January, 2007 praised the doctor who told him, "patients should not know too much about the illness"
- I was sitting with Dr E, a psychiatrist who was conducting an outpatient clinic. He was seeing a young man with schizophrenia for a follow up appointment. His mother asked him to do a dam (reading some verses of Quran and blowing air on the person). Which he did. He later explained this is a common practice. Some psychiatrists' advice patients to say prayers or even write advice on the back of their prescriptions.
- I decided to travel by train and buses in Pakistan. I thought that it will give me a chance to talk to people outside my acquaintances who were mostly from medical background. I was travelling by train from Lahore to Rahim Yar Khan. I found many books and magazines, on the railway stations on topics related to spirituality, occult sciences, for example palmistry and numerology etc. there were also many books on treating health problems using, vegetables, fruits, colors and lot of naturally occurring remedies. I then went to other travelling spots, for example the big bus station in Lahore. I found similar books and magazines there too. During the next couple of years I realized that many book shops had such books. The booksellers also told me how popular they are. This could be a Pakistani version of self help manuals.
- Beliefs about magic, ghosts and spirits are very common and are not limited to the less educated. One of my very educated friends (IB) told me the story of a girl who was possessed by jin. How a religious healer was asked to recite. And jin left her. He also told me about his spells.
- My first outpatient clinic was a bit of an experience. I started at 10 and had to finish at 2. I saw 25 new patients and 25 for follow up. Patients don't have any notes. You have to guess everything from the prescription. Out of these most had a depressive illness, 3 had Learning Disability, 5 had

substance misuse. The patients present mainly with headache or GIT symptoms. Women mainly came with depression and mainly social and relationship problems. I didn't see one single man with depression. Men had either a diagnosis of substance misuse or manic depressive illness. One patient's family told me his family had sold the goat they had to afford their visit to the clinic to seek help. It had taken them one day to travel to the hospital. Another family had travelled for two days to come to the clinic.

- I also noticed that patients with learning disability were living an almost normal life. They were all from rural background. The family called them "simple" and arranges jobs for them which were according to their abilities (for example preparing food for the animals or similar tasks on the farm).
- On my first day to the ward I noticed that most of the inpatients women were diagnosed with dissociative disorders.
- People generally don't express their emotions. However, i noticed that when a patient died on the ward. Relatives and friends cried in loud voices for a long time.
- Patients are usually seen in a big room. Patients are not generally concerned over privacy. Usually there are 10 to 15 patients in the room. It made me feel uncomfortable and i asked many times that only one patient and his family should come to the clinic room. However, this never happened. One female patient wanted to talk to me in privacy and asked her husband to leave; however, she did not seem to be bothered about other people who were in the room.
- Most patients ask for parhez (what should be avoided to speed up recovery). They are especially interested in which foods can be avoided and which might be helpful.
- When talking with people i realized that they usually make their point by narrating long stories or jokes.
- Patients don't like talking about their symptoms in details. When i asked a patient, what problem do you have, and how can i help you at the start of the interviews, he replied, you should know what problem i have, you are the doctor.
- It is considered a sign of weakness to talk about small problems which might be causing stress and emotional pain. It is customary to say "thanks to God". It's a religious duty of people to say thanks to god. Some people told me that it is a sin to be not thankful to God and therefore we should not moan about our problems.
- I also noticed within the first few days that there are no local translations for simple questions, for example, "How is your mood? How is your energy?, Do you enjoy anything these days?". So it is not possible to ask open ended questions, for most disorders.
- One patient with anxiety and depression described her symptoms as "i have a ball of gas in my stomach which rises to my head and then i start feeling dizzy".
- One doctor with whom i worked and who was a medical teacher in public health told me that "people become depressed when they don't follow the religion and commit sins".
- According to a psychiatrist colleague, when he informs the family that the patient suffers with depression, very often a family member might say, "but how is this possible, she has got everything she can imagine".
- One cardiologist colleague told me, how he wanted to refer patients but they refuse due ot the stigma. He also said, that nearly half of the paints he sees have a psychiatric problem
- When i first told a patient that we can work together to help him using CBT, he told me he would rather like me to give him instructions and he will act on these.

