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Using cognitive behaviour therapy with South Asian Muslims: Findings from the culturally sensitive CBT project

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Abstract

It has been suggested that cognitive behaviour therapy (CBT) needs adaptation for it to be effective for patients from collectivistic cultures, as currently CBT is underpinned by individualistic values. In prior studies we have demonstrated that CBT could be adapted for Pakistani patients in Southampton, UK, and for local populations in Pakistan. Findings from these studies suggest that CBT can be adapted for patients from collectivistic cultures using a series of steps. In this paper we focus on these steps, and the process of adapting CBT for specific groups. The adaptation process should focus on three major areas of therapy, rather than simple translation of therapy manuals. These include (1) awareness of relevant cultural issues and preparation for therapy, (2) assessment and engagement, and (3) adjustments in therapy. We also discuss the best practice guidelines that evolved from this work to help therapists working with this population. We reiterate that CBT can be adapted effectively for patients from traditional cultures. This is, however, an emerging area in psychotherapy, and further work is required to refine the methodology and to test adapted CBT.

Introduction

Cognitive behaviour therapy and culture

Cognitive behaviour therapy (CBT) has a strong evidence base and is recommended by the National Institute of Health and Clinical Excellence (NICE) in the UK and by the American Psychiatric Association (APA) in the USA for a variety of emotional and mental health problems (American Psychiatric Association, 1993; National Institute of Clinical Excellence, 2009). However, it has been suggested that CBT is underpinned by cultural values of individualistic cultures such as those of the UK and the USA (Hays, 2009; Scorzelli & Reinke-Scorzelli, 1994). It is believed that people from these cultures differ from people from collectivistic cultures in important ways, such as core values, cultural orientation, and attention paid to cognitions versus emotions (Laungani, 2004). Thus there are valid reasons for CBT to beculturally adapted to be effective for patients from collectivistic cultures (Rathod & Kingdon, 2009).

Therapists working with ethnic minority patients in the USA have highlighted the core principles for adapting therapeutic techniques (Bernal et al., 1995; Hwang, 2006; Hwang et al., 2006; Tseng, 2004). Most of these studies describe therapists' experiences of working with Chinese or Latino patients, and address wider therapeutic issues rather than issues pertaining to a particular therapy. Further, these studies do not directly examine outcomes resulting from adapting therapeutic techniques and/or addressing cultural issues in therapy. There are notable examples of successful adaption of CBT for refugee groups (Hinton et al., 2005, 2012; Hinton & Jalal, 2014). This pioneering work emphasized teaching flexibility, working on somatic complaints, emphasis on muscle relaxation, and a focus on behavioural methods. Similarly, family intervention has been culturally tested and found to be effective (Kumpfer et al., 2002).

The literature describing guidance for cognitive therapists is limited (Hays, 2009). Van Loon et al. (2013) conducted a systematic review of culturally adapted treatments for anxiety and depression. They reported that most of the studies were conducted in the USA, and that two such studies demonstrated significant benefits. However, results could only be generalized to groups in cultures characterized as 'high-power individualistic' (HPI) cultures (Fernando, 2012), which focus on the individual and on independence. Only two studies described processes of adaptation, in which therapy was developed

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in collaboration with the targeted ethnic groups through focus groups. This approach helped the authors to adapt therapy for the given population.

While studies and discussions of culturally adapted therapy for ethnic minority patients in the USA are few, even less information is available for therapists working with South Asian patients. Ahmed and Amer (2011) provide some much-needed information on counselling Muslim patients living outside of their countries of origin, and there is some information on the relevance of CBT for Muslim patients (Amer & Jalal, 2011), but empirical data on adapting CBT for Pakistani patients is sparse. We therefore undertook to adapt CBT for this patient group for depression and psychosis in Pakistan, and for psychosis in the UK. This paper will describe the process and focus of adaptation of CBT, along with the findings. The main focus of the paper is on adaptation work with local populations in Pakistan.

Pakistan: cultural and religious background and healing systems

Pakistan was a part of India until independence in 1947. It is located along either side of the historic Indus River from which India gets its name, and, home to the Indus valley civilization (Kenoyer, 1991). Pakistan's 796,095 km^2 of territory include a wide variety of landscapes, from arid deserts to lush green valleys, to the snow-covered mountains of the Himalayas. To the south is the Arabian Sea, with 1046 km of coastline. The most recent estimates of the Pakistani population put it at nearly 180 million (Talbot, 2009). The majority of the Pakistani people (95–97%) are Muslims, while the remaining 3–5% are Christian, Hindu, or of other religious faiths. *Sunnis* are the majority while the *Shia* make up between 5 and 20% of the total Muslim population of the country. The two official languages of Pakistan are Urdu and English, while several regional languages are also spoken by the people (Punjabi, Pashto, Sindhi, Balochi, Kashmiri, Brahui, Shina, Balti, Khowar and Burushaski). The majority of Pakistanis live in rural areas.

There are four major ethnic groups in Pakistan – Punjabi (55.6%), Pathan (12.0%), Sindhi (18.2%), and Baluchi (3.6%). In addition, during the last 40 years millions of Afghan refugees moved to live in Pakistan due to the ongoing conflicts in Afghanistan (Craig, 2014). 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 invaders. This also meant mixes of the cultures and traditions. Persians, Greeks, Romans, Turks, Arabs, Central Asians, British and Russians (in that order), have all moved through and lived there (Bearden, 2001). The famous Silk Route also passes through Pakistan. The northern areas of Pakistan (Khyber Pakhtun-khwa, and the Federally Administered Tribal Areas) are acknowledged by many to be the origin of Hinduism and cradle of Buddhism (Rahman, 1993).

Pakistan has a long history of adversity. Independence from India in itself was a bloody and traumatic event, causing a vast number of deaths (approximately 200,000 to 500,000), and destruction on both sides of the border (Brass, 2011). Pakistan has also experienced some of the worst floods and earthquakes in the region (a total of 11 major floods and four earthquakes (International Disaster Database, 2015)). Pakistan's involvement in the Soviet-Afghan War (1979–1989) brought destruction and ongoing trauma that continues today (Johnson & Mason, 2008). A recent complication is the rise of the Taliban, who believe in a 'purist' Islam that can be in conflict with Sufism (an orientation or denomination within Islam that focuses on mysticism and spiritualism). A large number of Pakistanis practised Sufism until the war in Afghanistan that began in the 1970s. In the last two decades the Taliban have killed numerous followers of Sufism and destroyed their shrines (BBC, 2009). It is quite likely that this destruction resulted in severe trauma while also depriving those traumatized of their source of spiritual healing and relief.

