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Pakistani Psychologists' Experiences with Cognitive Behavior Therapy of Obsessive Compulsive Disorder

Kiran Ishfaq, Farah Malik & Iffat Batool
Department of Psychology
GC University, Lahore.

The purpose of this study was to explore experiences of clinical psychologists of Pakistan with Cognitive Behavior Therapy (CBT) in dealing with patients of Obsessive Compulsive Disorder (OCD), and to incorporate their recommendations in indigenous therapeutic protocol of CBT for OCD patients of Pakistan. For this purpose, in depth semi-structured one to one interviews, of one hour duration on an average, were conducted with five professionally trained clinical psychologists working in public and private sectors. These recorded interviews were analyzed employing thematic analysis to recognize and understand the answers of inquiry questions. To ensure rigor in research, different validation strategies were employed. Study results revealed that CBT professionals of Pakistan are following the western trends of CBT with slight modifications according to the cultural, religious and educational aspects of patients thus acknowledging the role of culture, religion and personal aspects in phenomenology, thought pattern and CBT management of individual OCD patients. This study, by motivating researchers to study effectiveness of CBT in our culture, is hopefully opening the path towards the bright future of CBT as an effective therapeutic approach in Pakistan.

Keywords: Pakistan, CBT, OCD, Psychologists, Experiences, Indigenous

Cognitive-Behavior therapy, an evidence-based and very popular approach to psychotherapy, has established its individual and group setting efficacy in number of psychiatric disorders in western society (Hodges & Oei, 2006), and especially for treating anxiety disorders, in developed countries (Hofmann, Asnaani, Vonk, Sawyer &Fang, 2012). For Obsessive Compulsive Disorder (OCD), formerly categorized as an anxiety disorder (APA, 2000) but now has a distinct classification with life time prevalence of 1.1% to 1.8% across the world (APA, 2013). CBT is considered an effective treatment approach which help individuals to manage their anxiety associated with obsessions and compulsions, and to change their dysfunctional beliefs related to obsessions (Overholser,1999). CBT, after incorporating ERP in its treatment protocol for OCD patients is rated as the most effective treatment for the management and relapse prevention of OCD (Clark, 2000), and is now considered treatment of choice for it (Expert Consensus Guidelines; Fances, Docherty, & Kahn, 1997; as cited in Whiteside & Abramowtiz, 2006).

Since late 70's different CBT therapists came forward with their CBT protocols based on different theoretical models of CBT for OCD management. Among those Beck's model (1992) of logical persuasion, Salkovskis's model of over-responsibility of controlling harm and thoughts, and Wells (2008) meta-cognitive model is worth mentioning. These CBT professionals have put forward standardized therapeutic protocols based on CBT along with different assessment tools specifically devised on CBT model and are useful in eliciting dysfunctional thoughts and underlying beliefs (Wells, 2008).

Correspondence concerning this article should be addressed to Kiran Ishfaq, Department of Psychiatry, Jinnah Hospital, Lahore. E-mail: kiranishfaq@gmail.com

The studies conducting CBT with reference to its effectiveness on OCD can be divided into five types mainly which are: (a) studies conducted on assessment measures based on CBT model of OCD, (b) outcome studies based on individual sessions and based on group sessions, (c) single case studies, (d) comparative studies with medication and Behavior therapy, and (f) meta-analysis of outcome studies of OCD.

Studies conducted on the assessment measures based on CBT model of OCD validated the CBT conceptualization of OCD (Salkovskis, 2000; Foa, Amir, Bogert, Molnar, & Przeworski ,2001; Ghassemzadeh, Bolhari, Birask, & Salavati, 2005; Woods & Rubeck, n.d.; Calmes & Roberts, 2007; Tolin, Worhunsky, Brady, & Maltby, 2007). These studies supported the CBT model of OCD by assessing the validity of measures based on this model (underlying beliefs of OCD). On the basis of these studies it can be assumed that CBT's explanation of phenomenon of OCD is valid which further predicts CBT effectiveness in OCD treatment and that recent cognitive-behavioral models are promising approaches and are helpful in conceptualizing OCD (Clarke, 2013; Salkovskis et, al 2000; as cited in Taylor, McKay, & Abramowitz, 2005). While efficacy studies of CBT based on individual sessions conducted by different researchers (Warren & Thomas, 2001; Benazon, Agar, & Rosenberg, 2002; Tundo, Salvati, Busto, Di Spingo & Falcini, 2007), studies conducted in group settings (Bouvard, 2002; Halford, Bernoth-Doolan & Eadie, 2002; Ghassemzadeh, Bolhari, Birask, & Salavati, 2005), and various single case studies (Abramowtiz, 2002; Rosqvist, Thomas, Egan, & Haney, 2002; van Oppen, 2004; Fernandez, Storch, Lewin, Murphy, & Geffken, 2006; Michel, 2006; Whiteside & Abramowtiz, 2006; Albano & KleinTasman, 2007) indicated significant symptom reduction among OCD patients with effect size ranging from 1.65 to 2.70. Meta-analysis of efficacy studies also indicated towards significant effect size (ES=1.45) even more than effect size (ES= .45) of pharmacotherapy (Hofmann & Smith, 2008; Watson & Rees, 2008). Comparative studies of CBT with medication (March, 2004) and Behavior therapy (Bouvard, 2002) also indicated superior efficacy of CBT

(incorporating Exposure & Response Prevention) over medication and Behavior Therapy as far as effect on associated features (anxiety & depression) and relapse prevention were concerned.