- I was in trouble with some of my senior colleagues because i had expressed my opinion in front of him, although i was very polite
- There is no local expression for assertiveness
- One patient with schizophrenia and his family travelled from a long distance to come to see me. It turned out that they wanted me to prescribe the patient something to “cure” his illness.
- Mental health professionals often talk about the role of faith healers and religious healers. On the other hand i saw many patients who were referred by a faith healer.
- People talked about talking to their elders and faith and religious healers for advice and support, when I talked to them about the idea of counseling and psychotherapy
- I regularly used verses from Quran and Ahadis and examples from life of Muhammad with patients for example in explaining assertiveness, domestic violence and bringing about change during psychotherapy.

Appendix 2a. Hospital Anxiety and Depression Scale (HADS)

	ہوسپٹل انکزایٹی اور ڈیپریشن سکیل				
		تقریباً ہمیشہ 1	اکثراوقات 2	کبھی کبھار 3	بالکل نہیں 4
1	میں تناؤیا ذہنی دباؤ محسوس کرتا / کرتی ہوں۔				
2	جو چیزیں مجھے پہلے اچھی لگتی تھیں وہ اب بھی مجھے اچھی لگتی ہیں۔				
3	مجھے اس بات کا دھڑکا لگ جاتا ہے کہ کوئی بری یا خطرناک بات ہونے والی ہے۔				
4	اگر مجھے کوئی بات مزاحیہ لگے تو مجھے ہنسی آجاتی ہے۔				
5	میرے ذہن میں پریشانی کی سوچیں آتی رہتی ہیں۔				
6	میں خوشی محسوس کرسکتا / سکتی ہوں۔				
7	میں آرام سے بیٹھ سکتا / سکتی ہوں اور سکون محسوس کرسکتا / سکتی ہوں۔				
8	مجھے لگتا ہے کہ میں پہلے کی نسبت سست ہوگیا / گئی ہوں۔				
9	مجھے بغیر وجہ کے خوف محسوس ہوتا ہے اور پیٹ میں گڑبڑ شروع ہوجاتی ہے۔				
10	میں نے اپنا خیال رکھنا چھوڑ دیا ہے۔				
11	میں بے چینی محسوس کرتا / کرتی ہوں اور ٹک کر نہیں بیٹھ سکتا / سکتی۔				
12	میں آنے والے واقعات کا خوشی سے انتظار کرتا / کرتی ہوں۔				
13	مجھ پر ایک دم شدید گھبراہٹ کا دورہ پڑتا ہے۔				
14	میں اچھی کتاب یا ریڈیو یا ٹی وی پروگرام سے لطف اندوز ہوسکتا / سکتی ہوں۔				

Appendix 2b. Bradford Somatic Inventory (BSI)

برڈفورڈ سوماٹک انوینٹری

نام _____ جنس _____ عمر _____ مطالعہ نمبر _____

ہم جاننا چاہتے ہیں اگر آپ کو پچھلے مہینے میں کوئی جسمانی امراض تھیں۔ برائے مہربانی کسی بھی مناسب باکس میں صرف ٹک کا نشان لگا کر تمام سوالات کے جوابات دیں۔ یاد رکھیں ہم آپ کی ان امراض کو جاننا چاہتے ہیں جو آپ کو پچھلے مہینے میں تھیں نہ کہ وہ جو آپ کو اس سے پہلے کبھی ہوئیں تھیں۔

آپ کے تعاون کا بہت بہت شکریہ!