Pakistan's varied history of migrations is reflected in the healing traditions that are followed there today. For example Pakistani physical health healers can be observed using old Greek, Arabic, Indian and Chinese methods of healing. Additionally faith and religious healers use magic, palmistry, numbers, cards and Sufism to help people for sexual, psychological, and relationship problems (Farooqi, 2006). The main reasons for consulting these healers are proximity, affordability, availability, family pressure, and the strong beliefs and opinions of the community (Shaikh & Hatcher, 2005a).

Faith healers and traditional medicines are often used for therapeutic purposes in Pakistan. Researchers Saeed et al. (2000) reported that about 40% of total attendees of a faith healer qualified for a psychiatric diagnosis, the most common ones being depressive illness, psychosis, and epilepsy, with depressive illness and dissociative disorders being more common in women and psychosis among men. A similar study (Farooqi, 2006) found that patients with different psychiatric disorders sought multiple traditional healing methods for their problems, including somatoform disorders (73%), personality/conduct disorder (73%), schizophrenia (70%), affective disorders (68%), and anxiety disorders (55%). More male than female patients used multiple traditional healing practices (Farooqi, 2006).

A person's beliefs about the healers and the healing system are important, as these might predict patterns of consultations and follow up. A study of patients' perceptions with regard to spirituality in medical practice found that 92% of respondents believed in physicians having healing powers given by God, while 78% felt that physicians should consider the religious needs of the patient during treatment (Qidwai & Tayyab, 2004). Another 44% believed that it is the competence of a physician that results in his/her healing ability. A significant proportion (30%) sought treatment from faith healers and believed that medical care should include faith healing. Ninety-four respondents (94%) believed that praying and reciting the Quran helps in healing. Most respondents (63–97% with regard to each of the practices listed) also expected that 'a physician be regular with regard to prayers, fasting, *zakat* [charity that every Muslim should offer once a year], donation, and avoiding sins' (Qidwai & Tayyab, 2004, p. 643). These studies highlight the significant role of religion and spirituality in healing in Pakistani society, as well as the expectations people have of their healers.

The need for culturally responsive interventions

The discussion above highlights the deeply troubled past of Pakistanis, the traditional nature of beliefs and practices in health and support systems, and the need for addressing the emotional consequences of both natural and human-made traumas. The rates of mental health problems are high, and there is a need to develop culturally relevant and acceptable psychosocial interventions to support those with emotional and mental health problems. We selected cognitive behaviour therapy (CBT) for multiple reasons: (1) it is short-term, focused, cost effective and is evidence based, (2) there was at least some literature describing its use with patients from collectivistic backgrounds, and (3) for practical reasons – most of our team members were trained in CBT. However, the existing evidence from the literature also points out that CBT might need adapting for it to be effective with people from traditional cultures (Hays & Iwamasa, 2006; Scorzelli & Reinke-Scorzelli, 1994). Thus there are valid reasons for CBT being culturally adapted to be effective for patients from these cultures (Rathod & Kingdon, 2009).

Adapting CBT for the Pakistani context: methodology

Several studies were conducted in Pakistan, and in the UK with Pakistani people. We conducted a series of qualitative studies, which were underpinned by an ethnographic approach (e.g. Naeem, Habib et al., 2014). Culturally sensitive CBT thus developed was tested in small feasibility studies and was found to be effective. In the first Pakistani study, clinical psychologists ($n = 5$) were interviewed about their experiences of providing therapy, in particular CBT, to depressed patients (Naeem et al., 2010). Depressed patients ($n = 9$) were also interviewed, with questions focusing on presenting symptoms, referral behaviour, attribution styles, acceptability of talking therapies, and obstacles in its delivery (Naeem et al., 2012). Finally, focus groups were conducted with university students ($n = 34$) to find out the extent to which CBT was consistent with their personal, religious, family, social and cultural values (Naeem et al., 2009). The study group further utilized their help in the selection of culturally equivalent terminology used in CBT. Information gathered from these preparatory qualitative studies, as well as the first author's own field observations and experience of therapy was collated to develop an adaptation framework that guided the CBT adaptation process (Naeem et al., 2009). Preliminary evaluation of adapted CBT found it to be effective in primary care settings (Naeem et al., 2011). A larger randomized controlled trial (RCT) was then conducted that demonstrated that a brief version of this culturally adapted CBT was more effective than 'treatment as usual' (Naeem, Gul et al., 2015). A multi-centre randomised controlled trial also found a culturally adapted, CBT-based (CaCBT) self-help intervention to be effective (Naeem, Sarhandi et al., 2014). The self-help manual is available for use (Naeem et al., 2013), and semi-structured interviews can be obtained from the first author on request.

The qualitative studies in Pakistan aimed to culturally adapt CBT for use in patients with psychosis (Naeem, Habib et al., 2014). Semi-structured interviews were used for this study. In our previous work in Pakistan to culturally adapt CBT for depression, open ended interviews were conducted by a psychiatrist trained in CBT and qualitative methods. We therefore wanted to develop a semi-structured questionnaire that could be used by psychology graduates, thus task-shifting, reducing the cost of the intervention, and further standardizing the process of interviews. A total of 92 interviews with mental health professionals ($n = 29$), patients ($n = 33$) and their carers ($n = 30$) were conducted by three psychologists. CaCBT for psychosis has also been tested in Pakistan in inpatient settings (Habib et al., 2014). A brief version of CaCBT for patients with psychosis was tested in a RCT, and was found to be significantly more effective than treatment as usual (Naeem, Saeed et al., 2015).

