ISSN PRINT 2319 1775 Online 2320 7876

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COMPARISON OF COGNITIVE BEHAVIOURAL THERAPY AND CULTURAL MODIFIED COGNITIVE BEHAVIOURAL THERAPY FOR PSYCHOLOGICAL DISORDERS

Dr, Rubia Jan [1], Dr, Shawkat Ahmad Shah[2], Dr, Arshad Hussain[3],
[1]Research scholar, [2] Professor in the department of psychology,
[3] Professor in the department of psychaitry

ABSTRACT: The onset of psychological disorders (anxiety& depression) is influenced by cultural underpinnings in addition to individual and situational factors. When someone is healing from a big traumatic incident, cultural beliefs and practices, norms, familial origins, and social roles all play a key part in psychosocial regulation. There are limited studies on culture-based therapy approaches, despite numerous studies comparing western and eastern interventions. It is challenging and counterproductive to develop a universal treatment for persons from various cultural origins due to individual variances. Cultural understanding is crucial for therapists to comprehend patients' symptoms in the context of their cultural surroundings. In order to treat anxiety and depression, the study compares the efficacy of CBT and modified CBT. , the study compares how well CBT and modified CBT work for treating anxiety, and depression. The study also looked at how different intervention strategies affected people's quality of life.

The study included fifty (50) patients, of which twenty-five (25) participants were randomly assigned to the CBT group, and twenty-five (25) to the modified CBT group. . Both groups were evaluated before and after therapy using a variety of assessment measures, including the quality of life scale(QOL), the hospital anxiety and depression scale(HADS). The study's findings showed that both therapies significantly lessened anxiety and depression symptoms. The study's findings showed that both treatments significantly lessen anxiety, and depression symptoms while also enhancing patients' quality of life.

Keywords: ***CBT, Modified CBT, Anxiety, Depression, and Quality of life.***

Introduction: The effect of trauma can be elusive, devious, or downright damaging. How a event impacts anyone depends on multiple reasons: the psychological predisposition of an individual, the category, and physiognomies of the happenings, developing courses, the connotation of the trauma, and the socio-cultural situations. Although most of the victims display instant responses, these normally go on without long-term severe repercussions. Mostly this is because most of the survivors of traumatic events are highly resistant and develop suitable surviving mechanisms, including the use of societal help, in dealing with the aftermath of the same. The most common markers linked to trauma are ASD and PTSD, with the caveat that trauma is also linked to the initiation of a variety of miscellaneous psychological health issues predominantly problems associated with substance use, mood disorders, personality disorders and anxiety disorders.Depression is a kind of mood disorder characterized by pervasive

ISSN PRINT 2319 1775 Online 2320 7876

 UGC CARE Listed (Group -I) Journal Volume 07, Iss 04, 2018

sadness that lasts for a long time and disturbs an individual's daily life. Depression manifests itself in various ways, including feelings of melancholy, worthlessness, helplessness, feeling of irritability, changes in physical activity, sleep patterns, and hunger. On other hand, anxiety is a debilitating state and is considered a problem in situations where there is no real danger or threat. So we can say that anxiety is the outcome of how individuals interpret events when there is perceived no real threat. Therefore it is possible that two individuals gave different reactions to the same situation. When an individual perceives any dangerous or threatening situation, anxiety is a normal reaction, but the loop of negative and dysfunctional thoughts leads a person towards anxiety and depression, which ultimately lowers down mood; it brings changes in appetite, sleep, energy, and feelings. Hall et al. (2013) found that individuals who have developed PTSD are more likely to develop depression and anxiety. Walter et al. (2013) evaluated that 80% of patients who have PTSD have at least one psychological disorder, with anxiety and depression being the most frequent. According to another study, individuals who have PTSD half of those are such who would inevitably acquire depression (Flory 2015).The term "quality of life" refers to what level a person is healthy, functional, and able to cherish enjoyable and happy moments. Generally, the word "Quality of life" refers to an individual's experience as well as his or her living conditions. As a result, we could say that the concept of quality of life is subjective, as some individuals interpret it in terms of wealth, while others interpret it in terms of how content they are with their lives. Many people relate it with their capacities, how able they are to live a meaningful and happy life (emotional wellbeing). So it may be possible that a handicapped individual reports good quality of life rather than a healthy individual who may have lost his job or something else. It is a multi-dimensional construct that includes emotional, physical, material aspects, and social dimensions. Various types of assessors measure the quality of life such as generic measures, specific and individual assessments. Individual measures measure the individual quality of life, including an individual's subjective experience about his or her quality of life. Generic measures assess medical-related health facets of quality of life, while specific assessments measure specific diseases or illness-related aspects of quality of life. The quality of life has been reported by World Health Organization (WHO) to be one of the important facets which govern and determine the overall health of an individual. WHO defines the quality of life as *"Individuals' perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concern." A* Study conducted by Glassman (2019) suggests that PTSD patients have significantly lower QOL. Danielsson et al. (2018) revealed that PTSD lower's down QOL. Another study carried out by Cohen et al. (2009) reported that treatment of PTSD improves QOL among cardiovascular patients.