Conclusively, available literature proved that CBT is effective for the management of OCD regardless of the age and intellectual capabilities of the subject (Pence Jr, Aldea, Sulkowski, & Storch, 2011). In group settings, CBT was found to be equally effective (Bouvard, 2002; Halford, Bernoth-Doolan, & Eadie, 2002) when combined with individual therapy. These Studies also provided strong evidence for the use of CBT as first choice psychological treatment for OCD it deals not only with obsessions and compulsions directly through ERP but also provides relapse prevention by letting the patient to manage his/her anxiety and to change cognitive distortions into positive, healthy realistic beliefs and ideas.

Despite being so popular in terms of its use and efficacy in developed countries, CBT has limited research data available on population of developing countries, although this lack of research support could not stop CBT popularity in developed countries (Abstracts of first Asian Cognitive Behavior Therapy conference, 2006; as cited in Hodges & Oei, 2006). And efforts are being made to determine CBT efficacy in these countries by validating the CBT theoretical assumptions related to OCD, efficacy in individual and group settings, single case studies, and also the comparative efficacy with pharmacotherapy and other modalities of treatment. Ghassemzadeh, Bolhari, Birask and Salavati (2005) found the Salkovskis's model (2000) valid for the population in Iran. In Turkey, the validity and specificity of cognitive factors and model of CBT for OCD was supported by research findings (Yorulmaz, Karanci, Bastug, Kisa, and Goka, 2008). Alizadeh (2012) claimed CBT to be quite effective in an experimental study with OCD patients of Iran , but in Japan, the efficacy of CBT in RCTs was found to be quite low as compare to western data (Ono, Furukawa, Shimizu, Okamoto, Nakagawa, Fujisawa, & Nakajima, 2011). Considering the role of religion in developing societies and its relationship with OCD, some studies have focused on this aspect too. In Italy, the religiosity was found to be an important factor in phenomenology of OCD and there was found to be positive correlation among degree of religiosity and different cognitive distortions commonly present in OCD patients according CBT (Sica, Novara & Sanavio, 2002). Yorulmaz (2007) in his cross cultural comparison of OCD symptoms and vulnerability factors found religiousness as only significant factor in symptom presentation of OCD. Like other developing countries, in Pakistan, CBT is gaining popularity and in response to it, studies are being conducted in determining its efficacy with different psychiatric disorders. Despite showing good effectiveness of CBT, the data available is quite limited and cannot be generalized because all these studies are rather single case or small-n study designs (Khan & Kausar, 2005;Khan & Malik, 2005; Rehman & Mohsin, 2000;Rehman & Sadiq, 1999; Farooqi, Saleem, & Syed,1999). Considering the need to explore the CBT status in Pakistan, a qualitative study was conducted by Naeem, Gobbi, Ayub, and Kingdon (2010) in which in depth interviews were conducted with working professionally trained clinical psychologists in government set up of Pakistani hospitals to explore their experiences with and adaptations in CBT application with Pakistani population. The study results indicated the need to adapt CBT according to cultural and religious practices and beliefs, and need to expand the research data in this area.

All psychotherapies deal with humans and effect of culture, society, and religion on human mind and personality cannot be denied. To gain good efficacy, psychotherapy has to incorporate cultural aspects in its techniques, and CBT is not an exception. Cognitive Behavior therapy (CBT) claimed to be effective cross culturally on the basis of its adaptability according to individual needs (Hays, 1995). But on the other hand, it is a fact that CBT was developed in western society where certain culture specific values such as assertiveness, independence and individuality are entertained while these values are not much valued in eastern and developing societies (Hays, 1995). This value difference needs CBT to be adapted according to cultural needs of eastern and developing societies (Iwmasa, 1993; Laungani, 2004). Like other cultures, the need to amend CBT techniques according to Pakistani patients' cultural and religious beliefs and practices is very much crucial if professionals want to attain good efficacy of CBT with their patients. And this the very purpose of present study to explore the professionals' experiences with CBT in dealing OCD patients and to incorporate certain adaptations in pre-existing western models of CBT with OCD, on the basis of their views and experiences.

Method

The present study was based on qualitative paradigm, which best suits the purpose, to explore and discover the experiences and opinions of relevant professionals in using CBT with patients of Obsessive Compulsive Disorder (OCD) in Pakistan (Cresswell, 1994).

Objectives

1. To discover the adaptations opted by Pakistani professionals and problems faced by them in applying Cognitive Behavior Therapy (CBT).