The above studies also addressed barriers to effective therapy, helpful and unhelpful techniques, and factors that influence the outcome of therapy. Presenting symptoms, referral behaviour, attribution styles, and acceptability of and obstacles to

using talking therapies in patients were addressed, and the extent to which CBT was consistent with the personal, religious, family, social and cultural values of Pakistanis in the general population were discussed. The guidelines developed from the above mentioned work were also used to deliver and test a brief psychological intervention for self-harm (Husain et al., 2014) and a group psychosocial intervention for depression (Husain et al., 2013) in Pakistan.

In the UK project similar methodology was undertaken with specific ethnic groups (Black British, African Caribbean, Black African and Pakistani and Bangladeshi) in two centres (Hampshire and West London) (Rathod et al., 2010). In-depth, face-to-face, semi-structured interviews and focus group interviews were conducted with participants with psychosis ($n = 15$), lay members from respective communities ($n = 52$), CBT therapists ($n = 22$), and health professionals with experience of working with service users from these groups ($n = 25$). This was followed by a randomized controlled trial to test the acceptability and feasibility of culturally adapted CBT for psychosis (Rathod et al., 2013).

All of the studies mentioned above provide the information for and context in which the issues of cultural adaptation are discussed below.

Process of adaptation of CBT

The process of adaptation of CBT starts with gathering information from the different stake holders using a qualitative methodology. This information is then analysed to develop guidance that can be used to deliver culturally adapted CBT. The therapy material or manual is then translated, and culturally adapted in the light of guidance developed from the qualitative analyses. The adapted therapy is field tested in the last step, and adjustments are made to further refine the adaptation.

The following areas are typically explored in interviews and focus groups (1) to explore the beliefs of the patients with a given illness, its causes and the treatment, especially non-medical treatments, and patient's experience of any non-pharmacological help they had received, (2) to gain an understanding of carers' views about the problem, its causes and treatment, and their beliefs about help seeking and any non-pharmacological treatment, and (3) to explore the experience of health professionals, including therapists, who help patients with the given problem and what barriers they have to overcome in helping these patients. Questions were asked to further identify techniques the helpers believed needed modifying, and those which they found useful. These semi-structured interviews can be obtained from the first author on request. Fig. 1 highlights the stages in the adaptation process.

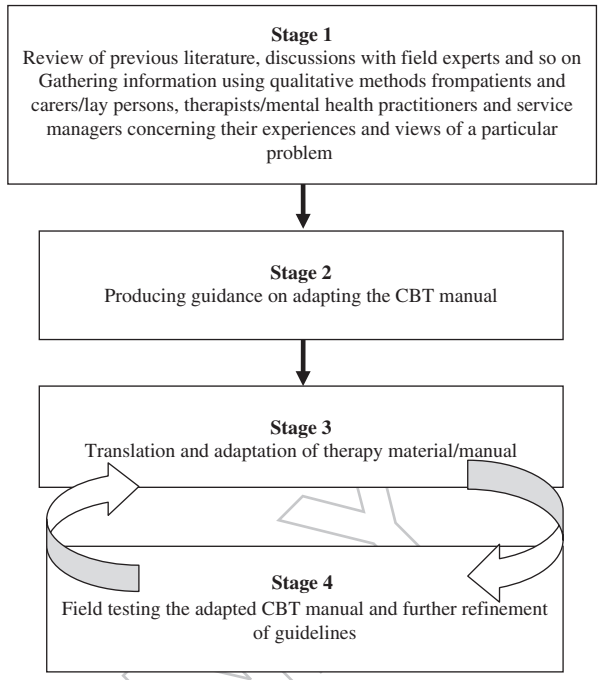


Fig. 1. Flow chart outlining stages of the adaptation process.

Areas of focus in the adaptation process

Cultural adaptation of therapy goes beyond translation of a therapy manual. It involves multiple aspects of therapy. Fig. 2 describes the areas that need attention during the adaptation.

Working with Pakistani patients in the UK

Table 1 describes differences in delivering CBT for Pakistani patients in the UK, by focusing mainly on issues relevant to British Pakistani patients.

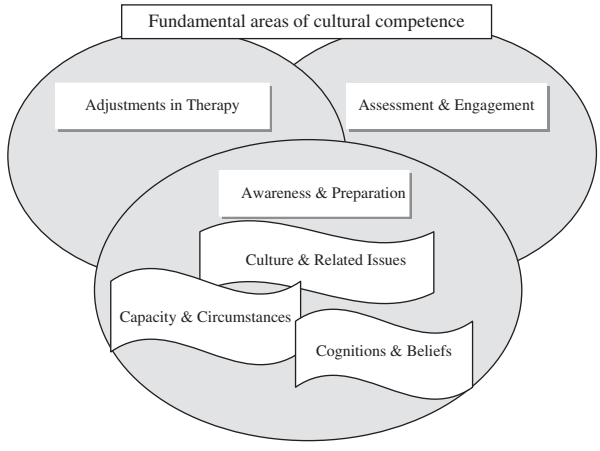


Fig. 2. The focus of adaptation of CBT.

Table 1. Issues to consider for working with Pakistani patients living in the West.

Awareness of culture and religion

- A Pakistani therapist working with Pakistanis is more likely to be aware of the cultural and religious factors and can easily adjust therapy compared with a therapist from a non-Pakistani background, who might not be aware of patients' culture and religion.
- Non-Pakistani therapists' awareness of their own cultural beliefs and attitudes towards Pakistanis and Muslims needs to be addressed, as these can interfere with therapy and result in a therapist's assumptions that 'it is the patient posing difficulties with engaging', rather than the therapist's own beliefs. Where therapists have limited knowledge of Muslim religion (a cornerstone for most but not all Pakistani patients), consulting experts or liaising with local imams for support and guidance is recommended.
- Although language might not be an issue when working with second-generation patients in individualistic cultures, it can be a barrier if the patient cannot communicate in a common language.
- Therapists might view living in an extended or joint family as overly-dependent on the family. However, this is normal and is even viewed in a positive light in Asian cultures. This is not limited only to Pakistanis or Muslims and is fairly common among Indian families. The parents are elders of the family and considered to be a source of support, guidance, and blessings.
- Some Pakistani patients might not be fully aware of health systems. The patients' knowledge of the health system, available treatments, and their likely outcomes are important factors in service utilization and engagement.