Rationale: Despite the fact that there are several studies comparing eastern and western interventions, there are few studies about culturally-based treatment approaches. Due to individual variances, creating a universal treatment for persons from various cultural backgrounds is neither simple nor effective. The therapists' ability to comprehend patient symptoms in the context of their particular culture depends on their cultural understanding.

ISSN PRINT 2319 1775 Online 2320 7876

 UGC CARE Listed (Group -I) Journal Volume 07, Iss 04, 2018

Asian patients are more eager to undertake treatment when eastern techniques are incorporated, as individuals with diverse cultural backgrounds require distinct therapeutic modalities in order to achieve the greatest treatment outcomes. So, it becomes essential for the therapist to take cultural considerations, incorporate particular cultural practises, and alter therapy to meet the needs of their patients. Marsella (2003) proposed a new approach to psychology named "Global community psychology," which stated that western psychology is biased. It is not the only psychology throughout the world as it is dominant not because of its accuracy but because of its social, economic and political power. It ignores indigenous healing principles and cultural practices and focuses on individualism, mechanism, and, objectivity and maintains dominance by ignoring respective cultures of the world. He says the western way of thinking is fabricated. Therefore, eastern psychologies will bring a new way of thinking and also lower down indiscrimination of using the psychology of the west in all contexts. This new approach to psychology is multicultural, multilingual, multidisciplinary, and multispectral. It will understand the issues of ethnocentricity and also help in understanding the cultural determinants of human behavior. Mental health practitioners and researchers now acknowledge the role of culture in depressive disorders. Now they realize that it is important to preserve cultural diversity by using culturally appropriate treatments and understanding phenomena from their unique cultural context. This does not mean ignoring previous knowledge of the west, but it means one should be aware of using concept its limitations and applications. If cultural factors are ignored in the assessment, diagnosis, and treatment of mental disorders, this means we are destroying cultural pluralism that is base for human survival. Wallace et al. (2021) study the effectiveness of cultural adaptation of CBT for the treatment of panic and anxiety disorders in women of African and American origin. The study found that a culturally adapted version of CBT is effective in the treatment of panic and anxiety disorders. In a study, Etzelmueller (2020) assessed the usefulness of Internet-based CBT in the treatment of anxiety and depression. The findings reveal that Internet- based CBT helped in lowering anxiety and depression symptoms. Jalal et al. (2020) conducted a study on the adaptation of CBT for a traumatized individual belonging to the Sepedi culture of South Africa. Twenty patients were taken into the study, and a comparison between adapted CBT and Muscle relaxation was made. The result of the study showed that culturally adapted CBT is more effective in lowering depressive and other somatic symptoms of PTSD than Muscle relaxation. A similar study was conducted by Rathod et al. (2020) highlighted the role of cultural intervention in the treatment of mental disorders belonging to a minority culture. In a study, Heim et al. (2019) made a cultural adaptation of CBT and put emphasis on three elements while adapting therapy such as the cultural meaning of distress, various components used in the treatment, and effective delivery of treatmentSanabria et al. (2018) assessed the effectiveness of internet-based cultural adaptation of CBT and found that the internet-based cultural adapted form of CBT effectively reduces depressive symptoms The study further suggested that new techniques should be added to CBT to produce better outcomes. Kananian et al. (2017) conducted a study on cultural adaptation of CBT for the treatment of distress among Farsi speaking. Nine male refugees from Iran and Afghanistan were taken into the study. The

