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ScienceDirect

Cognitive and Behavioral Practice 24 (2017) 58-71

Cognitive and Behavioral Practice

www.elsevier.com/locate/cabp

Adaptation of CBT for Traumatized Egyptians: Examples from Culturally Adapted CBT (CA-CBT)

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In this article we illustrate how CBT can be adapted to a traumatized Egyptian population with Islamic beliefs, giving examples from our adaptation of Culturally Adapted–CBT (CA-CBT) for this cultural group. We discuss a culturally sensitive assessment measure of local somatic complaints and cultural syndromes that was devised based on clinical experience with traumatized Egyptians. We also demonstrate how to normalize symptoms, create positive expectancy about the treatment, and educate about trauma. We give examples of how mindfulness can be adapted for an Egyptian Islamic population, and we describe local religious strategies, such as dhikr (religious chanting), salah (ritualistic prayer), and dua (supplication), that may be used to promote attentional shift from rumination topics and to teach attentional control. We describe how "loving kindness" can be adapted for this group. We outline how to modify culturally generated catastrophic cognitions and how to conduct interoceptive exposure and to create positive re-associations in a culturally sensitive manner. We describe how worry themes are explored and addressed based on a heuristic panic attack–PTSD model; how to teach anger management in a culturally sensitive way; and how to address sleep-related problems in this population. We suggest using cultural transitional "rituals" at the end of the treatment to give patients a sense of closure and a positive feeling of transformation. A case example is presented to illustrate cultural challenges associated with delivering CA-CBT to an Egyptian population. We introduce certain concepts such as cultural grounding and explanatory model bridging, both therapeutic techniques that increase adherence, positive expectancy, and cultural consonance.

There are many challenges when adapting standard CBT treatments (Foa & Rothbaum, 1998; Resick & Schnicke, 1996) to traumatized cultural groups. Such groups often have low education, extensive traumas, and stigma about mental health. Moreover, a standard part of CBT is addressing catastrophic cognitions about symptoms such as about PTSD symptoms, somatic symptoms, and comorbid conditions like worry, but these catastrophic cognitions may vary across cultures (Hinton, Rivera, et al., 2012). So as a treatment challenge, the clinician should identify and address key catastrophic cognitions that emerge from local ethnopsychology, ethnophysiology, and ethnospirituality, such as how these understandings give rise to catastrophic cognitions about "worry" and worry-induced symptoms. Likewise, another symptom of arousal is anger, which is a major treatment issue in cultural groups (Hinton, Rasmussen, Nou, Pollack, & Good, 2009).

Keywords: cognitive behavioral therapy; cultural adaptation; PTSD

Moreover, for several reasons, traditional exposure (i.e., *prolonged exposure*) may not be conducted in a manner that is optimal for ethnic minorities and many cultural groups, particularly those living in situations of great stress and adversity (for details see, Hinton, Rivera, et al., 2012). In one study, traditional exposure was poorly tolerated by ethnic minorities and refugees, with African Americans dropping out twice as often as Caucasian patients (55% vs. 27%) (Lester, Resick, Young-Xu, & Artz, 2010), though a recent article discusses how to adapt exposure for African Americans to make it more tolerable (Williams et al., 2014). Research suggests that exposure works by creating new nonthreatening associations to the trauma memory network. The person does not need to experience high levels of distress to achieve this result (Craske et al., 2008). Moreover, researchers have increasingly realized that emotion regulation techniques should be taught prior to conducting exposure so that the patient's level of arousal is reduced such that the patient is able to tolerate exposure. This is often called a phase approach (e.g., Cloitre, Cohen, & Koenen, 2006), which is especially important in highly traumatized populations and with patients under great stress (Markowitz, 2010), such as found with many minority and refugee populations. In

addition, particularly given the somatization tendency of many cultural groups, it may be that exposure to somatic sensations is indicated (e.g., Otto & Hinton, 2006).

