

## Making psychotherapy culturally relevant to South Asia

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### Burden of mental illnesses in South Asia

Psychiatric disorders account for more than 14% of the global burden of disease (Prince et al., 2007). It is projected to increase further by 2020 and the situation is more serious in developing countries (Murray & Lopez, 1997). Considering the higher prevalence of mental disorders in the South Asian region, the need to address this issue is even greater (Steel et al., 2014). Despite its higher prevalence and significant impairment to individuals, mental illnesses are under-treated in South Asia (Chisholm et al., 2007). Studies done in the region on pathways to mental health care found traditional healing methods to be widely accessed (Hashimoto et al., 2015). Lack of cultural relevance has led to poor use of existing mental health services, making traditional healing rituals a popular treatment option for psychiatric conditions in rural and suburban areas (Samarasekare, Lloyd, & Siribaddana, 2012).

### Need for cultural modification of psychotherapy

Psychotherapy alone or in combination with other treatment is effective in managing a wide range of mental disorders (Hunsley, 2013). While both psychiatrists and patients in the region identify psychotherapy as an essential and desirable therapeutic option, its provision and utilization has been low (Holikatti et al., 2012; Wasan, Neufeld, & Jayaram, 2009). One of the main reasons identified is the lack of culturally appropriate psychotherapies.

Culture impacts on how people exhibit symptoms of mental illness, use coping mechanisms, use social supports, and seek care or assistance (Gelso & Fretz, 2001). Main stream or generic psychotherapies are developed in the West

and reflect the values of western culture, most notably a persistent bias toward individualism (Sue, Zane, Nagayama Hall, & Berger, 2009). Unlike the western society, South Asian cultures are considered to be collectivistic in that they promote interdependence and co-operation (Kleinman & Good, 1985). Therefore universalism, a concept suggesting that all interventions suit all cultural groups, a 'one size fits all' approach, has little value. Psychotherapy will be relevant only if it uses the cultural values, beliefs and aspirations of a society (Tseng, 2001). It is not surprising therefore that a meta-analytic review of culturally adapted mental health interventions found culturally focused interventions to be four times more effective than generic interventions and to have lower treatment drop-outs (Griner & Smith, 2006).

A few theoretical models have been developed to guide therapy modification. Bernal, Bonilla and Bellido (1995) suggested adapting eight different dimensions including language, persons, metaphors, content, concepts, goals, methods, and context in developing culturally sensitive treatment. Resnicow et al (1999) described interventions adapted at 'surface structure' and those adapted at 'deep structure'. Surface structure interventions are concerned with matching observable characteristics, such as people and language, while deep structure interventions engage with cultural, social, environmental and psychological forces that influence health behaviour such as religious and cultural values, beliefs, aspirations and goals. Hwang (2009) argued that ground-up community-based approaches may supplement theoretically driven approaches to cultural adaptation by confirming theory-related adaptations. Therefore Hwang proposed the formative method for adapting psychotherapy which consists of 5-phases: (a) generating knowledge and collaborating with

stakeholders (b) integrating generated information with theory and empirical and clinical knowledge, (c) reviewing the initial culturally adapted clinical intervention with stakeholders and revising the culturally adapted intervention, (d) testing the culturally adapted intervention, and (e) finalizing the culturally adapted intervention.

## Culturally modified psychotherapies in South Asia

It has been suggested that culturally modified psychotherapy for the region should be short term, flexible, eclectic, crisis oriented, supportive and tuned to the socio-cultural conditions (Avasthi, 2011). Incorporation of concepts from mythology and religious philosophy, the therapist playing an active and authoritarian role, promoting interdependency, clear involvement of family, less emphasis on strict confidentiality, more explicit use of environmental manipulation, suggestions, sympathy and reassurance have been described as cultural modification to mainstream psychotherapies in India. However, there is a severe dearth of literature related to cultural modifications of psychotherapy in the South Asian region and outcome research, in particular (Manickam, 2010). Rathod et al (2013) and Naeem et al (2011) successfully demonstrated how culturally modified cognitive behaviour therapy (CBT) for psychosis can be developed to suit the cultural context in the South Asian region.

In the pursuit of developing culturally relevant CBT for depression in Sri Lanka, we have generated knowledge from collaboration with patients, carers, families, psychiatrists, psychotherapists, traditional healers and lay counsellors. The modified therapy would include shorter and limited number of sessions, more instructional/directive approach, better focus on physical/somatic symptoms, increased emphasis on education, activity scheduling, mindfulness and problem solving skills and explicit use of folk stories and religious literature. The feasibility and efficacy of the modified CBT is being tested.

A culturally adapted, short term and focused psychotherapeutic intervention that could be administered by auxiliary psychiatric personnel may reduce the treatment gap and improve patient

satisfaction. Such treatment is a strongly felt need in the South Asian region.

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