ISSN PRINT 2319 1775 Online 2320 7876

 UGC CARE Listed (Group -I) Journal Volume 07, Iss 04, 2018

result of the study vindicated that culturally adapted CBT is effective in reducing symptoms of distress and improving the quality of life among refugees. In the absence of a cure for PTSD, the main goal of treatment is to improve patients' health by minimizing disease symptoms, optimizing utility, and boosting the quality of life. Razaei et al. (2020) conducted a study and examined the relation between CBT and quality of life among women having hypothyroidism. A total of 96 women were randomly allocated into the treatment and control groups. The result of the study revealed that CBT effectively improves the emotional and general health aspects of Quality of life. Kahrazei (2019) conducted a study on the effectiveness of CBT and Quality of life among cancer patients. The result of the study showed that CBT is effective in improving Quality of life and social functioning among cancer patients. A study conducted by Riyahi (2017) reviewed the effectiveness of CBT with quality of life among individuals having Hepatitis B. The study outcomes vindicated that CBT enhances the quality of life among Hepatitis patients In a study, Henriksson (2016) explored and examined the link between CBT and health-related aspects of quality of life. According to the findings, CBT is beneficial in increasing health-related aspects of quality of life and optimism in people. The research review portrays that again mixed response is evident regarding the effectiveness of CBT and other treatment techniques for anxiety and depression disorders. Cultural adaptations of various therapies also have a significant role in the treatment process. Research needs to be carried intensively to generalize the results and to ensure the effectiveness status of cultural-based or culturally adapted techniques. Besides this, scientific procedures must be strictly followed while framing cultural-based therapy modules as methodological issues have been constantly highlighted in the research studies.The main goal of treatment is to improve patients' health by minimizing disease symptoms, optimizing utility, and boosting the quality of life. Study carried out by Rababa et al (2020) evaluated the effectiveness of CBT in relieving symptoms of Ageism among nurses. A total of 110 nurses were assigned to the experimental and control groups at random. The findings of this research suggested that CBT was found to be effective in relieving symptoms of ageism. Razaei et al. (2020) conducted a study and examined the relation between CBT and quality of life among women having hypothyroidism. A total of 96 women were randomly allocated into the treatment and control groups. The result of the study revealed that CBT effectively improves the emotional and general health aspects of Quality of life. Kahrazei (2019) conducted a study on the effectiveness of CBT and Quality of life among cancer patients. The result of the study showed that CBT is effective in improving Quality of life and social functioning among cancer patients. A study conducted by Riyahi (2017) reviewed the effectiveness of CBT with quality of life among individuals having Hepatitis B. The study outcomes vindicated that CBT enhances the quality of life among Hepatitis patients Henriksson (2016) explored and examined the link between CBT and health-related aspects of quality of life. According to the findings, CBT is beneficial in increasing health-related aspects of quality of life and optimism in people. Nekouei et al. (2012) studied the relationship between cognitive behavioral therapy and quality of life in cardiovascular patients. There were 56 patients divided into two groups at random. A pre-test-post-test design was used. The outcome of this research vindicated that cognitive