Assessment

- Cultural identity, acculturation, religious/spiritual orientation and difficulties in cultural adjustments are important consideration when providing therapy to this patient group in individualistic cultures. This involves assessment of a patient's level of cultural adjustments and religious orientation. The therapist can start exploring this area by finding out whether the patient is a first-generation or second-generation immigrant. The Asian Cultural Identity Schedule (Bhugra et al.,1999) can be used to assess a patient's cultural identity and adjustment to the host culture, which can help the therapist in adjusting therapy to the patient's level of acculturation. This scale describes the key concepts of cultural identity such as religion, attitudes to the family, leisure activities, rites of passage, and food and language preference. However, this is a lengthy instrument and therapists should familiarize themselves with the instrument and perhaps use only those questions that they consider relevant to their work. Additional questions are those relating to marriage (arranged or otherwise) how family members relate to others, religious practices, celebrating religious festivals, and sources of spiritual and religious support. A patient with a higher level of acculturation to individualistic values might need little adjustment in therapy.
- The therapist should also assess family involvement and consider both the advantages and disadvantages of involving the family. Questions can be asked about the patient's living situation (whether living in an extended family or nuclear), and attempts can be made to provide support to parents of the patient (even when the patient is an adult). Therapist can also ask the family to identify a person as the main carer, with whom the therapist can work if the patient and family wish that to be the case. Caution in involving the family is warranted when the patient's problems are a result of the family, when dealing with acculturation problems (between young and old generations), when a family member becomes controlling and insists on knowing everything the patient talks about in therapy (versus what the patient wants them to know), when there is a fear by family members that they may be criticized for the patients' illness, and when dealing with issues of shame, guilt, and stigma about mental illness in the family and its communal impact for future suitors.
- The therapist should identify the language needs of the patient, whether the patient can speak the therapist's language fluently, or whether there is a need to involve an interpreter. There is some evidence to suggest that CBT can be delivered through interpreters. However, this area needs further exploration.

Engagement

- Unlike their counterparts in HPI cultures, patients might not feel comfortable with a therapist who is trying to treat them equally. Patients like to see their therapist as a parental figure. Patients prefer advice from the therapist and might lose faith in a therapist who wants to work on an equal footing.
- The personal touch might make patients feel warmer towards the therapist. Personal disclosure about non-significant matters, particularly focusing on similarity and closeness, can be helpful. For example, 'Oh, I also have three children', 'My mother lives in that area where you live', or 'My neighbours come from the Pakistani area where your parents came from' may help the patient to bond with the therapist.

Adjustments in therapy

- Some patients might find it easier to read and write in their native language. This needs to be sensitively assessed so that alternative methods can be used, e.g. audio tapes and audio diaries, beads, counters or symbols for writing diaries. Self-help material is available in Urdu and can be obtained from the first author.

Issues in adapting CBT to Pakistani culture

The process of adaptation should focus on three fundamental areas of delivery of therapy, which we refer to as the 'Triple-A' principle:

I. *Awareness* of relevant cultural issues and preparation for therapy
II. *Assessment* and engagement
III. *Adjustments* in therapy techniques (technical adjustments)

These areas and subareas are further discussed below.

I. Awareness and preparation

There are three areas for consideration here. More detailed discussions of these areas have been provided in prior studies (see Naeem et al., 2009, 2010, 2012, 2013; Naeem, Habib et al., 2014). Here we will provide summaries of those discussions.

Culture and related issues (culture, religion and spirituality; language and communication; family-related issues)

Culture, religion and spirituality. Culture, religion and spirituality influence the belief systems of people,

including beliefs about illness, its causes and treatment. Culture and religion influence the cause and effect relationship (Cinnirella & Loewenthal, 1999; Ismail et al., 2005; Razali et al., 1996). For example, the cause of a mishap might be described as the 'evil eye' (a curse believed to be cast by a malevolent glare) or even God's Will. People are also likely to use religious coping strategies, when dealing with distress (Bhugra & Bhui, 1998). On the other hand, culture, religion and spirituality give rise to myths and stigmas associated with mental illness (for example, some Muslims believe that not being a good follower can make you depressed (Naeem et al., 2012). See Box 1 for an example.

Beliefs about the causes of mental illness can influence decisions about choice of treatment and help-seeking pathways (Lloyd et al., 1998). Exploring a patient's beliefs about illness and its causes and most importantly their expectations from the health system is important (Magiorkinis et al., 2013; Nestler, 2002). The influence of ancient Greek and Chinese medicine can be readily seen, e.g. participants in our study described phlegm (Greek concept) and heat in liver (Chinese concept) to be the cause of their illness. The concept of four bodily humours (blood, yellow bile, black bile, and phlegm) and their association with the four elements (air – hot and wet; water – cold and wet; fire – hot and dry; and earth – cold and dry) is well recognized from ancient Greek concepts (Jackson, 2001; Stelmack & Stalikas, 1991), and are subscribed to by Pakistani patients. Similarly, there is belief in the four temperaments that are connected to these humours: sanguine (optimistic, leader-like), choleric (bad-tempered or irritable), melancholic (analytical and quiet), and phlegmatic (relaxed and peaceful). Medicines which cause dryness of the mouth are considered to cause heat in the body, and therefore might be less acceptable (some patients might drink milk as an antidote for dryness).

Language and communication. It is important to consider language in at least two areas, first, with regard to translation of psychological concepts, and second, with regard to communication skills. Assertiveness can be used to further highlight the importance of language in this regard. Patients can be taught to use culturally sensitive assertiveness techniques such as the 'apology technique' in which an individual begins a sentence with the following statements or phrases: '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 state that my opinion is….' A person from these cultures, while disagreeing, also appears humble, with behaviours such as lowering his/her gaze (as a sign of respect). Box 2 gives an example.

Similarly, it is common for Pakistani patients to use indirect or non-verbal communication (for example, talking to a father through their mother, out of respect). While patients are generally advised to use a direct approach (by engaging in culturally sensitive assertiveness training using the language noted above), when this direct approach does not work, patients are advised to use the indirect technique, i.e. finding a senior relative to convey the message or even to write to the elder. Therapists should explore the patterns of communication and conflict management before this is agreed upon. In essence, fewer confrontational techniques are advisable.

