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Chapter

Culture Free CBT for Diverse Groups

Peter Phiri, Isabel Clarke, Lydia Baxter, Kathryn Elliot, Shanaya Rathod and Farooq Naeem

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Abstract

Traumatic experiences are known to have a significant impact upon one's physical and mental health. Post-traumatic stress disorder (PTSD) is understood to be a common mental health consequence of trauma. However, Complex Trauma and consequences of adverse childhood experiences appear more prevalent and a serious public health concern that hinders the individual's daily existence, thus emphasising the need to implement a culturally free treatment intervention. In this chapter, we begin by introducing traumatic experiences in several contexts and explore the treatment for trauma. It will focus on a research study that employs Comprehend, Cope and Connect (CCC), a third wave CBT approach, to deliver a culturally free form of therapy that has been adapted for individuals from diverse populations. The CCC approach's relevance to cultural adaptation is explained and discussed through the use of two case examples from the main study. The Culture Free study found that CCC was both feasible and acceptable in diverse populations, echoing existing research on cultural adaptations which found use of mindfulness to be accepted and appreciated as an effective intervention that can elicit concrete positive change across a broad range of mental health presentations, including trauma and trans-diagnostically. Further investigations utilising a robust methodology and powered sample are warranted in particular with diverse populations presenting with complex trauma.

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Keywords: comprehend, cope, connect, CBT, trauma, ethnicity, culture

1. Introduction

This chapter explores the treatment of trauma taken in a research study employing the Comprehend, Cope and Connect (CCC), third wave CBT approach, in delivering therapy to people from diverse ethnicities within a primary and secondary care service setting. CCC and its relevance to the treatment of diverse ethnicities will be explained; the CCC approach to trauma will be elucidated, and illustrated by discussing two case examples in detail from the main study.

Trans-diagnostic approaches have been gaining favour recently [1, 2]. Promising outcomes have been found in trials of therapy that is trans-diagnostic across anxiety disorders [3, 4]. The need for more expertise in treatment of trauma within psychotherapy services such as recognised by Murray [5] 's programme to teach trauma focused CBT to 20 therapists from 10 IAPT services resulting in improvement in client outcomes on a PTSD measure following the training.

Because the approach used is trans-diagnostic, and formulates linking current crisis with past adversity, a broader definition of trauma is used. The study offers the opportunity to review aspects of trauma and past adversity as these impinge on current mental health challenges in a broad community sample, not selected specifically for trauma. This data allows a sense of the continuum of impact of the past on the present within an ethnically diverse, general mental health, sample to be gained.

1.1 Trauma in context

Complex trauma refers to repeated and cumulative trauma that usually occurs over a period of time and within a specific context. The term was developed in the past decade by researchers who discovered that certain forms of trauma were more complicated than others [6, 7]. Many forms of trauma fall into the category of complex trauma including, domestic violence and attachment trauma, due to these forms of abuse occurring over a significantly extended period of time. The understanding extends to other types of traumatization occurring in childhood and/or adulthood for example, armed conflict and war, displacement, refugee status and forced relocation. Trauma may also result from chronic and ongoing health conditions due to a single event such as being witness to a sudden traumatic death of another. While the concept of complex trauma has been accepted, neither the DSM nor the ICD has included it; however, the upcoming ICD 11 is going to include the diagnosis of complex PTSD to describe complex trauma.

There is a vast body of research that demonstrates the strong association between adverse childhood experiences and trauma and the development of negative health and social outcomes later on in life [8]. Compelling research on the Adverse Childhood Experiences (ACEs) has aided in comprehending these links [9]. ACEs refer to any traumatic or commonly occurring stressful event, such as various forms of abuse, neglect and witnessing violence, which occurred before the age of 18 years old. Several large scale population based studies confirm the causal relationship of ACEs with poor emotional and physical outcomes. Bellis [10, 11] studies reported 50% of children within the UK experience at least one ACE, with four or more ACEs experienced by 12% of the UK population. Those individuals who experience a greater number of ACEs are at a higher risk of negative socio-economic issues such as, lack of education and job opportunities, increased risk of experiencing intimate partner violence, low emotional wellbeing and life satisfaction. Furthermore, if a person experiences one form of abuse, there is an 87% increase they will endure other forms of abuse. This equates to the more abuse one experiences the higher their risk of negative health and psychosocial outcomes in years to come [9].

The various mental health outcomes for which ACEs are risk factors is very broad. Those that occur during childhood, include attention-deficit hyperactivity disorder and oppositional defiant disorder; and during adulthood include, depression, anxiety disorders and personality disorder as examples [12]. Individuals who have been subjected to childhood trauma of physical or sexual abuse are more prone to get an admission to a psychiatric hospital; increase of self-harm and suicidal behaviour, and an overall higher global symptom severity [13]. Kessler et al. [14] provided conclusive evidence from 21 countries, which stated childhood adversities associated with maladaptive family functioning (e.g., child abuse and parental mental illness) were the strongest predictors for mental health disorders. The implications of the research findings are significant in depicting the causal relationship of childhood adversity and mental health disorders in order to facilitate the development of appropriate treatment plans.

1.2 Racial bullying

Following on from the adverse childhood experiences mentioned above, there is an increasing number of publications examining the prevalence of bullying – a repeated aggressive verbal, physical, or psychological behaviour – among children and adolescents, and the psychological consequences of bullying. Research has found that those exposed to bullying as a student, whilst at school, has shown a strong association with a negative impact on mental and physical health later on in life [15]. Specific focus has been given for bullying based on stigmatised identity, for example their race. Racial bullying has many similarities in terms of characteristics with discrimination as the maltreatment of the individual is due to their membership of a socially disadvantaged group. An investigation found that within the youth population, racial bullying had significant associations with poor mental health and increase in substance use compared with non-stigma based bullying [16]. Rosenthal et al. [17] concluded similar findings, with greater experiences of racial bullying indirectly associated with multiple adverse health outcomes including an overall decrease in self-assessed health across the span of 2 years. Furthermore, emerging evidence suggests that bullying may be associated with the development of psychosis. Schreier et al. [18] investigated whether there was an association between peer victimisation and psychotic symptomatology in a cohort of adolescents aged 12 years and concluded that peer victimisation was associated with psychotic symptomatology in early childhood.

1.3 Repeated violent relationships

As mentioned, intimate partner violence (IPV) is traumatising and remains a serious public health concern that affects 30% of every partnered women globally. The most prevalent mental health outcome of IPV is PTSD, ranging from 31% to 84.4% among IPV survivors, second is depression with a weighted mean prevalence estimate of 48% [19]. An association has been reported by studies between previous IPV and subsequent violence highlighting the role of PTSD in increasing the risk of future psychological abuse. Krause et al. [20] longitudinal study of IPV survivors found PTSD symptoms significantly associated in the increased likelihood of IPV after 1-year follow-up. Additionally, Bell et al. [21] concluded similar results that the more severe PTSD symptoms in women increased the risk for psychological abuse at an 18-month follow-up. Finally, data from the Chicago Women's Health Study reported the severity of PTSD symptoms is a predictor for future IPV [22]. Therefore, three of the four published studies revealed PTSD symptoms to be a predictive factor for future IPV. Albeit that the prevalence of PTSD and depression are evident mental health risk factors for future interpersonal violence, yet there is limited research that determines the impact specific interventions have upon reducing and preventing mental health outcomes that pose as a risk for future IPV among this vulnerable population.