ISSN PRINT 2319 1775 Online 2320 7876

 UGC CARE Listed (Group -I) Journal Volume 07, Iss 04, 2018

behavioral therapy improves the quality of life in cardiovascular patients. Kahrazei et al. (2011) carried out a study on the effectiveness of cognitive-behavioral therapy and quality of life among cancer patients. Thirty participants were allocated to the experimental as well as to the control group at random. The study showed that cognitive-behavioral therapy improves the quality of life and social functioning in cancer patients. To sum up the review, it is evident that quality of life is significantly related to the treatment techniques. Quality of life has found to be one of the significant outcomes of treatment procedures. Besides, the successfulness of treatments has always been assessed in terms of improvement in patient's quality of life. In the light of the available literature presented above it is evident that CBT and other related techniques are beneficial in the prevention as well as in the treatment of PTSD, Depression, and anxiety, but the cultural based interventions developed across the world also have remained significant concern to the therapist. In the treatment of PTSD and other mental illnesses, these cultural-based strategies have proven to be quite successful and beneficial. Additionally, literature has witnessed that cultural based interventions have been found more effective than other treatments in certain circumstances. The overall picture depicted from the available literature suggested that CBI needs to be explored to examine its effectiveness by conducting further research in this field.

Methodology:

Research design: A research design is a methodical process for putting ideas to the test, collecting and analysing data, and coming to unbiased conclusions. Based on the study's justification and the characteristics of the study's variables, objective evaluations were conducted using a variety of statistical techniques. A completely randomised design (Pre-test, Post-test design) was used to accomplish the research objectives.

Variables of the study and their operational definitions: Independent variable

I. Types of therapeutic treatment:

This refers to the course of treatment (Cognitive behavioural therapy & Cultural based instructions). In each of the two treatment groups, there are ten weekly sessions. Each treatment lasts 60 minutes and is tailored to each patient separately.

Cognitive behavioral therapy (CBT): It is a style of talk therapy popular in the west that emphasises cognition. It facilitates the transformation of negative thoughts into constructive ones. Beck's worldview served as the foundation for the individual application of CBT. The patient had 10 sessions from the CBT manual over the course of 10 weeks. A licenced therapist provided CBT in the hospital setting.

Cultural modified (MCBT): It is a culturally generated variant of cognitive behavioural therapy. The FMAP paradigm served as the foundation for the creation of an instructional manual that incorporates CBT, RST, stress management, anger management, prayer therapy, Acceptance and commitment therapy, and interpersonal skills. A set of instructions was created for private administration. The patient received 10 treatments, each lasting 60 minutes, on a weekly basis.

ISSN PRINT 2319 1775 Online 2320 7876

 UGC CARE Listed (Group -I) Journal Volume 07, Iss 04, 2018

(a) Dependent variables:

(b) Anxiety and Depression*:* It means taking into account general anxiety and the anhedonic component that is an important part of depression. It includes only psychological symptoms of depression.

(c) Quality of life: Four dimensions of quality of life were taken into consideration, such as physical, psychological, social relationships, and environmental as per WHOQOL-BREF (1996).

***(d)* Procedure of Sampling**

(e) The patients were chosen from the Shri Maharaja Hari Singh hospital (SMHS), the Institute of Mental Health and Neurosciences Kashmir, Srinagar (IMHNS), and various clinics. Registered therapists provided treatments at the Institute of Mental Health and Neurosciences Kashmir Srinagar (IMHNS). 50 patients were chosen for the study out of the 101 patients.

***(f)* Assessment Tools / Techniques Used:**

(g) Assessment of Anxiety and Depression:

(h) For assessing the severity of anxiety and depression, the HADS (Zigmond and Snaith, 1983) Hospital Anxiety and Depressions scale was used. It is a fourteen-item scale and consists of two sub-scales, namely HADS-A consists of 7 items for assessing anxiety and HADS-D consists of 7 items for measuring anhedonic depressive symptoms. It is a 4 point scale that puts emphasis on total score, Greater than or equal to 1 indicates a clear- cut case of anxiety or depression.

(i) C. Assessment of Quality Of Life:

(j) Quality of life was measured using (WHOQOL-BREF1995). It is made up of 26 questions that assess the quality of life in four areas: physical, psychological, social, and environmental. Besides, there are two more items that measures the overall quality and general health of an individual.

(k) Statistical techniques

(l) Keeping in view the objectives of the study, nature of sample, and research design non- parametric statistical tests were applied that include the Mann-Whitney U Test, as well as the Kruskal-Wallis one-way analysis of variance, and the Wilcoxon Signed Rank test.

