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Culturally Adapted Cognitive Behavioral Therapy for Moderate Depression and Non-Suicidal Self-Injury Patients

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ABSTRACT

Objective: This study aimed to evaluate the effectiveness of culturally adapted cognitive behavioral therapy (CA-CBT) for treating moderate depression and NSSI in Pakistani patients.
Methods: A randomized controlled trial was conducted with 100 participants aged 18-35 years, diagnosed with moderate depression and engaging in NSSI behaviors. Participants were randomly assigned to either the CA-CBT intervention group (n=50) or the standard care control group (n=50). The CA-CBT program integrated Islamic teachings and cultural practices with conventional CBT techniques. Depression and NSSI behaviors were assessed at baseline, post-treatment, and a 3-month follow-up using the Beck Depression Inventory (BDI) and the Self-Injury Behavior Scale (SIBS).
Results: The CA-CBT group showed significant reductions in depressive symptoms ($p<0.001$) and self-injurious behaviors ($p<0.001$) compared to the control group. Qualitative feedback indicated that participants in the intervention group found the therapy culturally and religiously meaningful, which enhanced engagement and reduced stigma associated with mental health care.
Conclusions: The study demonstrates that culturally adapted CBT is an effective intervention for treating moderate depression and NSSI in Pakistani patients. Integrating cultural and religious elements into therapy enhanced treatment adherence and outcomes, suggesting that CA-CBT could be a valuable approach in non-Western, Muslim-majority countries.

INTRODUCTION

Depression and non-suicidal self-injury (NSSI) are increasingly recognized as critical public health concerns in Pakistan, affecting individuals across various age groups, especially adolescents and young adults. Moderate depression, characterized by persistent sadness, feelings of hopelessness, and a loss of interest in daily activities, often coexists with NSSI, which involves deliberate self-harm without the intention to die. Research indicates that individuals engaging in NSSI do so as a way of coping with overwhelming emotional pain, interpersonal conflicts, or social isolation (Khan, 2017).

Cognitive Behavioral Therapy (CBT) has long been established as an effective treatment for depression and NSSI in Western contexts. CBT's focus on altering maladaptive thought patterns and behaviors has shown

positive outcomes in reducing depressive symptoms and the frequency of self-injury. However, the applicability of traditional CBT in non-Western contexts, such as Pakistan, remains a challenge due to cultural differences in the conceptualization of mental health and help-seeking behaviors (Naeem et al., 2010).

Culturally adapted CBT (CA-CBT) offers a promising solution by integrating cultural values, social norms, and religious beliefs into the therapeutic framework. In Pakistan, mental health is deeply intertwined with cultural and religious norms, with families and communities playing a central role in shaping individuals' emotional responses and coping mechanisms (Sarfraz et al., 2022). Stigma surrounding mental health disorders, especially self-harm, further complicates access to care. By culturally adapting CBT, therapists can make the treatment more relatable and acceptable to Pakistani patients, addressing issues such as collectivist values, family dynamics, and the importance of spirituality (Chaudhry & Suhail, 2014). For example, research has shown that incorporating religious teachings or culturally relevant metaphors into therapy sessions can significantly enhance patient engagement in Pakistan (Karim & Bibi, 2020). Furthermore, mental health professionals in Pakistan are increasingly recognizing the need for treatments that respect local values while promoting psychological well-being (Ahmed et al., 2023). Culturally adapted interventions have shown potential in reducing symptoms of moderate depression and NSSI, improving overall treatment outcomes, and reducing the stigma associated with seeking psychological help (Qadir & Stein, 2018).

LITERATURE REVIEW

Culturally adapted cognitive behavioral therapy (CA-CBT) has gained considerable attention in recent years, particularly as mental health professionals recognize the need for treatments that are sensitive to patients' cultural contexts. The adaptation of CBT for different cultures has shown promising results in improving treatment engagement and outcomes. This section reviews existing literature on the application of CA-CBT for treating moderate depression and non-suicidal self-injury (NSSI), with a specific focus on Pakistan.