Box 1. Cultural and religious factors impacting therapy.

Mrs S, was a school teacher who presented with symptoms of anxiety and mild depression. She had two children and was currently living with her elder sister for 6 months. She was married to a university lecturer. She had left her husband because he shouted and scolded the children, was controlling, and emotionally abused his wife. He made decisions for everything in the family, did not give his wife sufficient money to run the house (he had made her leave her job soon after marriage) and did not allow his wife to meet with her parents. After 9 years of marriage the wife decided to leave him when one day he threatened the family with a knife if they did anything against his will. Mrs S said she had left her husband in the past on two occasions, but that the family had intervened and she had to return to him. But changes in her husband were short-lived. So she was now determined to never go back to him. The husband on the other hand was still contacting her and this was a source of constant conflict and anxiety for her.

Our initial work focused on helping Mrs S with anxiety, low mood and decision making. By the fourth session she had decided that she would consider giving her husband a 'last chance' if he fulfilled certain conditions (for example, permitting her to visit her parents regularly, and joining her in therapy for six sessions). The aim of the joint sessions was to help the couple address domestic abuse. The therapist further explored the husband's ideas about dealing with his family. Soon after joint therapy started it became obvious that the husband felt it 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 there was plenty of evidence that Islam encouraged cherishing one's wife. During the next session the husband was given a home-work assignment of writing the evidence for and against "treating his wife and children with cruelty" from the Quran and Hadis (sayings of the Prophet Muhammad).

The results were remarkable when the couple returned to therapy. The husband had a long list of *Ahadis* (religious verses) which contradicted his assumption. The couple stayed in therapy for another 4 weeks and worked on conflict management and social and communication skills. The wife then returned to her husband's home. The couple came back for follow up after 6 months. They brought with them a large basket of candy, which the therapist accepted with thanks.

Box 2. When assertiveness training fails.

Mr A was a 32-year-old man who lived with his parents and younger brother. He had an engineering degree from a university in city away from his home town. He had not been working in his field, but rather had been working for 2 years as a project manager in a small firm back in his home town. Mr A presented with constant headache, anxiety, low mood and disturbed sleep. During the assessment sessions it emerged that he was not happy with his job. He had no friends in his home town and wanted to return to the city where he attended university, and where he may have more opportunities to work as an engineer and improve his 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, his father 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 not only against their religion but also his family and cultural values; leaving would bring shame on his parents. The therapist worked on Mr A's feelings of shame and guilt related to cultural and family values before referring the young man to a local faith healer (the therapist had gained Mr A's consent to this). Meeting with the faith healer was helpful in clarifying the patient'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 rights as well as duties as a son. Finally he was able to discuss the issue with his father and in the end they both agreed that it would be better for Mr A to move.

Finally, shame and guilt are used by families and friends to control unacceptable behaviours (for example, use of alcohol or drugs). Shame and guilt can even prevent help-seeking for a mentally ill relative; family members might not bring the patient to the attention of health professional due to shame and stigma attached to mental illness. Sensitively exploring this might be helpful in improving follow-up in therapy.

Family-related issues. Pakistani patients often live within an extended or joint family. Involving family can improve engagement with therapy, ensure the completion of home-work assignments, and can even improve follow up. For an example see Box 3.

Capacity and circumstances (individual issues, systems of support and treatment, and pathways to care and help seeking behaviour)

Individual issues. Prior research has suggested that young, educated Pakistani men are more likely to engage in therapy (Naeem et al., 2010). Pakistani women are dependent on men to be brought to the hospitals. They also have to seek permission from the man in the house to seek help (Shaikh & Hatcher, 2005b). When working with female patients, it would therefore help to involve the accompanying man during the assessment and thereafter to talk to him on how the mental health of the woman can have a positive effect on the health of the family, and especially any children involved. Such inclusion also improves engagement.

Box 3. Family as a resource in therapy.

A depressed woman believed that her young son was under the magic spell of her daughter-in-law. Her son had married 6 month previously, and it had upset his mother to see that her son was paying more attention to his wife than to her. She concluded from this that her son was ignoring her because of the magic spell. She also believed that due to the magic she was also experiencing anxiety symptoms and sad mood. She began to feel depressed thinking that the change in her son's behaviour was due to a magic spell. Talking to family members was helpful because they did not share the woman's belief. The woman did not want to talk to the therapist about alternatives or even engage in therapy, as she was convinced that this was not going to change the effect of the magic. The therapist had a long conversation with the family in family therapy, and family members were encouraged to talk to the woman about the magic spell between sessions. The therapist advised the family on highlighting alternative explanations to her at home. This was very helpful, and on the next visit the woman was less distressed about magic and showed willingness to accept therapy for depression (although she continued to believe that magic was a possibility).

Health system related issues. In our study of patients with depression (Naeem et al., 2012) patients were unaware of any treatment except for antidepressant medication. Patients' and carers' awareness of resources, both human and financial, and the availability of the number of trained therapists, is vital here. Similarly, patients' knowledge of the health system, available treatments, and their likely outcomes are important factors in service utilization and engagement. It is possible that Pakistani patients referred by their general practitioners to mental health services do not expect any treatment other than medication (pills). A possible explanation for this might be that patients are not aware of psychological treatments when they come to a hospital.

Pathways to care and help seeking behaviour. The pathways to care and help-seeking behaviours are related to social systems, cultural and religious beliefs, and health systems (Shaikh & Hatcher, 2005b). Patients with psychosis are more likely to seek help from faith or spiritual healers (for example, the imam, a person who performs religious duties in a mosque, or pirs, practitioners of Sufism), while those with depression and anxiety often present with somatic complaints to traditional or non-traditional healing systems (for

example, to hakims, practitioners of old Greek or Chinese medicine; or homeopaths) (Naeem et al., 2012). Similar pathways have been reported for patients in India and Africa (Saravanan et al., 2007; Sorsdahl et al., 2010).