"پچھلے مہینے کے دوران ....."	غیر موجود	پچھلے مہینے میں پندرہ دن سے کم موجود تھی	پچھلے مہینے میں پندرہ دن سے زیادہ موجود تھی
۱ کیا آپ کو سخت سر درد ہوا تھا؟	☐	☐	☐
۲ کیا آپ کو معدے میں گھبراہٹ یا کوئی چیز پلٹتی محسوس ہوئی تھی؟	☐	☐	☐
۳ کیا آپ کی گردن اور کاندھوں میں درد یا کھچاؤ ہوا تھا؟	☐	☐	☐
۴ کیا آپ کی ساری جلد میں جلن اور خارش ہوتی رہی ہے؟	☐	☐	☐
۵ کیا آپ کو سر میں کساوٹ محسوس ہوئی تھی جیسے کہ کسی نے باہر سے مضبوطی سے پکڑ رکھا ہو؟	☐	☐	☐
۶ کیا آپ کو چھاتی یا دل میں درد محسوس ہوا تھا؟	☐	☐	☐
۷ کیا آپ کو منہ یا گلہ خشک محسوس ہوا تھا؟	☐	☐	☐
۸ کیا آپ کی آنکھوں کے سامنے اندھیرا آیا یا دھند ہوئی تھی؟	☐	☐	☐
۹۔ کیا آپ کو معدے میں جلن محسوس ہوئی تھی؟	☐	☐	☐
۱۰ کیا آپ کو اکثر کمزوری محسوس ہوئی تھی؟	☐	☐	☐
۱۱ کیا آپ کو سر میں گرمی یا جلن محسوس ہوئی تھی؟	☐	☐	☐
۱۲ کیا آپ کو پسینہ زیادہ آتا رہا ہے؟	☐	☐	☐
۱۳ کیا آپ کو ایسا محسوس ہوا تھا جیسے آپ کے دل یا چھاتی پر دباؤ یا کساؤ ہو؟	☐	☐	☐
۱۴ کیا آپ کو پیٹ میں درد یا بے آرامی تھی؟	☐	☐	☐
۱۵ کیا آپ کو گلے میں سانس (دم) رکتا ہوا محسوس ہوا تھا؟	☐	☐	☐
۱۶ کیا آپ کو ہاتھ یا پاؤں میں سوئیاں چبھتی محسوس ہوئیں تھیں یا آپکے ہاتھ یا پاؤں سو گئے تھے؟	☐	☐	☐
۱۷ کیا آپ کو سارا بدن دکھتا محسوس ہوتا تھا؟	☐	☐	☐
۱۸ کیا آپ کو بدن کے اندر گرمی محسوس ہوئی تھی؟	☐	☐	☐
۱۹ کیا آپ کو دل زیادہ دھڑکتا محسوس ہوتا رہا ہے؟	☐	☐	☐

پچھلے مہینے کے دوران .....