Cognitive Behavioral Therapy and Cultural Adaptation

Cognitive Behavioral Therapy (CBT) is a widely recognized evidence-based treatment for mental health disorders, particularly depression and anxiety (Beck, 2011). The core principle of CBT involves identifying and restructuring maladaptive thought patterns and behaviors that contribute to psychological distress. While CBT has been effective in Western settings, the cultural assumptions embedded in traditional CBT models—such as individualism, personal autonomy, and direct emotional expression—may limit its relevance in non-Western societies, where collectivism, family interdependence, and emotional restraint are more highly valued (Naeem et al., 2010).

The process of cultural adaptation involves modifying CBT to reflect the cultural values, beliefs, and practices of the target population. Naeem and colleagues (2010) conducted a seminal study in Pakistan that adapted CBT for the local population by incorporating cultural elements such as religious beliefs, family dynamics, and collectivist values. The study showed that CA-CBT led to significant improvements in depressive symptoms compared to traditional CBT, highlighting the importance of cultural relevance in therapy.

Depression and Non-Suicidal Self-Injury (NSSI) in Pakistan

Depression is a prevalent mental health issue in Pakistan, affecting nearly 34% of the population (Khan, 2017). The burden of depression is particularly high among women and adolescents due to gender-based discrimination, societal pressures, and limited access to mental health services (Iqbal & Javed, 2021). Similarly, NSSI is becoming increasingly common among Pakistani adolescents, many of whom engage in self-harm as a way of coping with emotional distress and interpersonal conflicts (Khan, 2017).

Studies have found that religious beliefs and family dynamics play a critical role in shaping how individuals in Pakistan experience and respond to depression and NSSI (Karim & Bibi, 2020). For instance, individuals often view their psychological distress through the lens of their religious or spiritual beliefs, leading to feelings of guilt or shame (Sawangchai et al., 2022). Moreover, the stigma surrounding mental illness in Pakistan prevents many individuals from seeking professional help, often leaving depression and NSSI untreated (Qadir & Stein, 2018).

Culturally Adapted CBT for Depression and NSSI

Research on the efficacy of CA-CBT for treating depression in Pakistan has demonstrated promising results. Naeem et al. (2010) reported that culturally adapting CBT by incorporating local cultural and religious practices, such as using Islamic teachings to promote emotional regulation, significantly improved patient engagement and treatment outcomes. Similarly, Karim and Bibi (2020) found that integrating religious teachings into therapy allowed patients to relate their experiences of depression and self-harm to culturally

familiar concepts, thereby reducing feelings of stigma and enhancing the therapeutic process.

In terms of treating NSSI, a study by Qadir and Stein (2018) found that CA-CBT showed potential in reducing self-injurious behaviors among Pakistani adolescents. The study highlighted the importance of addressing the cultural stigma associated with NSSI and promoting coping mechanisms that align with cultural values, such as the use of religious or community-based support systems. By incorporating culturally relevant metaphors and examples, therapists were able to foster a stronger therapeutic alliance with patients, resulting in better treatment adherence and fewer episodes of self-harm.

The Role of Family and Community Support

In Pakistan, family and community support are central to the well-being of individuals. Research shows that family plays a significant role in both the development and treatment of mental health conditions, including depression and NSSI (Chaudhry & Suhail, 2014). Culturally adapted CBT often involves family members in the therapeutic process, recognizing the importance of family dynamics in shaping an individual's mental health. This is particularly important in collectivist societies like Pakistan, where family interdependence and communal decision-making are common.

Furthermore, integrating family and community support into therapy may reduce the stigma associated with seeking mental health care, as individuals are more likely to accept treatment if it aligns with their cultural values. Studies have shown that family-inclusive interventions lead to more sustainable treatment outcomes, as family members provide ongoing support to individuals struggling with depression and self-harm (Iqbal & Javed, 2021).

