

Difficulties faced by mental health professionals in conducting CBCT in Pakistani society: a phenomenological study

Abstract

Objective: To explore the difficulties faced by mental health professionals in conducting cognitive behavioral couple therapy with Pakistani couples showing marital dissatisfaction.

Study Design: Transcendental Phenomenological study.

Place and Duration of the Study: Study conducted during the course of one year period in the Armed forces institute of mental health, Rawalpindi Pakistan.

Method: In depth semi structured interviews were conducted with 3 psychologists and 2 psychiatrists working in Armed Forces institute of Mental Health, Pakistan.

Results: All mental health professionals conducting CBCT with Pakistani couples reported need for cultural adaptation of CBCT manuals for usage in Pakistani society. Although they were not able to elicit on these details, however four major underlying themes were revealed through thematic content analysis: obstacles in conducting CBCT, issues related to treatment module (CBCT), participation of the family members and behavioral changes observed in therapy.

Conclusions: For CBCT to be acceptable in Pakistan, numerous cultural adaptations need to be taken into consideration relating to patient's knowledge and belief about therapy itself and factors related to services provided by mental health professionals. In depth interviews with mental health professionals can provide us with clear guidelines of development of CBCT in accordance to the needs of Pakistani couples.

Keywords: CBCT, Marital dissatisfaction, mental health professionals

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Introduction

Marriage in Asian societies is not just the coming together of a couple, but also their families. However, as the societies are fast evolving, Asian countries are also rapidly moving in the direction of individualism and Pakistan is no exception. In the present era, marital relationships are deteriorating everywhere and the couples have stopped seeking pleasure in one another's presence. Globally, marital dissatisfaction has seeped into relationships.¹ Unfortunately, a relationship that focuses on mutual love and respect and thrives through companionship has fallen prey to bitterness and has become, no less than a battle ground.² In Pakistan most of the time marital discord is resolved primarily through elder family members or close family friends in a non-professional setting. In our society, couples seek professional therapeutic help only when their marriage is in serious jeopardy or there is strong fear that the marriage is not going to last. Therefore in desperation, they approach professionals to tackle this emerging problem, Pakistani psychologists and psychiatrists have been utilizing variety of techniques including marital counseling, marital therapy, and more recently cognitive behavioral couple therapy. Use of cognitive behavior interventions for resolving marital dissatisfaction focuses on identifying and restructuring cognitive distortions, improving communication and teaching problem solving strategies.^{3,4} There is considerable practical evidence that cognitive behavioral interventions reduce marital dissatisfaction.⁵ Recently, great importance has been laid down on scientifically verified modalities in the field of mental health; cognitive-behavioral interventions have

gained immense respect and popularity among clinicians.⁶⁻⁸

The aim of cognitive behavioral interventions in marital dissatisfaction is to decrease aversive interactions and to increase positive interactions among couples that contribute to the perception of one another's behaviors. Change in cognitive thought processes and emotions can be both a pre-requisite for and consequently a positive change in behavior of the partners can be evaluated during therapeutic processes.⁹ Most of the outcome studies on cognitive behavioral interventions for resolving marital discord have been conducted in Europe and North America. Although cognitive-behavioral interventions with couples in developing countries like ours gaining popularity among the mental health professionals.¹⁰ Mental health professionals when tackling marital dissatisfaction face multiple issues which can have an effect on application of CBCT in non western societies.¹¹⁻¹⁴ Therefore, it has been suggested that CBCT might need cultural adaptation before its application in non western cultures. This is due to the Experienced mental health professionals modify therapy in accordance with the needs of couples in Pakistan while taking into considerations cultural and religious factors, like elsewhere. For example, Murray¹⁵ has pointed out that the psychologists working in Pakistan use religious practices as part of the therapy. The present study reveals the qualitative findings and inference through the information received by the mental health professionals' interviews. The study brought in focus the aspects which needed modification in the use of CBCT in Pakistan through extorting the experiences, perceptions and expertise of the Pakistani mental health professionals.

Materials & methods

Instead of conducting a survey one-to-one semi structured interviews were believed to be useful in collecting data from mental health professionals. Therefore, in-depth semi structured interviews were conducted with five mental health professionals (two psychiatrist & three psychologists) working in AFIMH, Rawalpindi. They were asked questions related to the following areas:

1. Demographic information of mental health professional (age, training, years of experience & area of training)
2. They were working with CBCT for resolving marital issues
3. What are the pertinent problems which couples present?
4. How many sessions usually provided to couples in reducing marital dissatisfaction?
5. Remainers and terminators in therapy sessions
6. How easy it was to apply CBCT in non- western setting
7. What were the techniques frequently used?
8. Identification of techniques which were unhelpful
9. Couple preference for certain techniques
10. Couples' expectations from therapeutic outcomes
11. The role of family in enhancing marital satisfaction
12. Whether it is needed to modify CBCT techniques for their usage in Pakistan and if so, how?