Result interpretation:

Table1.Comparison of pre and post test scores using Wilcoxon Signed Rank Test

Measures	***treatments***	***Pre-test score***	***Post-test score***	***Z value***	***P value***
HADS	***CBT/MCBT***				
Anxiety	CBT	10.00	4.32	4.381	.000
	MCBT	10.56	3.24	4.381	.000
Depression	CBT	9.92	4.64	4.352	.000
	MCBT	12.56	5.32	4.208	.000
QOL					

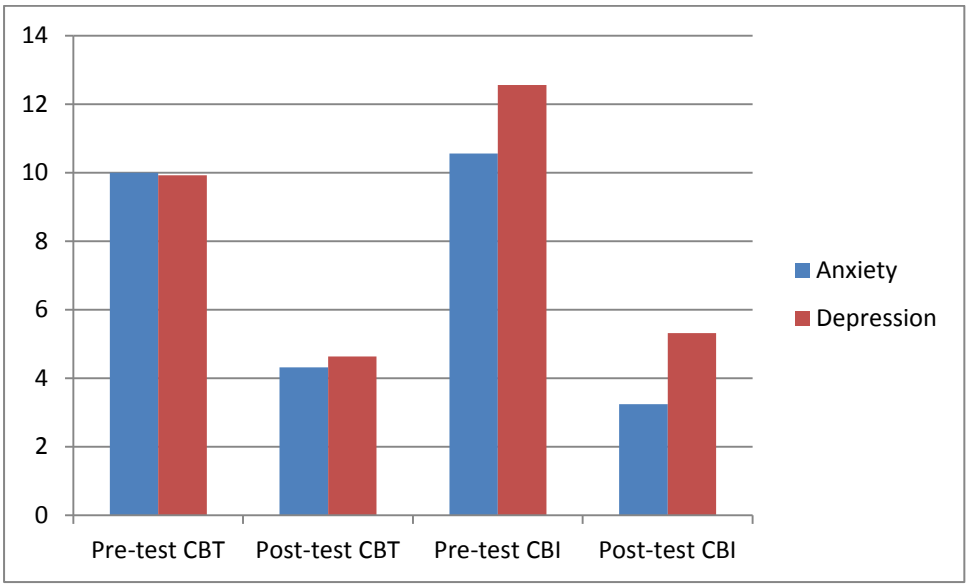
ISSN PRINT 2319 1775 Online 2320 7876

 UGC CARE Listed (Group -I) Journal Volume 07, Iss 04, 2018

Physical	CBT	19.44	23.08	4.390	.000
	MCBT	18.08	24.12	4.356	.000
Psychological	CBT	16.48	19.60	4.396	.000
	MCBT	14.84	19.60	4.213	.000
Social relations	CBT	9.24	9.88	.940	.347
	MCBT	9.28	9.98	2.887	.004
Environmental	CBT	24.16	25.44	2.717	.007
	MCBT	25.44	26.60	2.896	.004
					.000
			6.88	4.349	.000
			7.48	4.324	
Overall QOL	CBT	4.80			
	MCBT	4.20			

Table 1 show that both the treatments are effective in reducing the symptoms of anxiety, depression and improving the quality of life, as there is significant difference in scores before and after treatment.