	غیر موجود	پندرہ دن سے کم موجود تھی	پندرہ دن سے زیادہ موجود تھی
۲۰ کیا آپ کو آنکھوں میں درد جلن محسوس ہوئی تھی ؟	☐	☐	☐
۲۱ کیا آپ کو بدہضمی کی تکلیف رہی ہے ؟	☐	☐	☐
۲۲ کیا آپ کا پٹھے یا تھرتھراتے رہے ہیں ؟	☐	☐	☐
۲۳ کیا آپ کو بار بار پیشاب آتا رہا ہے ؟	☐	☐	☐
۲۴ کیا آپ کو کمر کی تکلیف رہی ہے ؟	☐	☐	☐
۲۵ کیا آپ کے پیٹ میں ابھار ہوا تھا یا پیٹ پھولا ہوا محسوس ہوتا تھا ؟	☐	☐	☐
۲۶ کیا آپ کا سر بھاری محسوس ہوتا تھا ؟	☐	☐	☐
۲۷ کیا کام نہ کرتے ہوئے بھی آپ کو تھکاوٹ محسوس ہوتی تھی ؟	☐	☐	☐
۲۸ کیا آپ کی ٹانگوں میں درد رہتا تھا ؟	☐	☐	☐
۲۹ کیا آپ کا جی کچا ہوتا (متلاتا) تھا ؟	☐	☐	☐
۳۰ کیا آپ کو سر کے اندر دباؤ (پریشر) محسوس ہوا تھا جیسے کہ آپ کا سر پھٹ جائے گا ؟	☐	☐	☐
۳۱ کیا آرام کی صورت میں بھی آپ کو سانس لینے میں مشکل ہوئی تھی ؟	☐	☐	☐
۳۲ کیا آپ کے سارے بدن میں جھنجھناہٹ (سوئیاں چبھتی) محسوس ہوتی تھی ؟	☐	☐	☐
۳۳ کیا آپ کو قبض کی شکایت ہوتی رہی ہے ؟	☐	☐	☐
۳۴ کیا آپ کو بار بار پاخانے کی حاجت ہوتی تھی ؟	☐	☐	☐
۳۵ کیا آپ کی ہتھیلیوں میں بہت پسینہ آتا رہا ہے ؟	☐	☐	☐
۳۶ کیا آپ کو نگلنے میں تکلیف ہوئی تھی جیسے کہ آپ کے گلے میں کوئی گولا تھا ؟	☐	☐	☐
۳۷ کیا آپ کے سر میں چکر وغیرہ آتے رہے ہیں ؟	☐	☐	☐
۳۸ کیا آپ کو مُنہ کا ذائقہ کڑوا محسوس ہوا تھا ؟	☐	☐	☐
۳۹ کیا آپ کو سارا بدن بھاری محسوس ہوتا تھا ؟	☐	☐	☐
۴۰ کیا آپ کو پیشاب کرتے وقت جلن محسوس ہوئی تھی ؟	☐	☐	☐
۴۱ کیا آپ کے کانوں یا سر میں سائیں سائیں (شاں شاں) کی آواز آتی رہی ہے ؟	☐	☐	☐
۴۲ کیا آپ کو دل کمزور یا ڈوبتا ہوا محسوس ہوا تھا ؟	☐	☐	☐
۴۳ کیا آپ کے پیٹ میں زیادہ گیس تھی یا ڈکاریں زیادہ آتی تھیں ؟	☐	☐	☐
۴۴ کیا آپ کے ہاتھ پاؤں ٹھنڈے ہو جاتے تھے ؟	☐	☐	☐
صرف مرد حضرات کے لئے :			
۴۵ کیا آپ کو پوری ہوشیاری نہ آنے کی شکایت ہوئی تھی ؟	☐	☐	☐
۴۶ کیا آپ کو ایسا محسوس ہوا تھا کہ آپ کے پیشاب میں منی خارج ہوتی تھی ؟	☐	☐	☐

Appendix 3a. Consent form for patients

CONSENT FORM FOR PATIENTS

Title: CBT for depression

Study Number: Version number: 1

Ethics Number: Dated: 10/01/07

Please initial box

1. I confirm that I have read and understand the information sheet, for the above study, and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw from the study at any time, without giving any reason, without my medical care or legal rights being affected. ☐

3. I agree to take part in the above study.

Name of Patient Date Signature

_____ _____

Name of Person taking consent Date Signature
(if different from researcher)

_____ _____

Researcher Date Signature

1 for patient, 1 for researcher

Appendix 3b. Consent form for professionals

CONSENT FORM FOR PROFESSIONALS

Title: CBT for depression

Study Number: Version number: 1

Ethics Number: Dated: 10/01/07

Please initial box

1. I confirm that I have read and understand the information sheet, For the above study, and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw from the study at any time, without giving any reason, without my medical care or legal rights being affected. ☐

3. I agree to take part in the above study. ☐

Name of Patient Date Signature

_____ _____

Name of Person taking consent Date Signature
(if different from researcher)

_____ _____

Researcher Date Signature

1 for patient, 1 for researcher

Appendix 3c. Consent form for students

CONSENT FORM FOR STUDENTS

Title: CBT for depression

Study Number: Version number: 1

Ethics Number: Dated: 10/01/07

Please initial box

1. I confirm that I have read and understand the information sheet, For the above study, and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw from the study at any time, without giving any reason, without my medical care or legal rights being affected. ☐

3. I agree to take part in the above study. ☐

Name of Patient Date Signature

_____ _____

Name of Person taking consent Date Signature
(if different from researcher)

_____ _____

Researcher Date Signature

1 for patient, 1 for researcher

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