Inquiry Question:
Are there any adaptations opted by clinical psychologists of Pakistan in using CBT for adult OCD patients?

Secondary Questions:

- Did Pakistani psychologists find CBT to be effective with adult OCD patients of Pakistan?
- What is the variety of techniques commonly used for the purpose?
- Do Pakistani psychologists follow any specific philosophy of life, other than western views, in case conceptualization and using Cognitive Restructuring for Pakistani patients?
- What types of problems and complications are being faced by professionals in applying CBT for the purpose? Are there any solutions to these problems?

Table 1
Sample Characteristics

Sr. No	Gender	Age (year)	Qualification	Client Type	Setting Public/ Private	Formal Training in CBT	Experience duration with CBT	Average time experience with CBT/day
1	Female	45	ADCP; PhD	Adult	Both	Yes	12 years	4-5hrs
2	Female	42	ADCP; PhD	Adult	Private	Yes	8 years	3hrs
3	Female	33	ADCP; MS	Adult	Public	Yes	5years	4hrs
4	Female	35	ADCP; MS	Adult	Both	Yes	5 years	4hrs
5	Female	46	ADCP; PhD	Adult	Both	Yes	12 years	4-5hrs

Participants

The sample was comprised five professional, trained, working clinical psychologists of Lahore, Pakistan, selected through Convenience sampling of non probability type, which involves selection of participants on the basis of their willingness and availability (Cresswell,1994).

The professionally qualified, trained clinical psychologists having minimum qualification of MS in clinical psychology and formal training in CBT with at least five years work experience in adult psychiatric setting and at least five years' experience of CBT, and willing to participate in this study were taken in sample of current study.

The exclusion criteria was clinical psychologist less qualified than MS in clinical psychology, without any formal training in CBT, work and CBT experience in adult psychiatric setting less than five years, and those who are not willing to participate in this study.

The sample of five professionally qualified, trained clinical psychologists consisted of all females with age ranges from 33 to 45. Among them, three were PhD in clinical psychology while two were M Phil. in Clinical Psychology and all had professional training course degrees in clinical psychology (ADCP) and formal training in CBT. Three professionals had experience of employing their knowledge and skills in public as well as private sector while one was working in public and one was only in private sector. All had been practically and professionally involved in dealing with adult psychiatric population only, while duration of their experience in conducting CBT ranged from 5 to 12 years. During their practice, they had been involved with CBT on an average of 3-5 hrs/day.

Instrumentation

The semi-structured in-depth interview was used as data collection method because it gives clear and vivid description of participants' views about research query. The interview protocol of this study comprised of 10 semi structured main questions and several probing questions based on areas related to topic under consideration. The questions were done from general to specific pattern and for that "funneling" technique was used.

The areas explored in interviews were introduction (bio data), personal Experience with CBT, Assessment in CBT, Models of CBT for OCD, Therapeutic trends and approaches and problems faced by professionals in conducting CBT with OCD patients, and their solutions.

Procedure

In current study, the in-depth interview protocol, devised by researcher based on inquiry questions to attain the objective of this study, was conducted on one-on-one basis in exclusive environment with sample. The interview sessions were recorded after taking formal written consent of participants after informing them purpose of study. They were ensured that their identities would not be disclosed. The duration of these interviews were one and half hour on an average. Whole data was collected in audio recording form. Before taking interviews, the consent was taken by participants after informing them about purpose and procedure of present research. The interviews were conducted at work places of participants to let them feel comfortable.

Data Analysis.

For data analysis, the thematic analysis approach was adapted that was appropriate to the objective of this research because in this research it was needed to identify and analyze common patterns of views and opinions so that inquiry questions could be answered (Braun & Clarke, 2013).

These recorded interviews were primarily listened one by one by first author and important ideas and views were noted down. Then to ensure the credibility of data analysis, each interview was listened repeatedly and notes were taken accordingly. Then this transcribed data of all interviews was analyzed together to extract themes which are common patterns of thoughts, views, opinions related with inquiry questions (Braun & Clarke, 2013). Then, this analysis was shared with other two authors along with original data and analysis was evaluated. After that, data was compiled in thematic pattern and results were reported to make data meaningful. These results were shared with participants (member checking) to improve credibility of findings (Fereday & Muir-Cochrane, 2006). To obtain transferability of results, the thick description of data was used in reporting the results (Braun & Clarke, 2013.). To ensure the confirmability, the triangulation technique was used. For dependability of results, the analysis was sent for peer review to three professionally qualified, trained clinical psychologists having degree of MS in clinical psychology and research experience (Braun & Clarke, 2013). In short, to make this study credible and rigor, different validation strategies were used.

Results

The current study's results revealed the following

Personal experience with CBT

In this section, the opinion and experience of professionals regarding CBT was explored.

Most preferred approach.