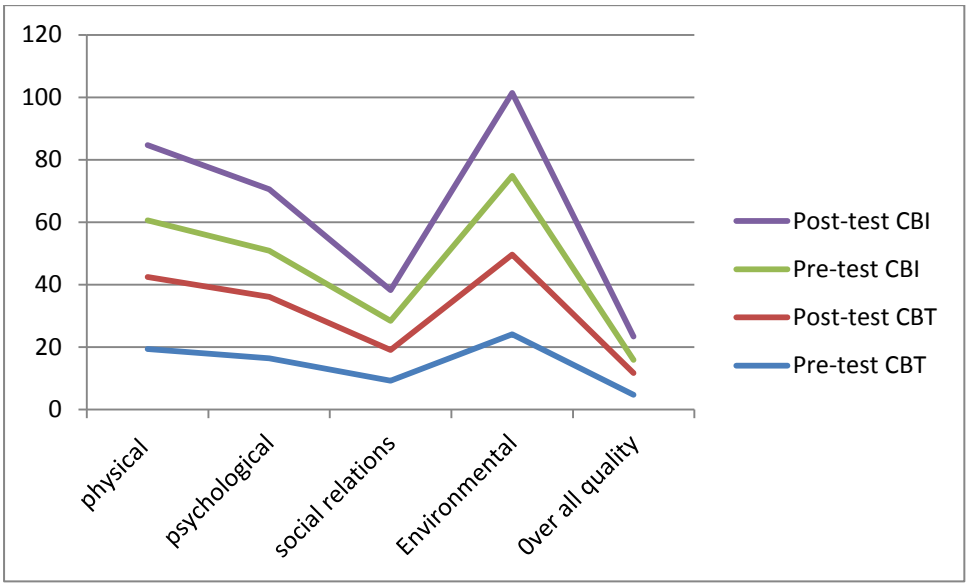
Figure 4.1 Graphical representations of dimensions of anxiety, depression and quality of life



HADS

ISSN PRINT 2319 1775 Online 2320 7876

 UGC CARE Listed (Group -I) Journal Volume 07, Iss 04, 2018



QOL

Dimension wise description of dimensions of HADS, and QOL.

(a) HADS

Anxiety symptoms: There is a significant decrease in the symptoms of anxiety after CBT treatment as reflected by pre-test score (10.00) and post-test score (4.32) with Z = 4.381 and p = .000

Depression symptoms: There is a significant decrease in the symptoms of depression after CBT treatment as reflected by the pre-test score (9.92) and post-test score (3.24) with Z = 4.381 p = .000

(b) Quality of Life

Physical dimension: There is a significant increase in physical dimensions of quality of life after CBT treatment as reflected by the pre-test score (19.44) and post-test score (23.08) with Z = 4.390 and p = .000

Psychological dimension: There is a significant increase in psychological dimensions of quality of life after CBT treatment as reflected by the pre-test score (16.48) and post-test score (19.60) with Z = 4.396 and p = .000

Social relations dimension: There is no significant difference in social relation dimension of quality of life after CBT treatment as reflected by the pre test score (9.24) and post test score (9.88) with Z = .940 and p = .347

Environmental dimension: There is a significant increase in environmental dimension of quality of life after CBT treatment as reflected by the pre-test score (24.16) and post-test score (25.44) with Z = 2.717 and p = .007

Overall quality of life: There is a significant increase in overall quality of life after CBT treatment as reflected by the pre-test score (4.80) and post-test score (6.88) with Z = 4.349 and p = .000

ISSN PRINT 2319 1775 Online 2320 7876

 UGC CARE Listed (Group -I) Journal Volume 07, Iss 04, 2018

2. Treatment (Modified CBT)

(a) ***Anxiety symptoms:*** There is a significant difference in the symptoms of anxiety after CBI treatment as reflected by the pre-test score (10.56) and post-test score (3.24) with Z = 4.381 and p = .000

(b) Depression symptoms: There is a significant decrease in the symptoms of depression after CBI treatment as reflected by the pre-test score (12.56) and post-test score (5.32) with Z = 4.208 and p = .000

(c) Quality of life

Physical dimension: There is a significant increase in physical dimensions of quality of life after CBI as reflected by the pre-test score (18.08) and post-test score (24.12) with Z = 4.356 and p = .000

Psychological dimension: There is a significant increase in psychological dimensions of quality of life before and after CBI treatment as pre-test score = (14.84), post-test score = (19.60), Z = 4.213 and p = .000

Social relations dimension: There is a significant increase in social relation dimension of quality of after CBI as reflected by the pre-test score (9.28) and post-test score (9.98) with Z = 2.887 and p = .004

Environmental dimension: There is a significant increase in environmental dimension of quality of life after CBI as reflected by the pre-test score (25.24) and post-test score (26.60) with Z = 2.896 and p = .000

Overall quality of life: There is a significant increase in overall quality of life after CBI treatment as reflected by the pre-test score (4.20) and post-test score (7.48) with Z = 4.324 p = .000

Table 2:

