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Adaptation of CBT for Traumatized South African Indigenous Groups: Examples from Multiplex CBT for PTSD

Baland Jalal, *University of Cambridge*
Qunessa Kruger, *Mokopane Hospital*
Devon E. Hinton, *Massaschusetts General Hospital and Harvard Medical School*

This article describes how Culturally Adapted Multiplex CBT, a treatment that emphasizes somatic processing and emotion regulation, was adapted for a traumatized South African indigenous group, the Sepedi. A model of psychopathology is presented, the Multiplex Model of Trauma-Related Disorder, which depicts the processes that generate multiple comorbidities and prominent somatization in minority, refugee, and other non-Western populations. The nine dimensions of Culturally Adapted Multiplex CBT are discussed, and so too the "cultural adaptation diamond." Concepts such as "explanatory model bridging" are presented. A culturally sensitive assessment measure of local somatic complaints and cultural syndromes (the Sepedi Symptom and Syndrome Addendum, or Sepedi SSA) is detailed, as well as how CBT techniques were implemented with this group—for example, modification of culturally specific catastrophic cognitions, doing exposure (e.g., interoceptive exposure), teaching attentional control and mindfulness techniques, and teaching "loving kindness." Case examples with clinical outcomes are provided to further illustrate how Multiplex CBT was adapted for the South African indigenous group.

There are numerous challenges when adapting standard CBT treatments to traumatized cultural groups. These include low education, extensive traumas, numerous somatic symptoms, extensive catastrophic cognitions about symptoms, multiple comorbidities, ongoing life difficulties (e.g., financial stresses), poor tolerance of traditional exposure, and considerable stigma about mental health (Hinton & Jalal, 2014a, 2014b). To address these challenges, Culturally Adapted Multiplex CBT was developed, which has been shown to be effective as compared to waitlist and applied muscle relaxation (AMR) in randomized controlled trials for Latino patients and for Southeast Asian refugee patients from Cambodia and Vietnam (Hinton, Pham, et al., 2004; Hinton, Pich, et al., 2004; Hinton, Chhean, et al., 2005; Hinton, Hofmann, Rivera, Otto, & Pollack, 2011).

Multiplex CBT for PTSD is based on a multiplex model of psychopathology. This is a general model of psychopathology developed working with traumatized minority, refugee, and non-Western populations to explain the high levels of PTSD and comorbid GAD, worry, panic, and somatization in these groups (Figure 1). The validity of this model of psychopathology and its relevance for minority and refugee populations has been explored in multiple studies (Hinton & Good, 2016; Hinton, Hinton, Loeum, & Pollack, 2008; Hinton, Hofmann, Pitman, Pollack, & Barlow, 2008; Hinton & Lewis-Fernández, 2011; Hinton, Nickerson, & Bryant, 2011; Hinton, Pich, Chhean, Pollack, & Barlow, 2004; Hinton & Simons, 2015). Based on this model, Multiplex CBT emphasizes sensorial processing and emotion regulation. The key elements and overall session structure of the treatment are shown in Table 1, with some of the key components shown in Figure 2.

Multiplex CBT was designed to be accessible to minimally educated populations and can be administered by therapists with lower levels of education. The treatment not only targets PTSD but also somatic sensations and comorbid psychopathological conditions including anger, anxiety-related processes such as worry and panic attacks, and poor sleep. The treatment promotes emotional regulation and psychological flexibility through techniques such as meditation and yoga-like stretching exercises that are paired to self-metaphors. It takes a novel approach to exposure by eliciting recent trauma recall followed by practicing emotion regulation techniques: mindfulness, loving kindness, and applied muscle stretching with a visualization. Multiplex CBT includes interoceptive exposure to somatic sensations with those sensations paired to positive associations (because somatic sensations may serve as trauma cues as well as a source of catastrophic cognitions

Keywords: cognitive behavioral therapy; cultural adaptation; PTSD

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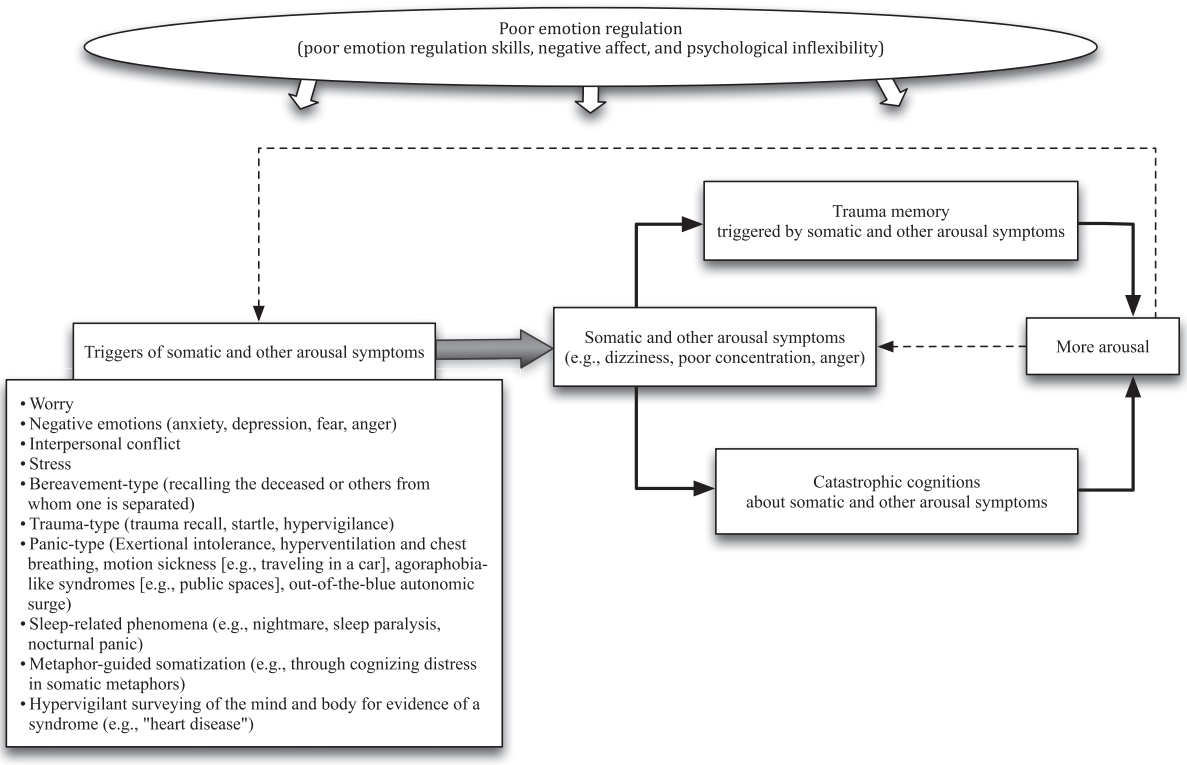

Figure 1. The Multiplex Model of the Generation of Trauma-Related Disorder

Table 1
Sessions in Multiplex 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

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