Cognitive errors and dysfunctional beliefs which are directly related to problem and its treatment

Dysfunctional beliefs and cognitive errors may vary from culture to culture (Padesky & Greenberger, 1995). Research on people from Turkey and Hong Kong, for example, provides evidence of such variations (Sahin & Sahin, 1992; Tam et al., 2007). Beliefs related to dependence on others, the need to please people close to you, the need to submit to the demands of loved ones, and sacrificing one's needs for the sake of family are common among Pakistanis. It is worth exploring family and other community members' beliefs to assess whether these are acceptable or whether these are dysfunctional beliefs.

II. Assessment and engagement

Assessment

Being aware of the factors described above can guide culturally sensitive assessment of Pakistani patients, and assessments should incorporate these variables. It is also important for the therapist to explore a Pakistani patient's beliefs about healing, which are underpinned by the patient's perception of aetiology, attitudes towards treatment, and health-seeking behaviour. For example, questions can be asked about what the patient/family thinks is the cause of the illness. If the therapist is not aware and respectful of the patient's beliefs about healing and his/her faith in other healing systems, the therapist might risk offending and losing the patient. It is possible that patients will not offer their views for fear of ridicule, so they could be questioned indirectly. For example, the therapist could ask what other people around the patient think about the cause of this illness. The therapist can also ask patients' opinions about spiritual and/or religious causes for symptoms (for example, whether the evil eye or sins are to blame).

The patient's/patient's family's expectations of the health system can be assessed. For example, questions could be asked about a patient's involvement with a healer outside the health system (including any faith healers, religious healers, hakims or homeopaths), and whether and how they were helped (including treatment regimens). The therapist should avoid criticizing patients if they are also engaging in practices recommended by a traditional or religious/faith healer (for example, reading verses from the holy Quran or drinking holy water) if the treatment does not seem to jeopardize the patient's health and safety. If the treatment is likely to harm the patient, the therapist should gently approach the topic by questioning whether the traditional therapy has worked thus far, and suggest trying a different intervention for a while.

Assessing beliefs about treatment and treatment providers can be very useful. Exploring a patient's beliefs about the best treatment and the healer can give an idea of the patient's expectations. This will also give the therapist some idea of how realistic the expectations are. For example, questions about who the patients believe can treat their illness, what the ideal treatment for their illness is, what they know about CBT, what they expect from CBT, and whether they have received any psychotherapy/CBT in the past, can provide important information and possible pathways for adapting CBT to best fit the patient.

Assessing dysfunctional beliefs is clearly a key component of CBT. Some of these beliefs might be shared by the family and may be culturally accepted. It is the degree, strength and extent of the beliefs that might need addressing. If unsure, discussing these beliefs with a family member or with a member of the Pakistani community might help the therapist to decide whether these are culturally accepted beliefs or not.

Assessing somatic concerns is also important. Many patients with anxiety or depressive illness present with physical complaints (Naeem, Sarhandi et al., 2014; Patel et al., 1998). Exploring patients' concerns about these symptoms helps with engagement. Exploration of stigma is an important part of the assessment, as it might be preventing patients or their family from seeking help. A patient with obsessional symptoms might present with depression and guilt because of obsessions which are religious in nature (e.g. obsessional thoughts related to God or the Prophet). It is also important to understand the patient's/patient's family's main concerns and address these (e.g. whether this illness might run in the family). At this stage therapists can also explore how the symptoms are seen, or even how the illness is seen in that particular culture, especially from ethical or religious points of view. Immediate relief can be provided by education and information about the problem. The therapist can ask further questions to explore how the symptoms and illnesses are usually dealt with in that community.

Structured assessment tools can be used to assess Pakistani patients. We have highlighted the importance of beliefs about illness and its treatment, and this can be assessed with the help of the Short Explanatory Model Interview (SEMI) (Lloyd et al., 1998). This interview explores the patient's cultural background, the nature of the presenting problem,

help-seeking behaviour, and interaction with the physician/healer and beliefs related to mental illness. Other commonly used instruments can be used in assessment. For example, the Dysfunctional Attitude Scale (DAS) (Weissman & Beck, 1978) can be used to assess dysfunctional beliefs, and in case of doubt can be used with family members or other members of the community to determine whether some of the dysfunctional beliefs are acceptable within this community.

Culturally relevant formulations. Treatment plans are based on an initial formulation, which can be shared with the patients and their family as the first step towards therapy. Discussion of treatment duration, course, and expected outcomes will then ensure engagement and compliance with therapy. A discussion should be conducted carefully and built on neutral ground, where the therapist initially does not strongly agree or strongly refute the patient's ideas of illness. This is a particularly useful strategy when dealing with patients who are convinced that their somatic symptoms are due to a physical illness or due to a religious or spiritual cause (Naeem, Sarhandi et al., 2014), demonstrating a 'biopsychospiritualsocial' approach to mental illness.

Engagement

Engagement and therapeutic alliance can be difficult when providing therapy to Pakistani patients (Naeem et al., 2010; Rathod et al., 2013). The first few sessions are vital in this context, and providing some relief can convince patients that the therapist is able to help and understand their problems. Initial focus on symptom management can be helpful. Other factors which were found to improve engagement are as follows.

Paying attention to non-verbal cues. Sometimes patients might not disagree openly with the therapist due to respect (although they might show their disagreement by not turning up for the next appointment). Therapists should therefore pay attention to the patient's body language, and subtle changes in language and expression.

Using examples from therapy as evidence. Patients like to know the therapist's success rate. While it is useful to describe evidence from research, providing stories of patients with similar problems who benefited from therapy might impress new patients more than research evidence.

Use of religious examples. Using examples from the Quran, the life of Prophet Muhammad and Muslim religious leaders (peace be upon him) can help therapists connect with the patient. These also have the clear advantage of conveying a concept in a language that is acceptable to religious patients. For examples see Box 4.

Food and gifts. It is normal to offer food or gifts to therapists. If the therapist is seeing a patient at home and the patient offers food, rejecting it might be considered rude.

Box 4. Religious verses that can be used in therapy.