The interviewees have found CBT the most frequently used and effective therapeutic approach during their clinical practice as interviewee 3 said, "I think from the day I have started practicing in my clinic, I found CBT to be my first choice and I think if I have this, I don't need any other approach to be used". And in opinion of interviewee 5, "In start of my practice I did use other therapeutic approaches for OCD but now with experience I think CBT best explains OCD and most effective in its management".

Assessment in CBT

The area of assessment in CBT was explored in this section. The detailed probing was conducted on preferred modes of assessment, problems faced in assessment procedures and their solutions.

Assessment is integral.

Like western trends, the professionals here consider assessment as an integral and fundamental part of therapy and do conduct detailed assessment to proceed in therapy. The overall trend was found to be similar to classic style of CBT in which first two sessions are based on assessment and case formulation. Its importance for CBT professionals of Pakistan can be highlighted by these words.

"I do spend at least initial 2 sessions to collect complete information required to formulate case and plan therapy" (Interviewee 5).

"For me assessment is a must". (Interviewee 1)

Formal tests are not in common practice.

The use of formal tests of CBT are not in frequent practice of professionals but they feel more comfortable in using Dysfunctional Thought Record Form (DTR), Behavioral tests, and interview to gain required information regarding symptoms description, cognitive biases and to do the case formulation.

"Frankly speaking I don't use formal tests in CBT but my main assessment tools are interview, DTR, and sometimes behavioral tests". (Interviewee 1)

The reason of not using much formal tests was turned out to be trend of Pakistani patients to be more comfortable and relaxed with interview probing. Besides that, most of patients in public sector were reported to be less educated while being devised on Western population the formal tests were believed to be providing less information than interview itself.

Interview as main tool.

The interview was found to be most preferred and useful tool for assessment purpose by all professionals.

"In my experience I think tests constructed on western population are not much useful for our population. I rather focus on detailed, in depth interview for probing and identifying thoughts, cognitive distortions, schemas and this helps me more in conceptualizing idiosyncratic case formulation of my patients". (Interviewee 4).

Behavioral Tests as alternative for illiterates' assessment.

Doing assessment with illiterate patients is found to be a bit more difficult and complicated but professionals resolved this problem by using interview, behavioral experiments, and co-therapist for the purpose.

"With illiterate patients, behavioral tests are much useful" (interviewee 4)

CBT Model

Living in an entirely different socio-cultural setup, researcher had a very pertinent question to be raised that if there is any needs to develop new model of CBT for Pakistani population. This question was mainly addressed in this section along with exploring any preferred model of CBT for OCD used by interviewees.

No need to develop indigenous model.

According to interviewees, there is no natively formulated model of CBT available for Pakistani population neither they feel its need.

"I don't feel any difficulty using already available western based models like Salkovskis's model which is my preferred one for OCD patients". (Interviewee 5)

Even the cognitive distortions, schemas, maladaptive belief patterns were found to be identical so interviewees felt no need to innovate new model.

"If we talk about perfectionism, over responsibility, thought-action fusion, over moralistic attitude, and dichotomous thinking, these all are present in our OCD patient population." Interviewee 3)

Role of Religion in Belief Patterns

On inquiry about role of social, cultural and religious impact over belief patterns and symptomatic presentation of OCD patients, professionals affirm the role of religion in establishing harsh, strict pattern of thinking but they also think that these ideas do exist in West as well and we can just modify them to fit in our cultural set up.

"If our patients are religious and do follow strict moral standards for cleanliness, etc, so is same for catholic Christians. These "paki napaki" obsessions and compulsions do exist there too, may be with different terms."(Interviewee 4)

"They too have certain social cultural, moral and religious beliefs affecting their thinking patterns such as over responsibility, perfectionism, while these kinds of thinking patterns do prevail here". (Interviewee 2)

Need to incorporate socio-cultural-religious beliefs in pre-existing CBT models.

They also expressed the need to incorporate these belief patterns according to our patients' experiences and beliefs. They also stressed to consider the patients' moral and ethical views, concept of God and authority figures during case formulation. The interviewees have common idea of integrating religious aspects such as concept of God & authority into Schema about others and morality views in schema about self.

"In my experience I think with slight modifications, our patients' beliefs do fit in already identified cognitive distortions". (Interviewee 1)

"For me the patients' overall religious attitude especially concept of God and of parents play important role in developing their moral, perfectionist, over responsibility beliefs". (Interviewee 4)

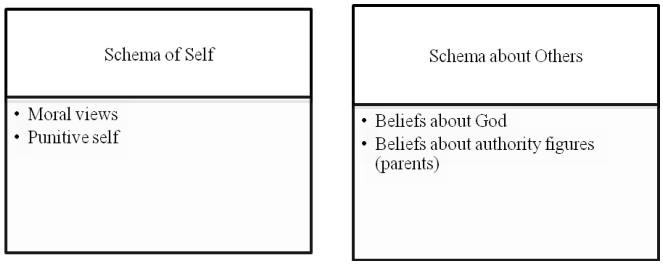


Figure. 1 Indicating Extracted Themes of Schemas

Need to incorporate all pre-existing CBT models of CBT

The need to incorporate different already existing CBT model for OCD in to 1 model and selection of appropriate model for each patient has been emerged from interviewees'' ideas.