1.4 Psychological impact of migration

Migration is a process whereby an individual leaves one geographical area for a prolonged or permanent move to another geographical area, due to reasons of economic gain, political upheaval, conflict or other reasoning. Over the last decade, migration has grown at an international level with an estimated 3.1% of the world population having internationally migrated. Migration is a complex process that differs for each individual, yet most often individuals experience stressful events such as violence, war, and persecution. There is often no adequate preparation

nor social support given, difficulties present in the form of barriers, leading to psychological distress and resulting in a negative impact on psychological well-being. There are several studies that globally depict the impact on migrant population's mental health, for instance, its impact on incidence of psychosis in African Caribbeans in the UK and Caribeean Islands [23, 24]. Another study by Bhugra [25] conducted in Trinidad and Barbados and on UK African Caribbean population confirmed the impact of migration on the UK migrants in comparison with those in the country of origin. This was further endorsed by Canter-Graae's and Selten [26] meta-analysis which established the significant risk of developing schizophrenia in the migrant populations. In a classic study [27], reported hospital admission rates for schizophrenia were higher among Norwegians who had migrated to the United States compared with Norwegians who stayed in Norway. The result of this increase was based on the migration process these individuals endured. This study is now the benchmark and set the standard for additional studies on comparing the rate of schizophrenia and other psychiatric illnesses in those who migrated to those who did not migrate. Research concludes the exceptional vulnerability migrants have for developing mental health disorder, and yet the local and international efforts to respond are unable to meet the demand. Psychological interventions need to consider the role of migration distress in assessment and formulation stages. It is paramount to understand why individuals might decide to migrate, elicit pre-migratory stressors and the risk factors associated with this phenomenon. There is an imperative need to develop culturally-sensitive services with trained professionals to implement appropriate interventions that aid in preventing psychological distress and promoting positive mental health and well-being among migrants.

1.5 Cognitive behaviour therapy

Cognitive Behaviour Therapy (CBT) stems from principles of cognitive theory [28] and implements both learning and conditioning in order to treat mental health disorders. Various techniques can be used including cognitive restructuring, exposure and the application of copying skills. CBT is typically delivered in 8 to 12 weekly sessions [29]. The general aim of cognitive therapy is to help individuals identify their unhelpful thoughts and modify beliefs in a way that encourages them to cope and ultimately change negative behaviours [30]. There is an abundance of research that supports the efficacy of cognitive therapy for treating trauma in adults. In addition, there is evidence to support using CBT to treat depression, anxiety, and symptoms of post-traumatic stress disorder (PTSD) resulting from sexual assault, industrial accidents and natural disasters [31].

CBT programs are typically implemented once a week over the course of a number of weeks, however, where this may be a barrier in regards to patient commitment to treatment over long periods of times, and interference with social functioning, researchers have argued for a more intensive delivery of CBT that has been proven to be just as effective as the standard delivery of cognitive therapy [32].

CBT has been consistently proven to be a better treatment of PTSD than relaxation training control groups. Furthermore, it has been shown that CBT is well maintained in follow-ups [33]. Despite the evidence suggesting the efficacy of CBT, many researchers still argue that the results obtained from randomised controlled trials are unlikely to be replicated in clinical settings. Reasons for this could include; inadequate staff training and experience, heavier caseloads, and more comorbidity among patients [33].

Research has found that psychological interventions can significantly reduce PTSD symptoms in adult survivors of childhood trauma. Previous meta-analyses emphasises that trauma-focused CBT (TF-CBT) is the most effective for PTSD. In

addition, researchers suggest that TF-CBT should be used as a first-line treatment for PTSD [34]. It has been argued that trauma-focused treatments show significantly larger effects compared to non-trauma interventions such as managing anxiety, problem solving and supportive interventions. A limitation of this research is that adult PTSD survivors from childhood abuse are significantly underrepresented in existing research. Some authors have argued that trauma-focused treatments are not appropriate for individuals with PTSD due to emotion regulation difficulties caused by childhood abuse and that participants would have to re-live traumatic events [34].

Much previous research regarding PTSD has focussed primarily on male veterans. Recent research has tested the efficacy of CBT with a female population. The results found that prolonged exposure (a type of CBT) resulted in a greater reduction of symptoms compared to women who received a supportive intervention [35]. Thus, highlighting that CBT can be effectively generalised to the female population.

In addition to using CBT to treat trauma in adults, research also shows that CBT is an effective treatment for PTSD in children. However, children suffering from trauma have limited access to evidence-based interventions. This is a huge issue as research proves that access to empirically supported PTSD treatment can be vital in treating the effects of trauma exposure [36].

2. Comprehend, cope and connect (CCC)

2.1 Rationale for culturally sensitive psychological interventions

The Western cultural bias of commonly available psychological therapies, including CBT has been identified as a barrier to both engagement and effective treatment of people from diverse ethnicities, and the development of culturally adapted and culturally sensitive forms of therapy is a response to this issue [37–46].

The current study seeks to address some challenges that have emerged during the course of this endeavour. Specifically, where adaptation relies on aligning to a particular culture, this limits applicability in a situation, such as that found in urban areas of the UK, where people from multiple ethnic groups co-exist. Further, mental health challenges are more likely to be viewed in spiritual and religious terms by non-Western societies and therapies such as conventional CBT tend to favour a diagnostic conceptualisation that can feel alienating to these cultures if not culturally responsive.

Third wave CBT approaches are built around the use of mindfulness in order to create distance from patterns of thought and behaviour leading to malfunction. These therapies are normally applied trans-diagnostically, and because of the spiritual origins of mindfulness, sit more easily with the non-Western mind-set. CCC, founded as it is in basic cognitive science, discards much of the complexity of other approaches and works with the universal human need to establish a tolerable internal state. Where this state is hard to reach, malfunctions that get labelled as 'symptoms' within the illness paradigm result, and can become established. The role of trauma in complicating the achievement of a good enough internal state, or sense of self, is given pride of place within the CCC formulation, and CCC has a distinctive approach to trauma which will be explored below.

2.2 The intervention

CCC was first evaluated within Acute Mental Health services [47–50], and developed for delivery in a primary care, Increasing Access to Psychological Therapies (IAPT) service, for complex cases [51]. Within primary care, the programme consisted of four individual, collaboratively arrived at, emotion and trauma-focused

formulation sessions, followed by a 12 week group, skills based, intervention, targeting emotion management and behaviour change. One or two review sessions concluded the programme. The manual for this primary care programme [51] was adapted for the CCC Culture Free manual by the authors IC, LB, PP & FN.

2.3 The manual

The adaptation welcomed inclusion of family members, carers, into the therapy, added somatic elements, made more space for spirituality and religion and added teaching stories.

The Culture Free therapy was briefer than the primary care version because it was targeted more widely. Within the IAPT service, the approach was reserved for complex presentations predicted or proved to be unresponsive to routine protocols. However, the participant group for the current study also included a high proportion of people with complex trauma and relationship issues. It was further hypothesised that involvement of the wider system might assist skills utilisation in the natural environment, so allowing for a briefer therapy, as noted in earlier studies (Naeem, personal communication).

The first four sessions covered open-minded listening to the individual's story and collaboratively drawing this together into an emotion-focused diagrammatic formulation. This incorporated the effect of trauma on current presentation and explained it to the client as covered in Section 3.2 below. Maintaining cycles are identified, along with skills needed to break them. Breaking these cycles informs the choice of goals. This formulation is also summed up in a compassionate letter discussed with and sent to the client. The subsequent four to eight sessions cover skills and behaviour change needed to break the vicious cycles.

2.4 Modifications to the manual

Refining the manual was a major aim of the study and the manual was revised in the light of new learning arising from the particular challenges that emerged during therapy delivery. Model adherent procedures to meet them were discussed in clinical supervision (with investigators IC, LB & PP), implemented and evaluated accordingly. Successful solutions were added to the manual, below.