- Surely Allah does not change the condition of a people until they change their own condition (Raad 13:11)
- O you who believe! If a liar comes to you with any news, verify it, lest you should harm people in ignorance, and afterwards you become regretful for what you have done (al-Hujuraat 49:6)
- The Prophet (pbuh) said 'Deliberation is from Allah and haste is from Satan' (Al-Silsilah al-Saheehah)
- The believer reserves judgement until the matter is proven (Al-Hasan al-Basri).
- The Prophet (pbuh) said 'It is enough lying for a man to speak of everything that he hears' (saheeh Muslim)
- Surely by Allah's remembrance are the hearts set at rest (Raad 13:28)
- Be sure we shall test you with something of fear and hunger, some loss in goods or lives or the fruits, but give glad tidings to the patient, who, when a calamity befalls them, say: Surely we are Allah's and to Him we shall surely return (Baqarah 155:156)
- The Prophet (pbuh) said 'Allah has forbidden you to disobey your mothers, to bury your daughters alive, to not pay the rights of others and to beg from others. And He dislikes gossip, asking too many questions, and wasting money' (al-Bukhaari)
- Worry is caused by thoughts not circumstances (Caliph Ali)
- Whoever believes and acts aright, they shall have no fear, nor shall they grieve (Anaam 6:48)
- Allah sets forth a parable that a goodly word is like a goodly tree, whose root is firmly fixed, and its branches are in the heaven, giving its fruit at all times by permission of its lord (Ibrahim 14: 24,25)
- Indeed, we created the human and know the whisperings of his soul, and we are closer to him than his life vein (Qaaf 50: 16).
- To you your religion and to me mine, and if they reject you, then say 'to me my deeds and to you your deeds and you are innocent of my accounts and I am innocent of yours' (*Al-Qur'an*10:41); For us our deeds and for you your deeds (*Al-Qur'an* 28:55)
- And we alternate such days between the people (Aal-e-Imran 3:140).
- So indeed, hardship is followed by ease, indeed, hardship is followed by ease (Inshirah 94: 5–6).
- They asked the Prophet (pbuh), should we make use of treatment? He replied: 'Make use of treatment, for God has not created an illness without appointing a remedy for it, with the exception of one illness, namely old age.'
- The Prophet (pbuh) saw a man leaving his camel untied next to a post. The Prophet (pbuh) asked, 'Why don't you tie up your camel?' The man replied, 'I put my trust in God.' The Prophet (pbuh) said, 'Tie your camel, then put your trust in God.'

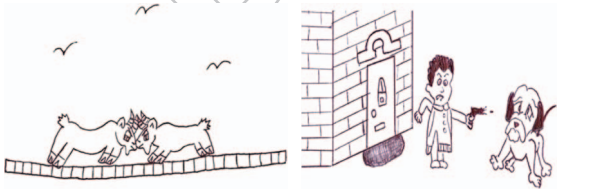
Use of terminology. Be careful with terminology and jargon. Use common language whenever possible (e.g. 'unhelpful ways of thinking' rather than 'negative thinking' and, 'it is a type of treatment in which you will learn techniques to help you with your problem' instead of 'talking therapy').

Using the family as a resource. The family can be a cause of conflict and stress as well as a valuable resource to help and support patients. Involving the family in a tactful manner, with consideration of boundaries, can enhance engagement. The family can especially assist in information gathering, therapy (by being a 'co-therapist'), supporting the patients, and bringing the patients back for follow-up.

III. Adjustments in therapy: process and techniques

Once therapy begins, adjustments can be made along the way. We have stressed the importance of using culturally acceptable idioms of distress. Experienced healers from this cultural background use stories and images to convey their messages. Stories can be highly successful in activating change (Naeem, Gul et al., 2015). Stories are especially useful when used along with the images provided in the self-help reading materials (Naeem et al., 2013) see Figs 3 and 4.

Style of therapy. A more directive counselling style might be preferable to a collaborative approach. The Asian model of spiritual healing is a saint or a guru who gives sermons, as opposed to teaching through a 'Socratic dialogue' that is preferred in individualistic cultures. Socratic dialogue and 'downward arrow' techniques are particularly difficult to use with this group. Patients feel uncomfortable if Socratic dialogue is used without sufficient preparation. Our impression is that patients try to give the 'right answer' to such questions, rather than the response they truly wish to give. It is better to avoid questions like 'What do you think about this treatment?' or 'Which treatment or strategy is best for you?'. Patients expect the therapist to provide answers rather than ask questions. Therefore patients can have serious doubts about the therapist's competence if the therapist is perceived as attempting to get answers from them that the therapist does not know. Once rapport and competence have been established the therapist can move on to a collaborative style after teaching patients about it.



Conflict management	Jumping to conclusions
Two quarrelsome goats fall from a one-lane bridge, because each tries to be the one crossing it. Two other intelligent goats cross it safely, because one sits down while the other jumps over it, demonstrating flexibility and the 'give and take' principle	A hunter kills his dog because it is covered in blood when it returns home one day. The hunter later discovers that the dog was trying to protect the family from a bear

Fig. 3. Use of images in hand-outs and self-help materials.

Focus of therapy. It is important to addresses patients' presenting concerns – for example, their physical symptoms – instead of conducting therapy in a mechanical manner. CA-CBT places great emphasis on structuring sessions around the patients' needs. It is the responsibility of the therapist to address the patients' concerns, engage them, and move on to therapeutic issues which the therapist believes 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 the therapist's concern (depressive illness, anxiety, or suicidal thoughts) and promotes the therapy agenda. See Box 5 for an example.

Homework. As with patients in other cultures, noncompliance with homework tasks can be a major hurdle in therapy with Pakistani patients. The therapist should focus on homework in particular. A major aspect of traditional CBT involves reading informational material or writing for various homework assignments. For Pakistani patients, less use of writing, regular reminders, and involving the family can be useful. Similarly, the use of beads, counters, audio recorders, and MP3 players (for example by providing audio tapes of the session or even bibliographic material) can be helpful in increasing homework compliance. Beads and counters are commonly used in this group for repeating religious verses or words and therefore can be used to count thoughts. In those with a religious inclination, time-keeping can be maintained through prayer times.