Culturally Adapted-CBT (CA-CBT) tries to address many of the challenges of working among refugee and minority populations (Hinton, Rivera, et al., 2012). The key elements and overall session structure of CA-CBT are shown in Table 1. For example, CA-CBT is presented in an accessible way so that it is easily understood by populations with low or no education, and can be administered by clinicians with minimal training. It relies on a unique approach to exposure, with an emphasis on the dysphoric state that is induced by asking about recent trauma recall (i.e., trauma memories in the previous week), as an opportunity to practice emotion regulation; that is, the patient is asked to describe the trauma recall and then encouraged to engage in emotion regulation techniques (i.e., what we call the Flashback Protocol; see Table 1) following the elicitation of trauma memories, including mindfulness, loving kindness, and applied muscle stretching with a visualization. It also includes interoceptive exposure to somatic sensations, many of which are assumed to encode trauma events; the somatic trauma cue is paired to a positive association (e.g., dizziness paired to positive memories of experiencing dizziness). CA-CBT uses yoga–like stretching and meditation techniques to promote emotional and psychological flexibility (i.e., an emotion–centered approach). It emphasizes the treatment of somatic sensations, targets comorbid anxiety conditions and anxiety-type psychopathological processes such as worry and panic attacks, and aims to reduce anger.

CA-CBT has been shown to be effective as compared to waitlist and applied muscle relaxation in randomized controlled trials for Latino patients and for Southeast Asian refugee patients from Cambodia and Vietnam (Hinton, Chhean, et al., 2005; Hinton, Hofmann, Rivera, Otto & Pollack, 2011; Hinton et al., 2004). The effectiveness of CA-CBT has been shown in both individual and group format. The effect sizes of these studies suggest that the effectiveness of CA-CBT is comparable to traditional CBT treatments.

Though there is evidence of CBT in English-speaking nonethnic populations (e.g., Blanchard et al., 2003; Cohen, Mannarino, & Murray, 2011; see also, Foa, Keane, Friedman, & Cohen, 2008), to date no culturally sensitive CBT treatment exists for traumatized Egyptians, and there is little available information on how to approach CBT among groups with Islamic religious beliefs. It has been suggested that CBT as a mode of therapy may be congruent with many aspects of Islamic culture and beliefs (Amer & Jalal, 2011; Hodge & Nadir 2008). More generally, given that there are 1.6 billion persons of the Islamic religious faith in the world (which is expected to rise to 2.2 billion by year 2030), investigating how CBT can be made culturally appropriate and culturally acceptable to these groups is a key research and clinical task (Pew Research Center, 2013).

Moreover, in Egypt there is a high rate of the kinds of traumatic events that cause PTSD, such as sexual violence

Table 1
Sessions in CA-CBT and Key Components of the Sessions

Session Number	Session Title	Emotional Exposure Followed by Practice of the Indicated Protocol	Applied Stretching Lesson at Session's end	Mindfulness Lesson at Session's End
1	Education about Trauma-Related Disorder	Anxiety	X	X
2	Muscle Relaxation and Stretching with Visualization	Anxiety	X	X
3	Applied Stretching with Visualization Protocol	Anxiety	X	X
4	Flashback Protocol	Anxiety	X	X
5	Education about Trauma-Related Disorder and Modifying Catastrophic Cognitions	Anxiety and Trauma	X	X
6	Interoceptive Exposure I: Head Rotation	Anxiety and Trauma	X	X
7	Interoceptive Exposure II: Hyperventilation	Anxiety and Trauma	X	X
8	Education about Breathing and Its Use for Relaxation	Anxiety and Trauma	X	X
9	Sleep Disturbance	Anxiety and Trauma	X	X
10	Generalized Anxiety Disorder	Anxiety and Trauma	X	X
11	Anger	Anxiety and Anger	X	X
12	Neck-, Shoulder-, and Headache-Focused Dysphoria and Panic	Anxiety and Anger	X	X
13	Other Somatic Symptoms and Associated Panic	Anxiety and Anger	X	X
14	Cultural Syndromes and Ethnophysiology Related to Anxiety: Closing	Anxiety and Anger	X	X

Note. The stretching modules differ by muscle group that is targeted. The mindfulness modules differ as well, with most teaching different types of multi-sensorial awareness; some involve performing loving-kindness. The applied stretching is practiced just before the mindfulness lesson.