"I don't follow only 1 model but do add other models if need. Although my preferred one is David Clark's model". (Interviewee 1)

"I do use Beck's model quite often but for situation-specific formulation, I do use well's". (Interviewee 4)

On the whole, it can be concluded that no major alterations in pre-existing CBT models of OCD are needed but incorporating schemas related to God and authority figures (parents), can improve case conceptualization for our patients.

Therapeutic Process

The therapeutic process like its stages, session format, effective and ineffective techniques were explored in this section.

Socialization is must.

Professionals in Pakistan do consider psycho-education a very useful tool to engage patient in therapy, to improve patients' compliance and motivation, and a technique to deal with their myths, misperceptions regarding illness and CBT.

They use written, verbal, sometimes recorded material based on list of cognitive distortions with examples, idiosyncratic case conceptualization, ways to do cognitive restructuring, etc.

"I focus much on socialization because I believe it is essential for therapeutic prognosis by improving patients' compliance, motivation and comprehension of CBT principles". (Interviewee 1)

"I do give complete case formulation in template form, use patients' self experiences, symptoms, thoughts as examples to give patients' complete understanding of their case". (Interviewee 2)

The significance and importance of socialisation in Pakistani professionals' view and their ways to modify it according to patients' needs can be understood by these words:

"I do always give written material to my patients even if they are illiterate, I do manage their family members to read it for them". (Interviewee 5)

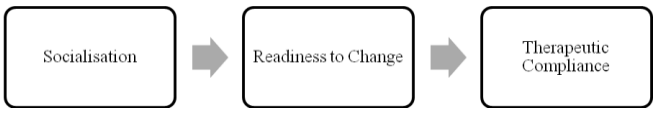


Figure 2 Focusing Importance of Socialisation

Pre-existing socialisation pattern is preferred.

All interviewees stressed upon BC connection, CBT's educational, collaborative empirical nature, importance of homework assignments, and role and ways of cognitive restructuring, role of patients' motivation, compliance and readiness to change, in their styles of socialisation. They also use translated material adapted from different books, online articles on the topic for socialisation of their patients on CBT.

Importance of Readiness to Change in compliance.

A very important factor in prognosis was identified during interviews and that was "establishing readiness to change" in patients.

"I always focus in my initial sessions to work on addressing patients' myths, misperceptions, fears, apprehension regarding illness and treatment itself. Because in my view, if we become successful in engaging patient in therapy and motivate him for change, we can improve the prognosis a lot." (Interviewee 1)

The professionals stressed upon working on motivation and readiness to change in initial therapeutic sessions because in their view it accelerates prognosis and prevents drop outs as well as relapse.

"If we don't work on motivating patients to engage in therapy they don't work on changing their beliefs enthusiastically, even not share these beliefs, and chances of poor prognosis, relapse or even drop outs increase". (Interviewee 4)

"Intrinsic motivation is necessary for prognosis and working on it through addressing patients' myths."(Interviewee 1)

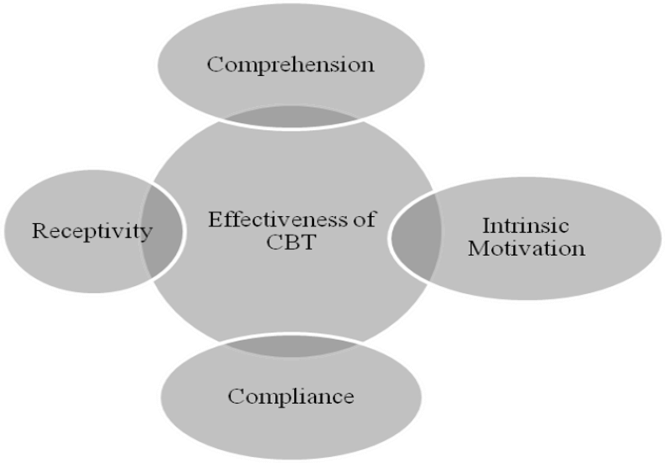


Figure. 3 Indicating Extracted Factors of Effectiveness of CBT

Simultaneous implementation of cognitive and behavioral reattribution techniques.

The majority opines that it is more effective if we do start cognitive as well as behavioral techniques simultaneously but focus of behavioral techniques should be strictly changing maladaptive beliefs.

"I found it more effective when for one belief I do use cognitive restructuring and behavioral techniques simultaneously and for that I divide my session into two parts". (Interviewee 2)

"For severe intensity of OCD or prominent compulsions, I do prefer behavioral attribution techniques first and then cognitive or verbal reattribution, but if severity is moderate, I use cognitive techniques first. Actually it all depends upon illness severity, patients' comprehension level and clinical insight". (Interviewee 5)

Use of religious philosophy in Cognitive Restructuring.