Specific modifications included:

- How to proceed, without psycho-education in the Western viewpoint, where the individual sees their issues in somatic rather than psychological terms.
- Cultural difference in attitudes to assertiveness and anger.
- Managing family expectations where these appear detrimental to mental health.
- Discussing sensitive issues such as sexual abuse in the context of religious and cultural complication.
- Framing psychosis in a religiously and culturally, non-stigmatising way.

The pilot aimed to explore the feasibility, acceptability and effectiveness of CCC a novel third wave CBT integrative approach as a trans-cultural therapy intervention. The objectives included reduction in symptoms of emotional health problems and disability.

2.5 Participants

A total of (n = 32) participants with mental health problems were recruited into the study from Improved Access to Psychological (IAPT) Services and secondary adult mental health services, in a Hampshire NHS Foundation Trust.

Outcome measures were administered at baseline, end of therapy and at eight week follow-up period.

These included:

- Clinical Outcomes in Routine Evaluation (CORE) [52]
- The Hospital Anxiety and Depression Scale (HADS) [53]
- The Bradford Somatic Inventory (BSI) [54]
- WHO Disability Assessment Schedule v2.0 (WHODAS) [55]
- Patient Experience Questionnaire (IAPT- PEQ) [56]

The final results of this pilot have been prepared for submission. Repeated measures analysis of variance (ANOVAs) for outcome variables: HADS –depression scores indicated a significant effect when all three time points were compared simultaneously; $F(2,36) = 12.81$, $p < .001$, partial $\eta^2 = .42$. Bonferroni adjusted pairwise comparisons indicated significant reductions from baseline vs. post-treatment 11.21 (SD =4.28) to 7.11 (SD = 3.99) on the HDAS –depression $p < .004$ and baseline vs. follow-up 7.21 (SD = 4.99), $p < .001$. However, there was no significant difference between post-treatment and follow-up, $p < 1.0$.

HADS –anxiety scores was significantly different when all three time-points were compared simultaneously, $F(2,26) = 9.93$, $p < .001$, partial $\eta^2 = .36$. Bonferroni adjusted pairwise comparisons indicated significant reductions from baseline vs. post-treatment 14.53 (SD =4.01) to 11.05 (SD = 3.40) on the HDAS –anxiety $p < .003$ and baseline vs. follow-up 11.21 (SD = 4.05), $p < .001$. However, there was no significant difference between post-treatment and follow-up, $p < .831$.

WHODAS was significantly different when all three time points where compared simultaneously, $F(1.29, 14.18) = 6.73$, $p < .001$, partial $\eta^2 = .38$. Bonferroni adjusted pairwise comparisons significantly reduced from baseline to post-treatment 66.58(SD = 40.13) to 44.42(SD = 44.42 (SD = 32.35), $p < .034$ and baseline to follow-up 38.75(SD = 26.499), $p < .014$.

CORE Total score was significantly different at three time points, $F(1.25, 18.72) = 14.98$, $p < .001$, partial $\eta^2 = .5$. Bonferroni adjusted pairwise comparisons indicated significant reductions from baseline to post –treatment 76.81 (SD = 23.26) to 49.25 (SD =27.00), $p < .002$, and baseline to follow-up, 52.19 (SD = 25.72), $p < .001$.

3. Trauma in CCC

This section will take a more CCC adherent definition of trauma. The therapy is founded on felt sense; how the individual manages their subjectively experienced internal state. This is impacted by trauma in the present because of the way the threat system operates across time. What is significant here is the individual perception and experience of threat. Frequently, this originates in an identifiable trauma, such as child abuse, rape, violent relationship etc. However, it is not always possible to pinpoint its origin so precisely. Memory is impacted by such circumstances. Family and other interpersonal dynamics that would not be identified objectively as

constituting trauma can be experienced at a level of acute threat, particularly allied to individual sensitivity. CCC judges trauma by current presentation; disproportionate response to events in the current environment evidences triggering of earlier experience that has sometimes become hazy or lost to consciousness. Validating the likelihood of this explanation is the first step to someone being able to take responsibility for distancing themselves from threat driven reactivity.

A total number of (n = 32) participants were recruited into the Culture Free study as per study protocol. However, the majority of the participants had suffered earlier adversity that impacted on their current functioning as identified within the formulation, and many of these fell within or near the category of Complex Trauma, that is included in the (draft) ICD 11 (but not DSM V). ICD-11 CPTSD includes the three PTSD clusters and three additional clusters that reflect 'disturbances in self-organization' (DSO): (1) affective dysregulation (AD), (2) negative self-concept (NSC), and (3) disturbances in relationships (DR). These disturbances are proposed to be typically associated with sustained, repeated, or multiple forms of traumatic exposure, including childhood sexual abuse and severe domestic violence, represented in some of this sample, reflecting loss of emotional, psychological, and social resources under conditions of prolonged adversity [57]. It is the effects as opposed to the originating circumstances that are treated in the current study.

3.1 How Trauma activates the body's threat system across time

An important element of CCC is communication and motivation, so that a way of presenting the interference of past trauma in current functioning that is both true to the facts, easily graspable and translates into practical management is key. There are two fundamental processes that need to be understood and communicated relevant to response to trauma. One is the autonomic arousal response, mediated by the parasympathetic nervous and poly vagal systems. The other is the singular nature of trauma memory.

To start with memory, dual processing models of human cognition provide a straightforward way of understanding the phenomenon of involuntary and immediate trauma recall. Brewin [58] reviews studies of animal conditioning and concludes: 'This evidence points to an important distinction between hippocampally-dependent and non-hippocampally-dependent forms of memory that are differentially affected by extreme stress.' This leads to the identification of separate memory systems underlying vivid re-experiencing versus ordinary autobiographical memories of trauma. Brewin [58] refer to these as verbally accessible memory (VAMS) and situationally accessible memory (SAMS). The differential effect of stress elucidates the facilitation of access to SAMS through high arousal states in the present. Ehlers & Clark [59, 60] incorporate the same sort of distinction into their widely adopted model of PTSD, using Roediger's [61] distinction between conceptual and data-driven memory processing, to explain this phenomenon of re-experience of past events.

Since that time, there has been extensive investigation of the nature and precursors of such intrusive memories, often using analogue studies of individuals shown traumatic film under various conditions. The wider role of hormones, including stress hormones and more precise information about the areas of the brain involved through use of fMRI images have been studied [62].

As well as featuring in time violating, intrusive memory, trauma disrupts the autonomic nervous system, leading to sensitization to perceived threat, and heightened vulnerability. This is aversive, and so in turn leads to avoidance, both of an ever generalising pool of triggers and reminders, and of close relationship, which disrupts the very sources of support people normally rely on. Early and repeated trauma, leading to overactive cortisol production, leads to lasting disruption to these systems [63].

As well as the heightened atunement to threat this represents, dissociation; involuntary mental absence; is another result of trauma. Physically this can be traced to the poly vagal response to extreme trauma; the freeze response. This has the additional effect of shutting off the affiliative arm of the poly vagal system [64].

3.2 The CCC explanation

The Interacting Cognitive Subsystems (ICS) model of cognitive architecture [65] distils this information into a useful map of connections and disconnections within the brain. ICS posits two central meaning making systems, the implicational and the propositional, each with their own memory system, representing the evolutionarily older and newer parts of the brain respectively. Normally these communicate, but can become desynchronized at high and low arousal. This leaves the older, emotional and threat attuned, implicational subsystem, in charge without access to the contextual information from the propositional. This model provides a succinct rationale for the background to trauma symptoms outlined above that is communicated within CCC by means of a modified form of the Dialectical Behaviour Therapy States of Mind diagram (**Figure 1** below) that adds the separate memory systems.