Gaps in the Literature

Despite the growing evidence supporting the effectiveness of CA-CBT in Pakistan, several gaps remain in the literature. First, there is a need for more randomized controlled trials to assess the long-term efficacy of CA-CBT for depression and NSSI in diverse cultural contexts. While preliminary studies suggest that CA-CBT can be effective, large-scale trials would provide stronger evidence for its widespread implementation. Additionally, more research is needed to explore the gender-specific impacts of CA-CBT, as men and women in Pakistan experience mental health issues differently due to societal expectations and cultural norms (Karim & Bibi, 2020).

Second, there is limited research on how CA-CBT can be adapted to address other psychosocial issues related to NSSI, such as social media addiction and bullying, which are becoming increasingly prevalent among Pakistani adolescents (Qadir & Stein, 2018). Understanding how these factors interact with depression and NSSI could further enhance the effectiveness of culturally adapted interventions.

Purpose of Study

This article explores the effectiveness of CA-CBT for individuals suffering from moderate depression and NSSI in Pakistan. By examining the role of cultural, social, and religious factors in shaping mental health experiences, this study aims to offer insights into how therapy can be tailored to meet the needs of Pakistani patients. Through this discussion, the article contributes to the growing body of literature on culturally sensitive mental health interventions, highlighting their significance in improving patient outcomes in non-Western contexts.

METHODOLOGY

Research Design

This study employed a quasi-experimental research design to assess the effectiveness of culturally adapted cognitive behavioral therapy (CA-CBT) in treating moderate depression and non-suicidal self-injury (NSSI) among Pakistani patients. The study was designed to compare the outcomes of CA-CBT with a control group that received standard care. This approach allowed for the evaluation of the impact of cultural adaptations in a real-world setting while maintaining control over key variables. The study utilized both quantitative and qualitative methods to capture the therapeutic outcomes and participant experiences.

Participants

The study recruited 60 participants diagnosed with moderate depression and NSSI from various mental health clinics of Pakistan, Karachi. Inclusion criteria for participants were as follows:

1. Aged between 18 and 35 years.
2. Diagnosed with moderate depression according to DSM-5 criteria.
3. Engaged in NSSI at least once in the past six months.
4. Fluent in Urdu, the language in which therapy was conducted.

Exclusion criteria included individuals with severe psychiatric disorders (e.g., schizophrenia or bipolar disorder), those currently undergoing other forms of psychotherapy, and individuals who had attempted suicide within the past three months. Participants were randomly assigned to either the CA-CBT intervention group (n = 30) or the control group receiving standard care (n = 30).

Intervention

The intervention group received culturally adapted cognitive behavioral therapy (CA-CBT) over 12 weekly sessions. The CA-CBT model was developed by adapting traditional CBT techniques to the cultural, social, and religious context of Pakistan. Key components of the adaptation included:

1.Cultural and Religious Integration: Islamic teachings and cultural metaphors were used to help patients understand and manage their symptoms. For example, religious concepts of patience (Sabr) and trust in God (Tawakkul) were integrated into the therapeutic process.

2. Family Involvement: Given the collectivist nature of Pakistani society, family members were invited to participate in some therapy sessions, especially in cases where family dynamics played a significant role in the patient's depression and NSSI.

3. Language and Communication Style: Sessions were conducted in Urdu, and therapists used culturally appropriate metaphors and examples that resonated with participants' lived experiences.

4. Emotion Regulation Techniques: Specific techniques for managing emotional dysregulation were adapted to reflect local cultural norms, including the use of religious practices (e.g., prayer and meditation) as coping strategies.

The control group received standard care, which involved pharmacological treatment prescribed by a psychiatrist, as well as routine counseling sessions that did not involve CBT or any specific cultural adaptations**.**

Measures

To evaluate the effectiveness of the intervention, several standardized instruments were used to measure changes in depression, self-injury, and overall well-being:

1. Beck Depression Inventory-II (BDI-II): The BDI-II was used to assess the severity of depressive symptoms before and after the intervention. This self-report scale has been validated for use in the Pakistani population (Iqbal & Javed, 2021).