Admitting the role of religion in belief formation, professionals affirmed the use of religious philosophy and teachings in process of cognitive restructuring.

"Yes, I do use hadith, aayat as examples to restructure dysfunctional beliefs especially associated with perfectionism, contamination and blasphemy" (Interviewee 2)

*Western pattern of session duration and number is followed.*A consensus was present in duration of sessions (1 hour) and average

number of sessions (14-16) as commonly practiced in west (Wells, 1997).

"My therapeutic sessions are of around 1 hour duration in my opinion, as far as my experience concern, around 14-16 therapeutic sessions we do achieve around 75% improvement". (Interviewee 3)

Termination criterion is 70% improvement.

The termination of therapy was considered to be based on patient's response and his family feedback, his functionality level, and clinician's assessment. Roughly professionals think that around 70% improvement is enough to terminate therapy and go for booster and follow up sessions.

"On an average 70% improvement is satisfactory, after that I focus on follow up sessions." (Interviewee 1)

Therapy termination is based on multiple factors.

In deciding termination of therapy, not only clinician's opinion but patient's and his family feedback and response are considered.

"Termination of therapy is based on patient's functionality and patient's as well as his family feedback, and obviously my own judgment too." (Interviewee 2)

Relapse prevention and booster sessions are in practice.

All professionals have acknowledged the importance of relapse prevention and booster sessions in long term efficacy of CBT. Their responses indicated that they do focus on conducting relapse prevention sessions, do give therapy blue prints, relevant session notes and reading material before terminating the therapy.

"Personally I do like the CBT concept of relapse prevention and therapy blue print. I always give my patients therapy blue print in written form and I feel they become more confidants of their learned skills in therapy". (Interviewee 1)

"I do conduct booster sessions and also the last two or three sessions of my therapy always based on relapse prevention". (Interviewee 3)

"For me relapse prevention sessions should be focused a lot. I use different techniques based on educational style, Socratic dialogue. I do ask them to make management plan of some hypothetical OCD case, I ask them to advise so imaginary friend having same OCD symptoms or having relapse signs, etc, to maintain cognitive change occurred in effect of CBT". (Interviewee 4)

Effective and Ineffective Techniques

The more and less effective techniques of CBT with OCD patients of Pakistan were identified in interviewing professionals. Professionals do stressed upon certain techniques they have found more effective for their OCD patients than others.

Behavioral Reattribution is much effective.

The Behavioral reattribution techniques were found much effective for majority of OCD patients as they told:

"I do conduct behavioral exposures, obviously focusing on challenging cognitive distortions by using behavioral methods such as Exposure, Survey, and Modeling."(Interviewee 1)

"For my resistant, defensive, less educated or with predominant compulsive symptoms, behavioral experiment technique of CBT has been better in terms of effectiveness". (Interviewee 4)

Detached Mindfulness for Obsessions.

To deal with obsessions, professionals found detached mindfulness quite effective technique.

"Detached mindfulness is a good enough technique, and better substitute of thought stopping and distractions, to manage obsessions, at least before starting cognitive restructuring, to give patient immediate relief from obsessions". (Interviewee 4)

Cognitive restructuring is most effective technique of CBT.

Western CBT professionals do consider cognitive restructuring as a most effective technique of CBT (Clark, 2004), and same is the ideas of Pakistani professionals. They do stressed upon extensive focus on using cognitive restructuring as main technique to deal with core beliefs, interpretations of obsessive thoughts, images, impulses, and compulsions, and maladaptive assumptions.

"As far as my most preferred technique of CBT for OCD, my choice will always be cognitive restructuring because it enables our patients to finally face, challenge and change maladaptive interpretations of obsessions and compulsions. Without it I can't even think of CBT." "Yes definitely I consider it the most effective technique to manage OCD". (Interviewee 1)

"Most effective technique is cognitive restructuring and I do use it as in CBT books like DTR, double, triple columns, defense attorney, role reversal, distancing, and even humor". (Interviewee 3)

Imagery limited to management of obsessional images.

Imagery techniques such as "Turn off imagery", "Finish out imagery", "Mastery imagery", etc are used by cognitive behavior therapist to deal with obsessional images (Beck, 1985). On question regarding its effectiveness for Pakistani OCD patients there was a mixed opinion by professionals.

"I think imagery techniques have no value at all in OCD management. In my practice of so many years I have never used them". (Interviewee 3)

"Yes off course, I use "finish out imagery", "turn off imagery" and other forms to deal with images in OCD, and I found it effective to some extent. But even using it, I focus more on altering patients' interpretations of those impulses". (Interviewee 1)

Relaxation and distraction techniques are contraindicated.

Relaxation, meditation, deep breathing was not much approved by CBT practitioners of Pakistan. They acknowledged the role of deep breathing and relaxation as immediate but temporary relief to intense anxiety and distress associated with obsessive compulsive symptoms, but rejected its role on long term basis because of their possible use as safety behaviors.