This states of mind diagram with addition of memory provides a normalising explanation. For many people, this lifts the stigma of a sense of innate pathology and substitutes a simple rationale for the unbearableness of current adversity which for other people would be more manageable.

It also ushers in the agenda of facing up to the past trauma and its potential to intrude into the present if not managed. Mindfulness provides a means to do this without being overwhelmed by the accompanying emotion, and, importantly, to disentangle what belongs to the past from what belongs to the present. Much of the therapy is focused on identifying strengths and potential and finding new, effective ways forward. There is growing clinical evidence, which needs back up by proper research study that this can enable people to move forward from even serious trauma without need for detailed reliving.

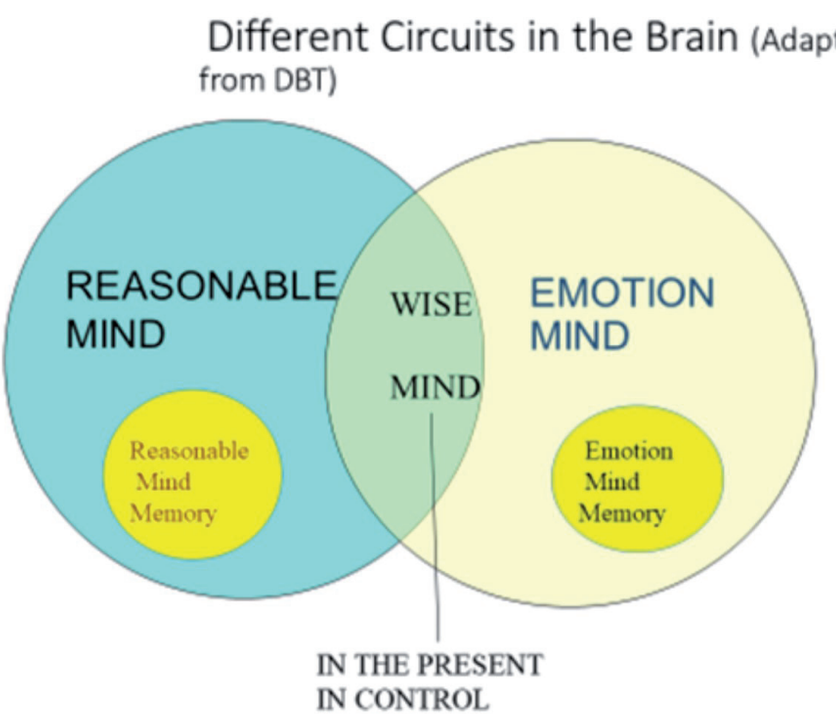


Figure 1.
States of the mind. From Clarke, I. (2016). Reproduced with permission from Hodder & Stoughton ltd.

Another feature of CCC is that it is trans-diagnostic – or perhaps more accurately, blind to diagnosis. Most of the literature on therapy for trauma starts with a diagnosis of PTSD, and this certainly makes research tidier. CCC has developed particularly in situations where diagnostic uncertainty abounds, such as Acute and Inpatient Mental Health Services [48] and those who fail to benefit from diagnostically organised protocols in primary care. Unsurprisingly, trauma of one sort or another, usually of the complex variety, features heavily in both these groups, and only a minority will have a diagnosis of PTSD.

3.2.1 Participants' experience of trauma

Table 1 above lists the IAPT study participants (n = 20) and elements, if any, of complex trauma as identified in their formulations, along with the disproportionate current response attributable to the impact of the past. This table illustrates the universality of some sort of trauma or earlier adversity impacting present functioning within a community sample selected for ethnic diversity. Some of the instances are culturally connected (e.g. illegal immigration status and racial bullying), but many would be found in any sample. This illustrates the ubiquity of the impact of such past adversity on mental health presentation. The table also lists the interventions applied in addition to mindfulness. See Appendix 2 for the principle interventions post formulation.

3.3 Case Example 1: 'Celine'

3.3.1 Background and contact with the service

Celine was a 58 years old woman of mixed race heritage, born in French Guyana. She moved to England with her family in her teens. She was a mother to three children, two older ones from a first marriage and a 10 year old daughter from her second marriage, at the time of therapy. Celine and her parents retained strong family connections with country of origin, Guyana. Relations with the wider family were important to her, but could also be a source of stress where she was expected to fulfil a particular role by powerful individuals.

She was recruited into the study and received 8 sessions of Culture Free CCC. Previous psychological history revealed several previous episodes with mental health services; two episodes for support with her employment difficulties, and one further episode when she first received generic group input, and was then stepped up for individual therapy and received 15 sessions of CBT for Generalised Anxiety Disorder (GAD), without achieving reliable improvement.

She was a well-educated high achiever and had made a good career as a Solicitor specialising in business and financial cases. A critical incident for her was in 2008 when she had loss in her daughter at about the same time as she lost a parent. She struggled to cope; she related that her second husband and the firm she worked for were unsupportive. Her psychiatric history revealed a diagnosis of depression in 2008 and she had been on anti-depressants from then on.

She reported that the attitude of her employer to her health struggles developed into bullying and discrimination with strong racial overtones. She reported feeling she did not fit into the firm and desperately wanted to leave the job and change career. She described her marital relationship had become increasingly abusive and controlling.

3.3.2 Initial therapy session

At the point at which Celine entered therapy, she had managed to separate from her husband, to leave her job and embark on a training for a new career in the social care

Case No	Earlier life experiences (Traumatic context)	Presenting problem and impact of past.	Specific CCC Coping Strategies in addition to Mindfulness.
1	Childhood abuse (by a close family member), age 4 years, and neglect; judgmental mother - unrealistic academic expectations.	Acquiring physical disability (fibromyalgia and chronic pain), triggers sadness, anger, shame and anxiety, and feeling useless	Building a new relationship with the past: Self compassion
2	Childhood abuse. Domestic violence from partners.	Anger and cannot cope when feeling unsupported, let down in the present. Unassertiveness.	Building a new relationship with the past: Self compassion; Positive Anger Work
3	Over-looked academically as a girl; sense of injustice. Sexual abuse by older brother told not to tell (approx. 7 years old) told mother, who blamed and chastised her for the act.	Unacknowledged in current family leading to disproportionate depression and anger	[+]Emotion Management; Self compassion
4	Punishing and neglectful mother. Anxious childhood.	Inability to deal with emotions. Avoidant of relationships	Self-compassion; [+]Emotion Management
5	Childhood trauma. Father nearly died in car crash when 9 years old. Family pre-occupied with impact on sibling.	Obsessional thoughts regarding harm to daughter. Avoidance.	[♦]Arousal Management; [*]Aspects of Self; Self compassion
6	Extreme childhood fear engendered by tales of black magic.	Post-natal fears for safety of son. High anxiety. Compensates with controlling pre-emptive and perfectionist behaviours.	Arousal Management; Building a new relationship with the past; [+]Emotion Management
7	Neglectful and chaotic childhood. Alcoholic father	Avoidance of emotion leading to constant activity and chronic stress. Alcohol.	[♦]Arousal Management; [+]Emotion Management
8	Multiple deaths of family members coming close together	Obsessive health anxiety	[♦]Arousal Management; Self compassion; [**]Relationship management
9	Shamed within family as teen for (culturally unacceptable) homosexuality. Physical and emotional abuse by mother. Father left when 3 years old.	Envy, anger, relationship and career difficulties. Loneliness Copes with perfectionist ideas but behavioural inactivity (fear of failure)	[♦]Emotion Management; [**]Relationship management
10	Sister preferred. Rape by ex-partner. Racism at work.	Low self-esteem. Perfectionism leading to high stress.	Positive Anger Work; Aspects of Self; Relationship management
11	Childhood trauma - Mother left. Sex abuse by a parent at 12 years. Abusive childhood. Adult trauma – Loss of daughter in a road traffic accident (RTA). Impact of RTA -reduced memory, increased emotionality and impulse control.	Flashbacks. Dissociation. Low self-esteem. Problems with emotions and relationships	Building a new relationship with the past; [+]Emotion Management; [**]Relationship management