Similar to patients in other cultures, Pakistani patients might find it difficult to distinguish between thoughts and emotions. Therapists in our project started by helping patients to identify thoughts and emotions, and provided examples to elicit these (Naeem, Gul et al., 2015; Naeem, Saeed et al., 2015). Patients found meditation and mindfulness exercises especially useful to help them recognize their thoughts and emotions. Therapists in our project used physical symptoms in thought diaries to help patients to

Angles of view (a commonly used expression in Pakistan to express multiple perspectives)

There is a famous fable in India and Pakistan about six blind men who went to see an elephant, to understand it. We use this to introduce the basic concept of CBT to patients.

According to the tale, the first man touched the side and said, 'The elephant is like a wall,' the second touched the tusk and said 'The elephant is like a spear,' the third who touched the trunk said 'The elephant is like a snake,' the fourth touched the animal's leg and said 'The elephant is like a tree,' the fifth touched the ear and said 'The elephant is like a fan,' and the sixth man who touched the elephant's tail shouted 'Ah! The elephant is like a rope.' They argued with each other for a long time as to what an elephant looks like. They were all looking at the elephant using a particular angle or point of view. We do this often in our lives. We look at only one aspect of an object, ignoring the full picture and not recognizing that we can look at the same thing using different points of view.

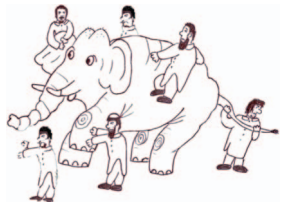


Fig. 4. Use of stories and images in therapy.

establish the link between thoughts, emotions and physical symptoms (Naeem, Gul et al., 2015) .

Patients find behavioural techniques (behavioural activation, experiments) and problem solving particularly easy to use. Use of behavioural activation is an effective strategy at the start of the therapy. Behavioural experiments can be used even for less educated patients, with effective results. Problem solving can be used without any changes or adjustments to the CBT protocol, and is especially useful for Pakistani patients, where depression has been found to be associated with social and financial difficulties. Thus problem-solving could focus on those difficulties, which can bring both social and psychological relief to patients.

Box 5. Use of locally accepted techniques in therapy.

Mrs K presented with headaches. She had symptoms of both anxiety and depression. She was angry because her doctor was not interested in her headache and had not even examined her. The first session therefore focused on the assessment of the headache. Mrs. K was convinced that the headache was due to physical reasons, and that she should be medically examined. We arranged for her to be examined by a physician using a behavioural experiment approach. Mrs K found this reassuring. She was then advised to use breathing exercises and muscle relaxation to help with anxiety, following psycho-education that involved establishing a link between anxiety and somatic symptoms. Mrs K asked whether Indian head massage might be useful. The therapist stated that it was a very good idea, and further advised the use of an extended head massage, to include massage of the head, neck, and shoulders. When the patient returned next week, she reported some recovery. The therapist further educated the patient on anxiety and depression, describing her symptoms and using her positive response to the relaxation exercises as evidence that her headache might be due to anxiety and not a physical illness. The patient was then happy to engage more fully in therapy.

Although meditation and mindfulness were used effectively in our work, caution is recommended with these techniques. Some of these techniques (e.g. yoga) are based in non-Muslim religions, and some patients might not feel comfortable if they realize this. An alternative might be the use of Sufism-based techniques (e.g. meditation, breathing and awareness exercises and Quranic recitation). However, prescription of these techniques requires religious or spiritual legitimacy. Permission from a senior Sufi is required to prescribe and to perform many Sufi practices in India and Pakistan. These practices are then performed under supervision of the senior Sufi.

Structural factors in therapy. Patients feel more comfortable if they are informed of the number of sessions at the start of the therapy and the nature of the sessions. This is also vitally helpful because therapy often has financial implications for the patient (e.g. travel costs or days missed from work). When a patient has an acute problem he/she might insist on seeing the therapist twice or more during a week. Starting therapy as an inpatient might also improve engagement.

Limitations

This paper describes principles of adaptation specifically for cognitive behaviour therapy; the

adaptations might not be applicable to other therapies. Additionally, we do not provide the specific circumstances under which specific techniques would be most effective. For example, while Socratic methods may be less effective in asking a patient questions about the current therapy (CBT), it may work in helping patients to try CBT as an alternative or supplement to their current 'therapy' (such as prayer or seeing a faith healer). Further, we acknowledge that although developing new interventions for a specific ethnic group is desirable, in practice it may not be feasible to develop a different form of CBT for every cultural group and subgroup within them. Every cultural group and subgroup has its own unique qualities and should not be considered homogenous. We also did not examine the cost-effectiveness of cultural adaptation and culturally adapted therapy.

Conclusions

The study of the application of psychotherapy across cultures (ethno-psychotherapy or ethno-CBT in this context) is an emerging field. CBT can be easily adapted for different ethnic minority groups in HPI cultures and for local populations in collectivistic cultures. As we have stated before, to develop therapies appropriate to a patient's needs, cultural adaptation of CBT in this context implies systematic changes in CBT for a group that has different cultural, ethnic, and/or religious values from those of HPI groups for whom CBT was originally developed. The focus of adaptation is on aspects such as its delivery and modification of techniques. However, this does not alter the theoretical underpinning of CBT. CBT does involve some adjustment in techniques when adapted for Pakistani patients. The process of adaptation can be accomplished using the series of steps discussed above. The adaptation process should focus on increased awareness of cultural factors, improving assessment and engagement, and adjusting therapy by focusing on the patient's concerns and then connecting those concerns to the therapeutic goals of CA-CBT. More systematic research on these processes is needed, such that the adaptation methodology can be further refined and standardized.

Future studies should focus on testing culturally adapted therapies in larger RCTs, and on making these therapies available in low-resource contexts. These therapies should also be compared with standard therapies. Cost-effectiveness is an important aspect when considering therapies in low- and middle-income countries, and future trials should consider these aspects of the therapy. Finally, cultural adaptation of therapies is just the starting point of making therapies accessible to patients from non-HPI cultures. Future research should address other barriers to therapy, such as low access to treatment facilities (due to lack of sufficient numbers of facilities, distance to the facility, and/or lack of transport), and the patient's ability to read and write.

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