"I do not consider deep breathing, relaxation in CBT because patient may use them as safety behaviors which obviously hinder our therapeutic goals. But yes with very anxious, distressed patients I sometimes advice deep breathing temporarily". (Interviewee 1)

"I never used deep breathing or relaxation or any distraction methods. I think these are against basic assumptions of CBT and even adversely affect prognosis". (Interviewee 3)

"I always suggest my patients to avoid using deep breathing because it may become a safety behavior". (Interviewee 2)

Effectiveness of CBT with Uneducated Patients

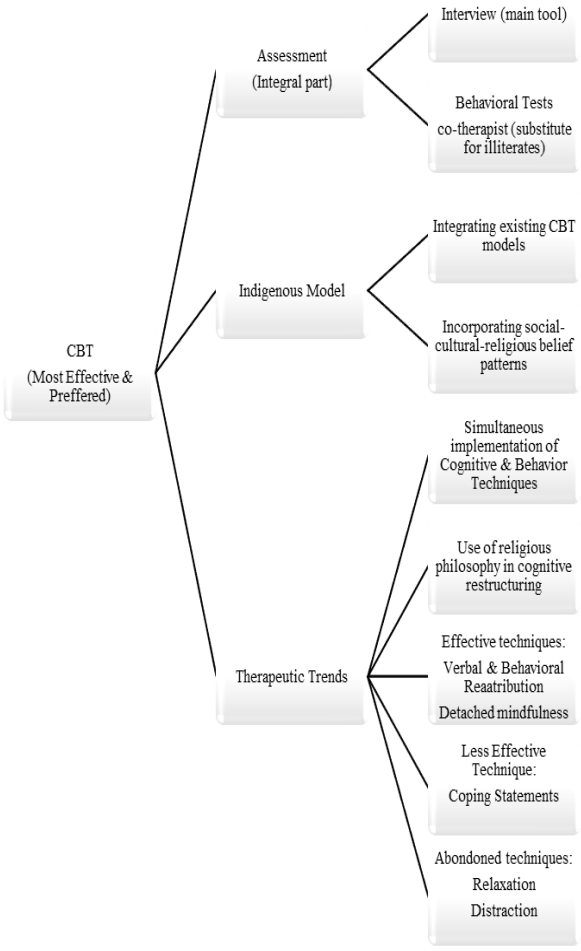
According to United Nations Educational, Scientific, and Cultural Organization (UNESCO) Institute for Statistics, the overall literacy rate of Pakistan in 2009 was found to be 54.89% (Pakistan-literacy rate, n.d.). This low rate of literacy demands the modification of CBT accordingly, which is a therapy of logic, reasoning and education, for OCD patients of Pakistan. Considering this a very pertinent query, this study has focused on inquiring whether CBT professionals of Pakistan have felt this need, and if yes, how they have modified CBT for their illiterate OCD patients.

CBT is effective for illiterates with slight modifications.

The consensus was found among all interviewees that CBT can be used with illiterate patients with slight modifications such as use of simple, specific, lay man terms, and translated materials from

CBT resources and more preliminary forms of techniques. They also stressed upon presence of experiential wisdom is enough for effectiveness of CBT with illiterates. "I use CBT tests and other written material in translated form" (interviewee 1). "We have to use simple, very concrete examples and methods of CBT to deal with illiterate patients". (Interviewee 3) "I often do try to be more guiding in cognitive restructuring of dysfunctional thoughts of illiterate patients". (Interviewee 4) "It is better to use simple, specific techniques, and avoid bombardment of lots of techniques with illiterate patients" (Interviewee 5) " You can use more behavioral reattribution techniques than cognitive ones with illiterates and if using cognitive, then it's better to use very simple and brief way" (Interviewee 1)

"With illiterates, I often prefer co-therapist and do try giving examples from their background and to their comprehension level, sometimes I used pictures rather than words to explain CBT concepts". (Interviewee 2).



Flow Chart Depicting the Common Themes

Discussion

The present study intended to explore every single area pertinent to Application CBT for OCD patients in Pakistan. On the basis of the responses from the professionals, not only the CBT status could be explored but an indigenous and effectively applicable therapeutic protocol of CBT for OCD patients in Pakistan can as well be planned. The information provided by the professionals had been of great help in achieving the goals of the study. The themes identified in this study indicated many similarities in trends of CBT in Pakistan with western trends but certain differences were also identified indicating the cultural adaptations made by CBT professionals here in their CBT practice.

Like its popularity in western countries for OCD (Clark, 2000), CBT here in Pakistan became successful in becoming therapy of choice for professionals when all professionals rated it as most effective, preferred, suitable and even only treatment of choice for OCD patients of Pakistan.

As per findings of the study the professionals here in Pakistan consider the assessment an integral part of CBT with OCD patients. It is an established fact through researches and responses of CBT professionals all over the world that ongoing assessment has been an essential element of CBT but also strength of CBT as evidence-based approach (Overholser, 1999). But one of the major findings of this study is that formal tests are not in common practice of professionals here in Pakistan which is quite different from traditional practice in the West.