Case No	Earlier life experiences (Traumatic context)	Presenting problem and impact of past.	Specific CCC Coping Strategies in addition to Mindfulness.
12	Childhood trauma – loving family, experienced war conflict while in Turkey during Kurdish and Turkish conflict – witnessed village members being tortured by soldiers. 'Reported seeing 'Jinns', dead bodies and evil spirits' – hallucinations? Adult trauma - Illegal immigrant for 14 years – experienced extreme anxiety and feeling under attack from others.	Panic, hypervigilance, avoidance of crowds and exercise.	♦Arousal Management; +Emotion Management
13	Mental, physical and sexual abuse.	Avoidance of emotion. Avoidance of intimacy.	Building a new relationship with the past; **Relationship management; +Emotion Management; *Aspects of Self
14	Childhood sexual abuse by a parent between 5 to 12 years. Experienced 13 years of mental and physical abuse from husband.	Emotionally overwhelmed. Withdrawal and unmotivated, or dysregulated anger.	♦Arousal Management; Relationship management; Self compassion
15	Emotionally abusing and criticising childhood.	Dissociation. Emotional overwhelm and relationship difficulties.	Positive Anger Work; +Emotion Management; Self compassion
16	Migration age 19 years of age; hostile in-laws. Major health difficulties severely impact marriage.	Suicidal and self-harm. Low mood.	♦Arousal Management; **Relationship management; Self compassion
17	Unhappy childhood; Migration distress. Breast cancer.	Obsessive anger at neighbours leading to conflict	♦Arousal Management Positive Anger Work; +Emotion Management
18	Diagnosed with Autism. Early childhood developmental problems.	Social avoidance.	+Arousal Management; Behavioural Activation; **Relationship management
19	Ran away from home age 11 years. 'Kicked out' of Family home at the age of 19 years. Loss of young sibling and felt excluded.	Suicidal. Avoidant of emotion.	Building a new relationship with the past; Self compassion; +Emotion Management
20	Long exploitative and abusive marriage plus racial bullying at work.	Stress, chronic hypertension. Relationship difficulties.	♦Arousal Management; +Emotion Management; Positive Anger Work; *Aspects of Self

Mindfulness is the core intervention; it informs the application of the others. ♦*Arousal Management includes Relaxation Breathing and lifestyle adjustment.*
+*Emotion management includes facing, expressing and letting go of emotion.*
**Aspects of Self is mindfulness managed subpersonality work.*
***Relationship management includes assertiveness.*

Table 1.
Case table.

sector. She related that she was proud of herself for managing to make the break, and enjoying her new career and receiving recognition for her abilities and achievements after years of being undervalued and bullied. However, many stresses remained. The course was demanding, both physically and mentally. She was a single parent.

However, she was left with a legacy of chronic hypertension and sleeplessness from long endurance of bullying and control in both work and marriage. This left her exhausted and reporting low energy levels and lack of self-confidence. Furthermore, a recent serious road traffic accident exacerbated her distress and lack of wellbeing, leaving her with chronic pain.

Relations with her ex-husband were another major source of stress. As she had previously had a high income and he was on statutory benefits. Celine felt he was trying to extract as much financial advantage as he could. However, she had experienced a major financial impact after her career change resulting in financial worries and anxiety.

She also experienced ongoing, realistic, anxiety that her ex-husband's cynical bid for custody of their daughter, she was able to recognise that this was unrealistic but she felt overwhelmed and stressed over child access arrangements. Her traumatic experiences left her universally mistrustful of people, meaning she was cut off from support and warmth from her two, surviving, older children and her friends.

3.3.3 Formulation

Her feelings and emotions were validated accordingly and her chronic hypertension and insomnia were discussed as understandable in light of long endurance of bullying and controlling former employer and marital problems. The intrusion of past sense of threat compounding current adversities was explained using the States of Mind diagram (**Figure 1** above). We worked collaboratively to make sense of her presenting problem using the CCC formulation diagram (**Figures 2** and **3**) which labelled the feelings of loneliness and mistrust; anxiety, regret and sadness at its heart. These emotions were understandable in the light of her current stressful situation and the car accident, but the loss of her son and the years of bullying and abuse were still active in her life, exacerbating the hypertension and mistrust.

The other legacy of the past that was interfering with life in the present was mistrust of people and avoidance of getting close. The trauma of the loss of her

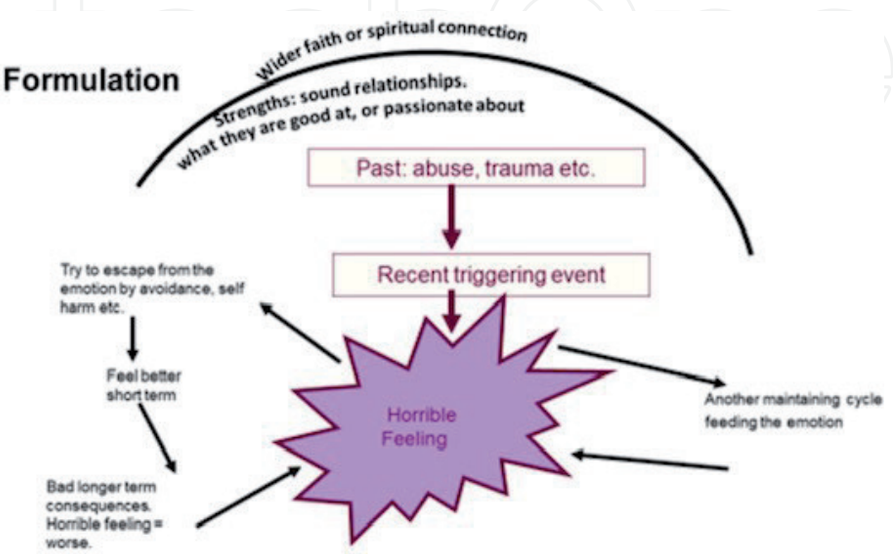


Figure 2.
Spikey formulation diagram. From Clarke & Nicholls (2018). Reproduced with permission from Hodder & Stoughton ltd [66].