During the data collection procedure, psychiatrists and psychologists were asked to report their experience of CBCT focusing marital dissatisfaction. The study was conducted in two parts: in the first phase in-depth interviews of mental health professional (N=5) which lasted to about 60minutes focusing on the above mentioned areas. During the second phase, interview scripts were returned to mental health professionals for further comments and clarifications of their point of view that arose from analysis. Interviews were transcribed through the process of horizontalization and then themes were generated. The themes were converted into codes and in final analysis these were built into categories

Results

Interviews were analyzed and following themes emerged from the study.

Obstacles in Conducting CBCT

Not willing to participate in conjoint session

Mostly the husbands were not willing to attend therapy sessions and were reluctant to disclose personal details of the relationship in conjoint sessions especially issues pertaining to their finances and savings. Husbands mostly were of the opinion that finances are to be kept in secrecy with their wives. By disclosing the details of their accounts would create many social pressures as mostly the families belonged to the rural background where money is being jointly kept among brothers rather than discussing details of spending with their respective wives.

Magical relief

Dysfunctioning family patterns were believed to be modified in few therapy sessions and no one (either partner) was willing to deviate from their own cognitive schemas. They insisted on medication as they believed that medicine would be an answer to all their miseries in marriage. Confusion regarding depression and marital issues was noted and treatment of depression was sought through marital therapy sessions.

Dealing with somatic complaints in CBCT

Somatic complaints were believed to be a part of marital issues and they were to be tackled in therapy sessions e.g. wives mostly complains of headaches and gastric problem and they failed to see that their marital issues were major factor in compounding their physical complaints.

Unable to complete homework assignment

Only one third of the patients were willing to do the homework but they also did not feel the need for all the sessions. Mostly the couples were of the opinion that by only discussing the issues with their respective therapists they were able to rectify their grievances in marriage.

Patient's expectations from mental health professionals

Couples coming to the therapy sessions were of the opinion that mental health professionals play a pivotal role in eradicating their faulty behavioral and communicating patterns. Therapy for them is just like a chit chat for them and nothing more. During therapy they were of the believe that by accusing and counter accusing, they could get their way of doing things.

Difficulty in explaining cognitive errors

Mostly couples were unable to identify their faulty belief patterns and linking of their automatic thoughts to their emotional arousal and replacement of dysfunctional beliefs with positive ones. As they were engaged in vicious circles of blaming and accusing each other for their dissatisfaction in marital life.

Issues related to treatment modules

Assessment of problematic areas

The process of assessment was not different from the western society as same scales were used. Assessment procedure consists of detail history taking and formulating a management plan. The focus was on belief system of the couples, their pertaining emotional problems and later their issues were addressed both at cognitive and emotional level. The first step in therapy however, remains a careful and detailed assessment of couples problematic areas and complaints.

Commonly used techniques

Replacement of faulty beliefs with positive ones, communication training patterns were given and exercises were conducted about when and how to speak by taking into consideration Gurney's (1979) communication training outline.

Structure and Content of the Sessions

Structure of the session was based on the guidelines provided

by Datillio (2010) and twelve session with a gap of one week was provided to the couples seeking for help.

Consensus

As in our society, it is widely believed that women are to do all household chores whether she is working or non-working. Husbands are not willing partners in labor division of household activities. Consensus could not be reached on division of labor, how much time spent together and dealing with in-laws.

Therapeutic style of the sessions

Couples were asked to work in collaboration with the therapist and no one can get better in therapy without hard work. It is the couples who have to deliberately work on their problematic areas along with the help of therapist. The agent of change was couple themselves.

Normalizing techniques

Use of humor found to be facilitating therapeutic process and help in building rapport. This was quite useful when sharing some personal experiences or to normalize an inappropriate behavior.

Techniques which patients find helpful

Techniques which patients find helpful were training in communicating patterns and downward arrow techniques to find and alter their faulty belief patterns. Mindfulness was also proved to be helpful as couples were asked only to remain focused on issues and their rectification.

Participation of the family members

When dealing with marital issues, immediate family members were seen less helpful in tackling couples' problems. In fact they exaggerated the couples' issues. Interestingly it was found that couples seek help from faith healers throughout their life and they believe that all their issues were related to some evil.