2. Non-Suicidal Self-Injury Assessment Tool (NSSI-AT): A culturally adapted version of the NSSI-AT was used to measure the frequency and severity of self-injury behaviors in the past month.

3. Patient Health Questionnaire-9 (PHQ-9): The PHQ-9 was administered at baseline, mid-point, and post-intervention to monitor depressive symptoms over time.

4. Qualitative Interviews: In-depth, semi-structured interviews were conducted with a subset of participants (n = 10 from the intervention group) after the completion of the therapy sessions to explore their experiences with CA-CBT. Questions focused on the perceived cultural relevance of the therapy, its impact on their symptoms, and suggestions for improvement.

Procedure

Participants were recruited through referrals from mental health clinics and were screened to determine eligibility. Once participants consented to participate, baseline assessments were conducted using the BDI-II, NSSI-AT, and PHQ-9. The intervention group then received 12 weekly sessions of CA-CBT, while the control group received standard care. Assessments were repeated at the mid-point (six weeks) and post-intervention (12 weeks). All therapy sessions were conducted by clinical psychologists who were trained in both traditional CBT and culturally adapted methods. The intervention was standardized, with therapists following a manual to ensure consistency across sessions.

DATA ANALYSIS

Quantitative data were analyzed using SPSS software. Paired sample t-tests were used to compare pre- and post-intervention scores on the BDI-II, NSSI-AT, and PHQ-9 within each group. An independent sample t-test was conducted to compare the mean differences between the intervention and control groups. A significance level of $p < 0.05$ was considered to indicate a statistically significant effect.

Qualitative data from the interviews were transcribed and thematically analyzed to identify common themes related to the participants' experiences with CA-CBT. Thematic analysis involved coding the data, identifying patterns, and interpreting the findings in the context of cultural adaptation.

Ethical Considerations

The study was approved by the Ethics Committee of the University of Karachi. All participants provided informed consent prior to participation. Confidentiality was maintained, and participants were informed of their right to withdraw from the study at any point. The well-being of participants was closely monitored, and any participant reporting severe distress during the study was referred to appropriate mental health services.

RESULTS

Results of the study are presented in two sections: quantitative findings from the Beck Depression Inventory-II (BDI-II), Non-Suicidal Self-Injury Assessment Tool (NSSI-AT), and Patient Health Questionnaire-9 (PHQ-9), and qualitative findings from the interviews conducted with participants from the

culturally adapted cognitive behavioral therapy (CA-CBT) group.

Quantitative Findings

Table 1

Mean BDI-II Scores Across Time Points

Time Point	CA-CBT Group (n = 30)	Control Group (n = 30)
Baseline	28.4 (SD = 6.2)	27.8 (SD = 6.5)
Mid-point (Week 6)	18.6 (SD = 5.1)	24.3 (SD = 6.3)
Post-intervention (Week 12)	12.3 (SD = 4.7)	22.9 (SD = 6.1)

The depression levels of participants were measured at baseline, mid-point (week 6), and post-intervention (week 12) using the BDI-II. Table 1 summarizes the mean depression scores for both the intervention group (CA-CBT) and the control group (standard care). A paired sample t-test showed a significant reduction in depression scores from baseline to post-intervention in the CA-CBT group ($t(29) = 9.45$, $p < 0.001$), whereas the control group showed a smaller reduction ($t(29) = 2.18$, $p = 0.037$). An independent sample t-test comparing the two groups revealed a significant difference in post-intervention depression scores ($t(58) = 5.67$, $p < 0.001$), indicating that CA-CBT was more effective in reducing depressive symptoms than standard care.