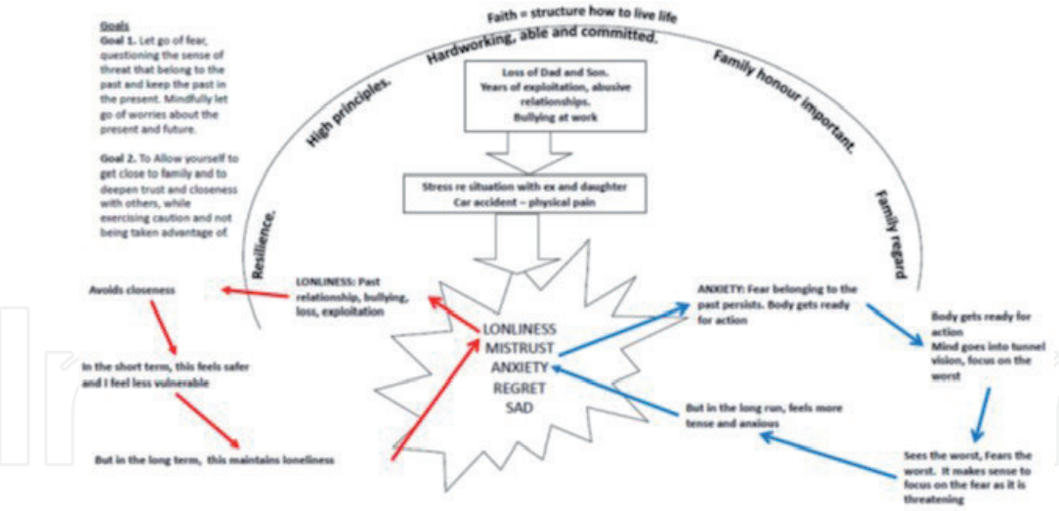


Figure 3.
Celine's spikey formulation.

son interfered with closeness within the family, so that, for instance, she avoided hugging her eldest child, which was a source of pain to both. This reticence also affected relationships with her other children and her friends. Long experience of bullying at work and the behaviour of her ex-husband made her highly mistrustful in relationships in the wider world, but at the same time, sapped her ability to be appropriately assertive, and so defend herself.

We identified Celine's many strengths; she was resilient and had high principles. She was committed, hardworking and able. She was held in high esteem in the extended family and family honour was important to her, as was her Christion faith which gave her the structure to live by.

We then identified the two major vicious circles that kept her trapped in the past, despite having broken free of abusive marriage and job through heroic effort.

3.3.4 Vicious circle 1

The fear she had lived with for so many years combined with current anxiety to maintain her body in a state of hypertension. This in turn oriented the mind to fear so that she always expected the worst, which maintained her stress levels.

The intervention following formulation was informed by goals agreed as the means to break the hold of the vicious circles, as follows:

Goal 1. Let go of fear, questioning the sense of threat that belongs to the past and keeps the past in the present. Mindfully let go of worries about the present and future.

- Face and accept that what happened did happen. Let it remain in the past.
- Be aware that the future will feel more threatening because bad things happened in the past. Mindfully note this and let go of it.
- Do this in a spirit of 'floating not fighting'.
- 'Floating not fighting' refers to the tendency of perfectionist people like Celine to approach challenge in a tense, 'fighting', mode, which paradoxically maintains the dominance of the Emotion Mind. Relationship with the body and how it is held is central within CCC because of the message that this sends to the mind – in this case, a message of relaxed strength.

3.3.5 Vicious circle 2

The other cycle tracked the way that long exploitation and bullying, combined with the loss of her son, had made her mistrustful of relationships and avoidant of closeness. This avoidance felt safer, so was maintained, but kept her lonely and unsupported. It was particularly undermining of her relationship with one of her children whom she did not dare hug as this brought back the loss of her daughter. It also caused distance from her other children.

To break this cycle we agreed **Goal 2** would focus on the following:

- To allow yourself to get close to family and to deepen trust and closeness with others, while exercising caution and not being taken advantage of.

The formulation phase was concluded with a compassionate letter, shared in Session 4 that summed up the formulation and the agreed goals of therapy.

3.3.6 Intervention phase [session 5–8]

We worked on breaking the first cycle by using breathing and mindfulness techniques in the short term. Celine was receptive to therapy and responsive to the use of mindfulness to enable her to observe and revise habitual patterns, and this brought a regular practice into her routine.

As the therapy progressed we did more work using emotions positively through mindfulness. This laid the ground work for rebuilding a new relationship with the past self. Self-Compassion is an important intervention, both to ensure that she was giving herself the best chance in the present, and in order to apply compassion for her past self, to enable her to accept and go forward from things that had gone wrong in her life. Positive anger work was also crucial here, in order to give her the courage to face the legacy of fear, without getting tangled up in bitterness. Targeted mourning enabled her to meet and let go of the sadness of all that had happened. Thus she was able to construct a new relationship with the past, facing it without letting it rule her. We never explored it in detail.

We used mindful awareness of the internal barriers to the impulse to hug to question and reverse them. Being able to hug her daughter proved something of a breakthrough, which she was able to translate into warmer relations with the wider family and friends.

3.3.7 End of therapy and clinical outcomes

By the end of therapy, Celine reported feeling more relaxed and able to take control of her life. In 'Aspects of Self-Work'[1] we did, she gained a sense of being able to use mindfulness to balance her confident, lonely persona that kept her separate, with her more gregarious and family oriented side, which had seen her exploited and bullied by others in the past. Paradoxically becoming more assertive with her ex-husband improved the relationship considerably.

Letting go of mistrust of people outside the family, born of her employment experience, was work in progress, but she knew how to proceed with it. Similarly, she had managed to reduce her ongoing hypertension significantly, but there was still progress to be made. This is in line with the philosophy of CCC, which takes the view that, once the formulation has been collaboratively arrived at and goals arising from breaking the cycles agreed, the rest of the therapy provides a tool kit of strategies, some of which will be successfully applied with the support of the therapy, but which the individual can continue to work with, helped by natural supporters, long after the end of therapy.

Celine's routine outcome measures on PHQ-9 and GAD-7 scores presented in **Figure 4** below are indicative of the progress she has made in this treatment. The spike in the graph December 2018 represents the coincidence of a bereavement, Christmas holiday, course and family pressures and was resolved by the next session meeting in January, with progress maintained at follow-up with GAD-7 scores significantly reducing to 7 at follow-up time point.

3.4 Case Example 2: Jade's journey through services

Jade was a 44-year-old married woman with two children, a 9-year-old boy and a 4-year-old girl. She grew up in the Seychelles and moved to the UK in her early adulthood to train as a teacher, leaving her family home and mother in The Seychelles. Due to the information she provided during her psychological assessment, which detailed traumatic experiences, and using the ICD-10, she was classified under the F43.1 Post-Traumatic Stress Disorder problem descriptor. Although with reference to the current ICD-11, she may have been classified under the 6B41 Complex Post-Traumatic Stress Disorder.

She defined her main problem as low mood and difficulty coping with her physical health issues (including chronic pain). "The low mood is to do with my past which I wish I could get out of my head and causes inactivity, depression and anxiety." She was recruited from the IAPT service's waiting list to take part in the Culture Free study as she met the inclusion criteria and consented to take part in this study. In line with the study protocol, she commenced a course of 12 CCC therapy sessions during the study period.

*3.4.1 **Initial therapy session** - Jade's background and current.*

During the first therapy session, Jade was encouraged to talk about what was not working in her life at the time. Using open ended questions and active listening, an exploration of her current difficulties and how these affects her life and relationships. Information about her early experiences and how these might impact on the current problem was also gathered.

Jade grew up in a single-parent household with what she described as "a strong and critical mother," who prided academic achievement overall and any deviation from this focus was met with physical punishment and critical verbal abuse. When Jade was 4 years old, she would spend time with her grandmother, but was sexually abuse by her male cousin during these visits to her grandmother's house. She told her mother of this sexual abuse, but her mother physically abused her

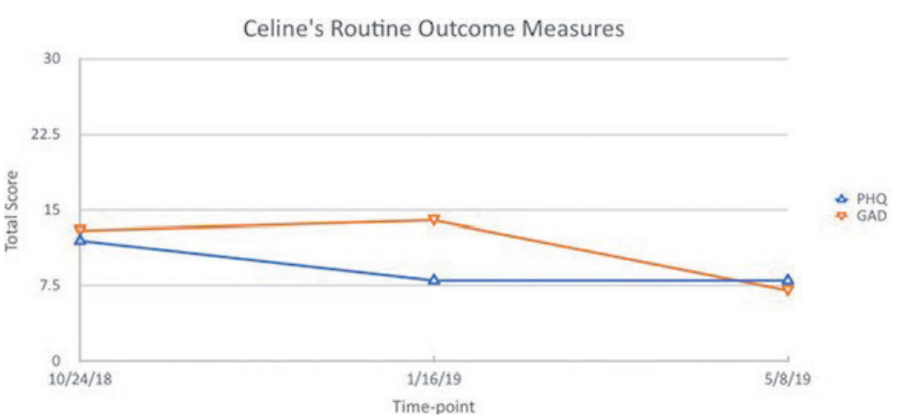


Figure 4.
Routine outcome measures: PHAQ-9 and GAD-7 scores.

and blaming her for provoking the cousin into these acts; although she never went back to her grandmother's house again.