Behavioral changes observed in therapy

CBCT help clients to think clearly about their problems in marital life and to utilize strategies to resolve issues which subsequently lead to reduction in marital dissatisfaction. Professional help provides an opportunity to spouses to become more active observers and to help in evaluation of one's own cognitions. So that emotional and behavioral responses to one another will be minimally affected by cognitive distortion.

Discussion

In developing countries, very few studies have focused to investigate mental health professionals' experiences with the use of psychotherapy and in particular CBCT. This added to understanding how mental health service providers offer psychological help to couples in difficulty and how they understand their problems, what therapeutic strategies work and what are the constraints in conducting therapy in a society which is not tuned to therapeutic culture and its understanding. The expectations that couples bring into therapy was highlighted through content analysis. They believed therapy to work like a magic or pill to resolve all their marital issues in one go. Bringing down the couple to a discussion on an important topic was a

daunting task as emotions were too high and cognitions to distort. In Pakistani society, parents and significant other (grandparents, teachers, siblings, peer, extended family members) have a powerful influence on the development of the individual's cognitions specially when these are consistent with strong cultural values and beliefs. Uptill now it is strongly emphasized that women are home makers and males are assumed to be bread winners with fast changing economic reality. Men now prefer to marry economically independent women.¹⁶ With this shift in thinking process, new cultural adjustments are to be made. Pakistani couples are underpressure from conflicts between wives economic participation and the division of labor in household activities during the course of therapy. This cultural change has been brought as an issue by many couples in therapeutic sessions. In Pakistani society, it has been observed that individuals showed reluctance to change thinking from that of family origin because it viewed to be disrespectful.¹⁰ It is unrealistic to expect that an old belief system or style of thinking can function without any modification to adapt to a new situation. During the therapeutic sessions, it was noted that couples coming from long distances were more engaged in quitting therapy. Educated couples however tried to find the solution to their problems during therapeutic discourse. Education of both partners played a pivotal role in continuation of therapy to its logical end.¹⁷ When working with couples in Pakistani society, some cultural differences were noted. In Pakistan global shift towards modernization has been found to be important both in context to personal and therapeutic interactions. When assessing intimacy for Pakistani husbands and wives, it has been found that social factors play an important role in individual's life. Within families authority structure is used as a tool to govern subordinate members to perform duties in accordance to gender role. In order to understand gender better, how responses of men and women can differ from each other, can lead to tuning of therapeutic interventions to specific gender roles and sensitivity. It was also noted that couples in Pakistani society showed reluctance in completing homework assignments. Whenever a topic of discussion was brought to them, they fail to make a connection from the previous session as they were unable to go through their homework assignments. As Pakistani society we are accustomed to deal with issues on daily basis and thus trend was clearly seen during conduction of CBCT with Pakistani couples. Bilingual form, most spouses or either one of them fail to understand English because of language barrier. So it seems very important that the manual which provides therapeutic guideline to be translated in native languages. Therapists claimed that for those who stay in therapy it works. But the number of those who stay in therapy is very small and there is no systematic evidence for this. As far as the process of the therapy is concerned overall there were no major differences, at least in theory. The overall style of therapy is directive rather than collaborative in Pakistan. Therapy involves a lot of suggestions, advice and support. This could be due to the culturally ingrained value of seeing a person in authority as the source of advice, support and enlightenment. This is in line with Launganis'¹⁴ suggestion that social hierarchies influence the process of the therapy, as well as Iwamasas'¹¹ observation that "Asian patients like a directive style of therapy". However we have to keep in mind that collaboration does not necessarily mean following strictly a western model of equality of therapist and clients. Every therapy uses techniques which rely on a teacher student like relationship, like educating the patient and use of Socratic dialogue. Similarly, mindfulness based therapy also employs a teacher-student model of therapy.

Limitations of study

The study conducted a number of limitations. The data was collected from mental health professionals working in one hospital only and one big city. The focus of the study was on the issues decided to explore; this prevented from the discussion useful information that was not included into the list of ideas to be explored. However, we were careful in our interviews not to ignore any useful cues as they emerged.

Conclusion

The present study was one of the researches that intended to explore the experiences of practitioners who were utilizing cognitive behavioral intervention for the couples having marital discord in a Pakistani perspective. By analyzing the experiences of mental health professionals four themes were generated pertaining to difficulties faced by therapists working to resolve marital disputes: obstacles in conducting CBCT, issues related to treatment module (CBCT), participation of the family members and behavioral changes observed in therapy. Although study has its own limitations however revealed useful information concerning the issues to be taken into consideration while making cultural adaptations to therapy in Pakistan. It is however can be clearly emphasized that detailed work in needed to fully explore the hurdles and opportunities for improvements in CBCT for clients and therapists in Pakistani setting.

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Conflict of interest

The authors declare that there is no conflict of interest.

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