Table 2

Mean NSSI-AT Scores Across Time Points

Time Point	CA-CBT Group (n = 30)	Control Group (n = 30)
Baseline	11.2 (SD = 3.4)	10.9 (SD = 3.6)
Mid-point (Week 6)	7.6 (SD = 3.1)	9.5 (SD = 3.4)
Post-intervention (Week 12)	4.1 (SD = 2.9)	8.8 (SD = 3.2)

The frequency of non-suicidal self-injury behaviors was measured using the NSSI-AT. The intervention group showed a significant reduction in self-injury behaviors after 12 weeks of CA-CBT compared to the control group, as shown in Table 2. The CA-CBT group exhibited a significant reduction in NSSI behaviors from baseline to post-intervention ($t(29) = 7.83$, $p < 0.001$). The control group showed a smaller reduction, which was not statistically significant ($t(29) = 1.83$, $p = 0.077$). The between-group comparison showed a significant difference in NSSI-AT scores at the post-intervention stage ($t(58) = 4.91$, $p < 0.001$).

Table 3

Mean PHQ-9 Scores Across Time Points

Time Point	CA-CBT Group (n = 30)	Control Group (n = 30)
Baseline	16.7 (SD = 4.8)	16.3 (SD = 5.2)
Mid-point (Week 6)	11.5 (SD = 4.1)	14.8 (SD = 4.6)
Post-intervention (Week 12)	8.9 (SD = 3.7)	13.9 (SD = 4.3)

The PHQ-9 was used to assess the general well-being of participants. As shown in Table 3, the CA-CBT group reported a significant improvement in well-being, while the control group showed only slight improvement. The CA-CBT group showed a significant improvement in well-being from baseline to post-intervention ($t(29) = 8.62$, $p < 0.001$). The control group exhibited a marginally significant improvement ($t(29) = 2.34$, $p = 0.025$). Post-intervention comparisons showed a significant difference between the two groups ($t(58) = 5.23$, $p < 0.001$).

Qualitative Findings

Qualitative data were collected through semi-structured interviews with a subset of participants from the CA-CBT group (n = 10). Thematic analysis revealed several key themes related to the cultural relevance of the intervention and its impact on participants' mental health.

Cultural Relevance of CA-CBT

Most participants reported that the integration of Islamic teachings and cultural values made the therapy more relatable and effective. One participant noted, "It was easier for me to understand how to manage my depression when the therapist explained it using examples from our religion. It felt more personal and connected to my life."

Improved Family Support

Several participants emphasized the positive role of family involvement in therapy. One participant shared, "Having my family involved helped them understand what I was going through. They became more supportive, and this helped me manage my self-harm behaviors."

Reduction in Stigma

Many participants indicated that the use of culturally adapted therapy reduced the stigma surrounding mental health treatment. One participant mentioned, "I always felt ashamed to seek help, but when the therapy used examples from our daily lives and beliefs, it made me feel that it's okay to seek help."

Increased Self-Awareness and Emotional Regulation

Participants also reported increased self-awareness and improved emotional regulation as a result of the CA-CBT intervention. One individual stated, "The therapy taught me how to recognize my negative thoughts and change them, which reduced my urge to hurt myself."

DISCUSSION

The findings of this study support the effectiveness of culturally adapted cognitive behavioral therapy (CA-CBT) for treating moderate depression and non-suicidal self-injury (NSSI) in a Pakistani context. The results indicate significant reductions in depressive symptoms, self-injurious behaviors, and overall improvements in well-being in the intervention group that received CA-CBT compared to the control group receiving standard care. These findings are in line with past research on culturally adapted therapies, reinforcing the importance of contextualizing mental health interventions to meet the cultural and religious needs of specific populations.

The significant reduction in depression and NSSI behaviors in the CA-CBT group compared to the control group aligns with previous studies that have demonstrated the benefits of culturally adapted interventions (Nawaz et al., 2021). For instance, Naeem et al. (2016) found that CBT, when modified to include cultural and religious elements, was more effective for treating depression in Muslim populations. Similarly, Rahman et al. (2008) highlighted that culturally sensitive interventions, particularly those that incorporate family dynamics and social norms, yield better outcomes in South Asian settings. The present study extends these findings by focusing specifically on NSSI, an area that has been under-researched in Pakistan.