She attributed this history as the cause of her current feelings of sadness and anger, as she thought about it often and wished she could stop these ruminations. Additionally, she discussed how having a punishing mother who expected academically high achieving children has made her self-critical and perfectionistic, which had an impact on her relationship with her health conditions. Her experiences of having fibromyalgia were also conveyed, specifically how this health condition affected her ability to do everyday tasks, such as housework, childcare and cooking. She expressed feeling guilt and shame regarding her reliance on her husband to assist with these duties, and often wished that her body functioned as it did when she was younger. This also led to feelings of sexual inadequacy and desired a "proper" relationship with her husband.

Validation was expressed regarding her current situation and emotional experiences in light of her history and current ways of coping. The states of mind diagram in **Figure 1** above was also explained to Jade using examples that she had shared to help her understand how her emotion mind memories were being experienced in the present, and also why she attempted to avoid feeling emotions by withdrawing and disconnecting with others. These psychoeducational interventions offered a normalising and validating explanation to her experiences and is an important part of CCC as it aids the person-therapist collaboration by establishing a warm and trusted therapeutic relationship, especially in cases such as Jade's who have experienced invalidating and neglectful relationships in the past. This validating, non-pathologising stance was adopted throughout therapy. Additionally, short mindfulness exercises were practiced from the start with a simple grounding, noticing practice being shared in the first session. Mindfulness continued to be introduced in each session throughout therapy.

3.4.2 The formulation

Figure 5 below illustrates Jade's spikey formulation diagram, that was collaboratively arrived at during sessions 2–4 and summarised Jade's past and current situations in a concise and clear manner. The formulation was started with the "spikey" in the centre, which focuses on the felt sense of the person. For Jade, this was sadness, anger, feeling "useless," shame, guilt, and anxiety. Situations where these feelings were triggered were explored next (the box above the spikey), and in the top box, her past

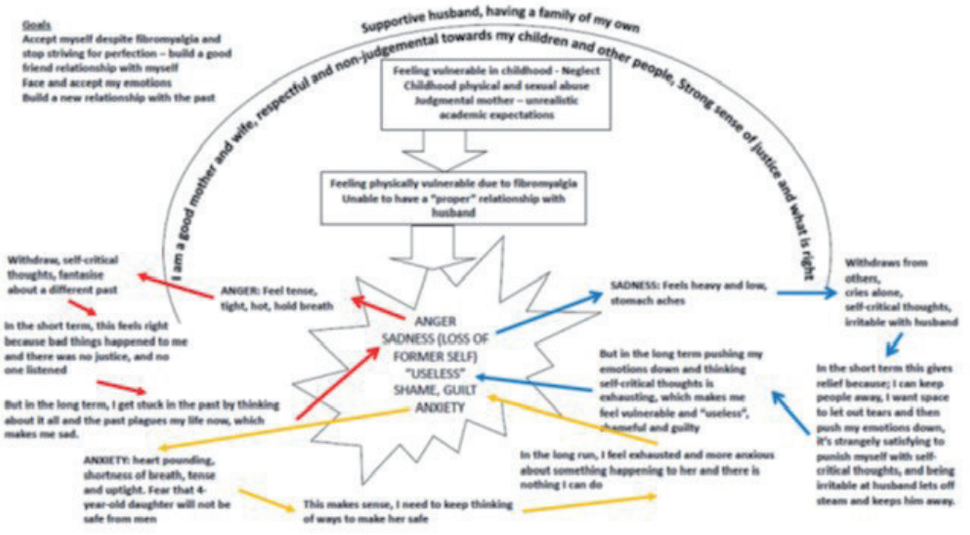


Figure 5.
Jade's spikey formulation diagram.

experiences were summarised in a way that both of us understood without too much unnecessary detail. Together, the diagram was evaluated and validation for her current felt sense was shared in light of the past that has led to a sensitivity to the triggers. Next her strengths were explored and are detailed in the two bowed texts at the top of the formulation diagram; she was proud to be a good mother and wife, with a strong sense of justice, respectfulness and was non-judgemental to her children. She also drew strength from having created her own loving and supportive family. Next her vicious cycles were explored, Jade chose to address her anger, sadness and anxiety and on each in turn identified the physical experience of the emotion, what this feeling led her to do, the reinforcer to managing the emotion in this way, and the consequences of coping in this way that keeps her stuck with the difficult emotions in the "spikey."

Her goals stated in the formulation diagram above were collaboratively arrived at from Jade's own ideas of what she wanted to achieve throughout therapy and also the therapist's understanding of the interventions that would aid a new ways of coping that might aid the breaking of the vicious cycles. These goals informed the interventions and the remaining therapy sessions.

3.4.3 Interventions

3.4.3.1 Managing your body's safety system

The CCC module entitled "managing your body's safety system" was covered with reference to the states of mind diagram and her individualised formulation diagram. This involved using specified examples applicable to her way of coping with responses for threat (fight, flight and freeze). Grounding mindfulness was an important intervention to help stabilise Jade and help her to feel safe in the present moment. For Jade this involved identifying that her threat system was being activated by triggers of her anxiety, anger, sadness and shame. These were based on the ways she had learned to manage her emotions as a child through her experiences of abuse and neglect, by covering up the fear of being punished by her mother. When Jade was younger, this was perceived as a sign of "strength" that acted as a reinforcer for being self-critical and perfectionistic, but as she grew older, she realised that this "strength" had made her miserable and disconnected from others.

Additionally, and specific to Jade's experiences of fibromyalgia, gaining an honest appraisal of her somatic experiences of her emotions, rather than overriding them, was key to her validating and accepting her emotions, which also aided the management of her pain and energy levels.

3.4.3.2 Your relationship with yourself

Self-compassion features heavily within the CCC programme and was addressed with Jade. Self-compassion, and becoming a good, honest friend with oneself, was explained as a way to break vicious cycles that featured self-criticism, which were evident in Jade's formulation diagram. This was initially tricky for her, especially the self-compassion mindfulness practice. She experienced a sense of dissociation from the feeling of welcoming herself as a person in need of care, love and protection. However, with practice in therapy and on her own between sessions Jade began to experience herself with a sense of worthiness.

3.4.3.3 Using anger positively

Within the CCC programme, anger is pitched as a very useful emotion that can facilitate action where sadness has kept people stuck. For Jade, she often suppressed

anger and withdrew from others when she felt angry. By acknowledging that anger was an emotion that alerted her to injustice, she began noticing situations where she was being taken advantage of or treated as undeserving, which she could .

Mindfulness of a strong centre was practiced alongside this module in order to instil a sense of being the observer of the situation and your own emotions without dissociating from the emotional experience.

3.4.3.4 Building a new relationship with the past

The states of mind diagram in **Figure 1** was used again to frame her emotional experiences of the past in terms of how memories is understood from the two ways of knowing; emotion mind knowing and reasonable mind knowing. The formulation diagram was also used to highlight how the past can be brought into the present by the person by them going around the vicious cycles and drawing in the past relevant to the emotion.