The possible reasons behind the fact are lack of adapted and devised CBT-based formal tests in Pakistan as well a lack of familiarity and comfort level of Pakistani population with questionnaires; moreover, a large number of uneducated population is unable to value of some such kind of a project. According to the findings of the study, as a substitute to formal tests, CBT professionals here do rely on conducting interview sessions as main mode of assessment, and behavioral tests as an additional tool as a substitute to dysfunctional thought record (DTR) forms.

Pakistani society is an Eastern society having religion as one of the most prominent values of culture. Dealing with such kind of society where eastern culture is colored with religion, the application of westernized models of CBT without any amendments is quite questionable. Because it has been found in various studies that cultural and religious aspects of the client's life should be focused in planning any therapy including CBT for that specific individual (Abramowitz, 2004; Good, 2010; Huppert, 2010; Waller, Trepka, Collerton & Hawkins, 2010).

Answering this question, the study found an essential need to incorporate social, cultural and religious beliefs and practices in the pre existing Western models of CBT so that an indigenous CBT based model for OCD patients of Pakistani population could be devised. The most important factor in case conceptualization of CBT with OCD patients was found to be their beliefs regarding strict moral and religious values, their punitive, critical self and most importantly their schema of God and authority figures as being harsh, critical and punitive.

In the light of certain research findings in which scrupulosity has been found not only a symptom but a factor of OCD (Elizabeth, Nelson, Abramowitz , Whiteside & Deacon, 2006), and perfectionism as a cognitive distortion commonly present in OCD patients (OCCWG, 2005), this finding of the present study is

justifiable. In a religious society, the philosophy of life being followed is usually based on religious values, practices and beliefs on the one hand and God along with major authority figures (parents) originates schema source. The schemata combined with perfectionist attitudes may compel individuals to develop obsessions and compulsions of scrupulosity, cleaning, washing, etc., and make individuals adopt certain dysfunctional thoughts related with perfectionism, over responsibility and need to control thoughts as the common obsessive beliefs of OCD (Cosgrove, 2011;Abramowitz,Deacon ,Woods, Tolin, 2004).

Participants of this study stressed upon incorporating the schemata in case formulation and the cognitive restructuring as it is suggested to include religious aspects in formulation and therapy of CBT (Huppert & Siev, 2010). Professionals' recommendations to use relevant religious literature in cognitive restructuring of the schemata and beliefs which have their roots in religion is also in line with the literature available on CBT which stressed upon incorporating cultural and religious aspects to tailor the therapeutic plans of patients (Caberara, 2013;Cosgrove, 2011).

The literacy rate in Pakistan is quite low as compared to that in the Western societies (indexmundi.com, 2013) which creates problems in implementation of CBT as an educational approach to psychotherapy. Dealing with this problem, professionals suggested certain modifications in implementation of techniques like use of simple language and concrete examples as it was suggested by Hays (1995) to tailor the therapy according to individuals' level of comprehension and language.

Despite these slight differences between CBT practices in Pakistan and the West, there is a consensus upon majority areas such as ways of socialisation, session duration and format, choice of effective and ineffective techniques, etc. In short, the study reveals that CBT professionals of Pakistan are trying to implement CBT in a more systematic and evidence-based way and also being culture-sensitive professionals, they not only acknowledge the need to modify CBT according to Pakistani culture but also have made attempts on individual level. But there is a need to made joint efforts to work on this aspect of CBT so that CBT can be applied more effectively in our society.

Recommendations for therapeutic protocol

On the basis of the analysis of interview, certain recommendations can be incorporated in pre-existing therapeutic protocols of CBT for OCD patients, in order to devise indigenous therapeutic protocol:

1. Assessment should be completed in first two sessions of 60-90 minutes duration each.
2. The Cognitive Therapy Assessment Interview (CTAI) should be used as main assessment tool.
3. Behavioral tests and Dysfunctional Thought Record (DTR) form along with formal tests can be considered as preferred assessment tools.
4. For illiterate and less educated patients, behavioral tests and co-therapist should be considered as alternative assessment modes.
5. For case formulation of patients, the beliefs about God and authority figures, and about moral values and punitive self should be considered.
6. Imagery techniques of CBT should only be used for obsessional images while relaxing or deep breathing; other imagery and distraction techniques in contrast with with CBT assumptions should not be the part of therapeutic protocol.
7. The religious teachings and philosophy should be used in cognitive restructuring.

Implications

The present study has focused on a relatively neglected aspect of research in Pakistan; as except one study (Naeem, Gobbi, Ayub, & Kingdon, 2010) no studies could be found on CBT status and its application in Pakistan. This study will significantly help in planning indigenous CBT therapeutic protocol for OCD patients in Pakistan. It may also motivate other researchers to explore this field regarding other psychiatric disorders, thus leading to efficacy studies of OCD.

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