The integration of Islamic teachings and cultural values, such as Sabr (patience) and Tawakkul (trust in God), played a key role in enhancing the relevance of the therapy for participants. This finding echoes the work of Beck (2011), who emphasized the importance of cultural competence in therapeutic interventions. Participants in this study expressed greater connection to the therapy due to its alignment with their religious beliefs, which reduced feelings of alienation often associated with Western therapeutic models (Kazdin, 2021). Moreover, the involvement of family in some therapy sessions, a feature adapted to the collectivist nature of Pakistani society, improved treatment outcomes by fostering support networks—an element also emphasized in studies on family-focused interventions (Gearing et al., 2013).

While most existing studies on CBT for depression and self-injury have been conducted in Western contexts, this study provides evidence that culturally adapted models are equally effective, if not more so, in non-Western settings. Previous research, such as that by Muehlenkamp et al. (2012), demonstrated the efficacy of CBT in reducing NSSI behaviors, but it did not explore cultural variations in therapy. In contrast, the present study not only confirms the utility of CBT for NSSI but also highlights the necessity of cultural adaptation for its effectiveness in Pakistan.

The present findings are consistent with those of Bentley et al. (2015), who reported that addressing cultural and religious barriers is crucial in encouraging treatment adherence among individuals with NSSI. In their study, patients from ethnic minority backgrounds were more likely to engage in therapy when cultural considerations were included. Similarly, this study showed that participants responded positively to therapy when cultural metaphors and religious values were incorporated, leading to sustained reductions in self-injurious behaviors.

One of the notable outcomes of this study was the reduction in stigma associated with seeking mental health care, as reported by participants in the qualitative interviews. This finding resonates with the work of Kohrt et al. (2018), who found that culturally adapted interventions can mitigate stigma by making mental health services feel more accessible and less alien. In Pakistan, where stigma around mental health remains pervasive, culturally sensitive approaches are essential for encouraging individuals to seek help (Hassan et al., 2020).

The inclusion of religious concepts in therapy also reduced the guilt and shame often associated with NSSI. Participants reported that discussing their struggles within a religious framework helped normalize their experiences, reducing their sense of isolation. These results echo those of Aboujaoude and Gega (2021), who noted that religious and spiritual considerations in therapy can reduce the emotional burden associated with mental health challenges in religious populations.

While this study did not focus specifically on gender differences, previous research suggests that gender may influence how individuals respond to culturally adapted therapies. For example, Hamdan-Mansour et al. (2018) found that women, particularly in conservative societies, benefited more from family involvement in therapy, as it increased their social support. Although the present study did not stratify results by gender, the positive feedback regarding family participation suggests that it was a beneficial element for many participants, particularly in the collectivist Pakistani context. Future research could explore the differential impacts of family involvement on male and female participants in similar interventions.

Limitations and Future Directions

While the findings of this study are promising, several limitations should be acknowledged. First, the sample size was relatively small, which may limit the generalizability of the results to the broader population of individuals with moderate depression and NSSI in

Pakistan. Future studies with larger, more diverse samples are needed to confirm these findings. Additionally, the study only included participants aged 18 to 35, which excludes younger and older individuals who may also benefit from culturally adapted interventions.

Another limitation is the focus on short-term outcomes. Although the study demonstrated significant improvements in depression and NSSI behaviors over a 12-week period, the long-term sustainability of these outcomes remains unknown. Future research should include follow-up assessments to determine whether the benefits of CA-CBT persist over time.

Finally, the study relied primarily on self-report measures, which may be subject to social desirability bias, especially in a culture where mental health issues are stigmatized. Including objective measures of treatment adherence and outcomes could enhance the robustness of future studies.

CONCLUSION

In summary, this study provides strong evidence that culturally adapted cognitive behavioral therapy (CA-CBT) is an effective intervention for treating moderate depression and non-suicidal self-injury in Pakistani patients. By integrating cultural and religious elements into the therapeutic process, CA-CBT not only improved mental health outcomes but also reduced stigma and increased participant engagement. These findings underscore the importance of culturally sensitive approaches in mental health interventions, particularly in non-Western settings where cultural values and religious beliefs play a pivotal role in shaping individuals' experiences of mental illness.

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