Mindfulness of an emotion and self-compassion helped Jade to accept the past, instead of fantasising of a preferred scenario or becoming self-critical about things she wished she had done differently.

Jade also made a connection between her own experiences aged 4 and her own daughter reaching that age, and her anxiety regarding keeping her safe from potential sexual abuse. This was acknowledged as an understandable fear, that Jade was doing all she could to keep her safe, and that she could work on reducing this fear with the use of long outbreath breathing and grounding mindfulness.

Towards the end of therapy, Jade shared that she had confronted her mother about her past. Although her mother did not acknowledge what she had to say and continued to be critical of her, she was satisfied that she had spoken her truth to her mother. She attributed the self-compassion and anger work as important in her being able to confront her mother and accept that she was not capable of being the loving mother that she wished she could have been, in a sense she had accepted the loss of the ideal mother.

3.5 End of therapy and clinical outcomes

At the end of therapy Jade reported feeling a sense of achievement that she had worked towards the goals from her formulation diagram. She felt that she had accepted herself, was less perfectionistic within the home, and more accepted of help from her husband. She had faced her past and accepted her relationship with her mother. She also felt that she was more in control of her emotions. This was reflected in her PHQ and GAD scores **Figure 6** below which shows a reliable recovery with both outcome measures. PHQ-9 score at baseline was 20 and reduced to 10, under the clinical cut off. GAD-7 score at baseline was 14 and reduced to 7 at the end of therapy.

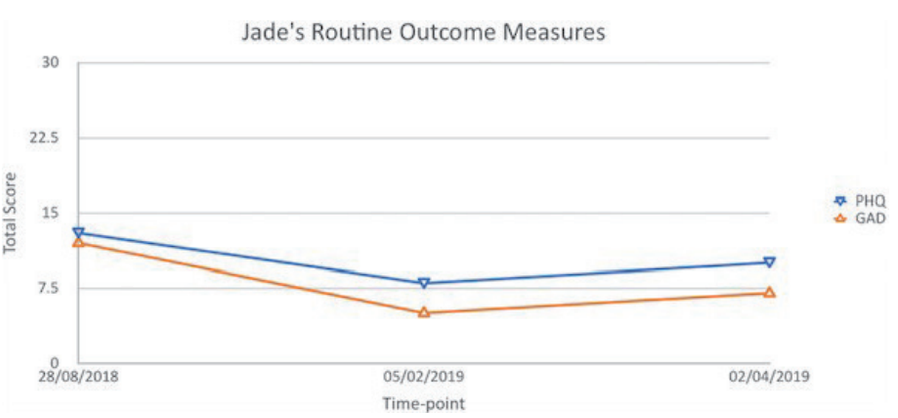


Figure 6.
Routine outcome measures: PHQ-9 and GAD-7 scores.

4. Conclusion

This research project has facilitated the development of a therapist's manual for working with cultural diversity in psychotherapy. Many aspects of cultural learning have been identified and used to develop this manual and evaluate it by therapists involved in the study. The study therapists reported that the CCC formulation was simple, effective, and validated the participants' experiences well. Whereas therapy drop-out rates among ethnically diverse populations are generally higher than for the general population, this study's retention rate of over 90% demonstrated the acceptability of this adapted intervention. A recent study of referrals to IAPT services by Baker [67] found that, compared to people from White British backgrounds, people from most Black, Asian and Minority Ethnic (BAME) groups were more likely to drop out of therapy (46% of white service users complete treatment in comparison to 40% of Asian service users). It was therefore agreed that the interventions were acceptable to participants and led to real concrete changes in behaviour.

Therapist's feedback was also used to evaluate and develop the manual for further studies and practice guidance. It was key to note that balancing Western and traditional cultures within the family is an important aspect that has been managed with mindfulness of emotions and self-compassion as well as exploring the development of interpersonal skills. Moreover, where religion is concerned, it can provide a source of strength and comfort as well as a sense of divine retribution. This challenging conflict can be explored with the individual by both validating their religious faithfulness and practicing self-compassion mindfulness exercises. The CCC conceptualisation of faith in terms of an experience of relationship with the divine opens the way to discussion of this relationship, where it is proving problematic, in ways that side-step religious dogma. Acceptability of therapy was assessed using the Patient Experience Questionnaire with overall experience rated high.

The study is also interesting in demonstrating the spectrum of trauma and past adversity contributing to current mental health difficulties across a primary care sample not selected for trauma. It further demonstrates the effectiveness of a structured way of working with trauma, using emotions positively, and drawing on identified strengths going forward, that does not entail reliving or detailed exploration of the trauma or past adverse events. This way of rebuilding a new relationship with the past is illustrated in both the case examples. By-passing detailed exploration of the past is useful, as reliving, though effective for many, can be unacceptable or inadvisable for a substantial minority of trauma sufferers. This element of CCC is as yet merely noted anecdotally and has not been systematically evaluated. Such evaluation awaits a future study.

The Culture Free study found that CCC was both feasible and acceptable in diverse populations, echoing existing research on cultural adaptions which found use of mindfulness to be accepted and appreciated as an effective intervention that can elicit concrete positive change across a broad range of mental health presentations, including trauma and trans-diagnostically. Further investigations utilising a robust methodology and powered sample are warranted in particular with diverse populations presenting with complex trauma.

Acknowledgements

The authors would like to thank all the participants contributed to the Culture Free Study. The authors would like to thank Matthew McNought and Carmen Caro Morente for their contributions as research therapists' project and Demi Perkins for her contribution to literature search.

Conflict of interest

All authors declare no conflict of interest.

Ethical statement

The authors have conducted this research in relation in accordance with Good Clinical Practice (GCP). Favourable ethical opinion was obtained from London-Camden & Kings Cross Research Ethics Committees Ref: 16/LO/1899.

Appendices and Nomenclature

Session 1. Listening. Introducing the States of Mind. Introducing mindfulness and/or breathing
Session 2. Collaboratively creating the formulation diagram
Session 3. Negotiating goals for therapy based on what is needed to break the vicious circles
Session 4. Sharing the draft compassionate summing up letter and looking forward to what to work on through the group programme
Sessions 5–8/12
Goals based interventions aimed at breaking the cycles. Mindfulness is the core intervention and the following are employed as indicated by the formulation:
Arousal Management, including Relaxation Breathing and lifestyle adjustment to reduce chronic stress.
Behavioural Activation
Emotion Management includes facing, expressing and letting go of emotion
Self-compassion
Aspects of Self; mindfulness managed subpersonality work.
Relationship management including assertiveness
Building a new relationship with the past.
Follow up two months after end of therapy.

Table 2.
Appendix 1 CCC schedule of sessions.

Intervention
Mindfulness is the core intervention; it informs the application of the others.
Arousal Management (relaxation breathing etc.)
Behavioural Activation
Facing, expressing and letting go of emotion
Self-compassion
Positive Anger Work
Aspects of Self (mindfulness managed subpersonality work)
Relationship management including assertiveness
Building a new relationship with the past

Table 3.
Appendix 2 principle interventions post formulation.

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Author details

Peter Phiri[1,2*], Isabel Clarke[2], Lydia Baxter[2], Kathryn Elliot[2], Shanaya Rathod[2] and Farooq Naeem[3]

1 Primary Care Population Sciences, Faculty of Medicine, University of Southampton, UK

2 Southern Health NHS Foundation Trust, Southampton, UK

3 Centre for Addiction and Mental Health, University of Toronto, Canada

*Address all correspondence to: peter.phiri@nhs.net

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