Mann Whitney U test of CBT and MCBT Post test Scores

Measures	*Treatment groups*	*Number*	*Mean rank*	*Sum of ranks*	*U value*	*P value*
HADS						
Anxiety	CBT	25	29.72	743.00	207.000	.036
	MCBT	25	21.28	532.00		
Depression	CBT	25	24.84	621.00	296.000	.746
	MCBT	25	26.16	654.00		
QOL						
Physical	CBT	25	23.38	584.50	259.500	.299
	MCBT	25	27.62	690.50		
Psychological	CBT	25	25.76	644.00	306.000	.899
	MCBT	25	25.24	631.00		

ISSN PRINT 2319 1775 Online 2320 7876

 UGC CARE Listed (Group -I) Journal Volume 07, Iss 04, 2018

Social Relations	CBT MCBT	25 25	26.00 25.00	650.00 625.00	300.000	.805
Environmental	CBT MCBT	25 25	24.42 26.58	610.50 664.50	285.500	.599
Overall QOL	CBT MCBT	25 25	22.18 28.82	554.50 720.50	229.500	.094

Table 2 shows a significant difference between CBT and MCBT in reducing the symptoms of anxiety and depression. Quality of life scores do not show any significant difference so for as CBT and MCBT are concerned.

Dimension wise description of HADS, and QOL are as:

1. **Treatment (CBT &MCBT)**
2. **HADS**

Anxiety symptoms: There is a significant reduction in the symptoms of anxiety by MCBT than CBT as significant difference exists between mean rank of CBT group (29.72) and mean rank of MCBT group (21.28) with U= 207.000 and p = .036. Here MCBT is more effective than CBT in reducing symptoms of anxiety.

Depression symptoms: There is no significant difference in the symptoms of depression by MCBT and CBT as no significant difference exist between mean rank of CBT group (24.84) and mean rank of MCBT group (26.16) with U = 296.000 and p = .746. Hence both the treatments are equally effective in reducing symptoms of depression.

3. ***Quality of Life***

Physical dimension: There is no significant difference in MCBT and CBT in improving the physical dimension of QOL of patient as significant difference does not exist between mean rank of CBT group (23.38) and mean rank of MCBT group (27.62) with U = 259.500 and p = .299. Hence both the treatments are equally effective in improving physical dimension of quality of life.

Psychological dimension: There is no significant difference in MCBT and CBT treatments in improving the psychological dimension of QOL as significant difference does not exist between mean rank of CBT group (25.76) and mean rank of MCBT group (25.24) with U = 306.000 and p = .899. Hence both the treatments are equally effective in improving psychological dimension of quality of life.

Social-relation dimension: There is no significant difference in MCBT and CBT in improving the social dimension as significant difference does not exist between mean rank of CBT group (26.00) and mean rank of MCBI group (25.00) with U = 300.000 and p = .805

Environmental dimension: There is no significant difference in MCBI and CBT treatments in improving the environmental dimension of QOL as significant difference does not exist between mean rank of CBT group (24.42) and mean rank of

ISSN PRINT 2319 1775 Online 2320 7876

 UGC CARE Listed (Group -I) Journal Volume 07, Iss 04, 2018

MCBT group (26.58) with U = 285.500 and p = .599 so we can say that both the treatments are equally effective in improving environmental dimension of quality of life.

Overall quality of life: There is no significant difference in MCBT and CBT in improving overall QOL as no significant difference exist between mean rank of CBT group (22.18) and mean rank of MCBT group (28.82) with U = 229.500 and p = .099. Hence CBI and CBT are equally effective in improving overall quality of life.

Discussion and conclusion: The findings of the present study revealed that cultural modified CBT are far more successful than CBT in minimizing the symptoms of anxiety, as there is a significant difference in the scores of anxiety between CBT and modified CBT. Moreover, study findings revealed that culture based modified CBT is equally effective in reducing symptoms of depression, as there is no significant difference found in depression scores between the CBI and culture based modified CBT groups. The study further reported that both CBT and CBI are equally effective in improving the quality of life of individuals suffering from PTSD, Anxiety, and Depression.

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