ORIGINAL ARTICLE

Cognitive Psychotherapy Experience with Kelantan Clients

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Summary

102 consecutive clients who attended the Psychotherapy Clinic of USM Hospital were routinely assessed by the Hamilton Anxiety Scale (HAS) or the Hamilton Depression Scale (HDS) at three monthly intervals as part of outcome recording. Results at the end of three and six months seem to point to the superiority of cognitive behaviour therapy (CBT) approach with the addition of religious sociocultural techniques in Kelantan clients.

A further assessment of 98 clients who received CBT indicate that it is an effective form of psychological treatment for a variety of disorders. Social phobics and obsessive compulsive disorder though responding favourably to CBT, seem to have a high drop out rate.

The use of CBT as a tool in managing clients' mental health seems promising and a proper controlled study using larger samples is warranted.

Key Words: Cognitive psychotherapy, Cognitive behaviour therapy, Depression, Anxiety, Religious psychotherapy

Introduction

The mode and duration of psychotherapy has been the subject of discussion for a long time. Smith *et al*[1] concluded that psychotherapy is effective. While Andrews and Harvey[2] reanalysed Smith's data and found that the behavioural psychotherapies were superior to the verbal psychotherapies and both were more effective than counselling. Prioleau[3] conducted a third analysis of the data and found that there was no evidence of benefit in the dynamic psychotherapy.

Andrews[4] reviewed evidence concerning the utility of dynamic psychotherapy and cognitive therapy for neurosis and personality disorders and concluded that cognitive behaviour therapy is a powerful specific treatment in the neurosis while dynamic psychotherapy although popular with clients and therapists has not been demonstrated to be superior to placebo.

This study reviewed all clients, who were sent for psychotherapy to the Psychotherapy clinic of our hospital. It is to assess the mode of therapy and usefulness of psychotherapy for our clients. This is especially important in Kelantan as the clients are less educated and less psychologically minded and more simplistic in their explanations of psychiatric illness. The assessment of the type of treatment provided and its usefulness for those clients would be of immense value to the therapists working in this part of the world. To the best of our knowledge, this is the first time such a study was conducted here. In this paper we are presenting our experience of psychotherapy in Kelantan clients.

Methodology

Consecutive clients with depression and generalized anxiety disorder attending the psychotherapy clinic of

the Hospital Universiti Sains Malaysia over two years formed the sample of the study. They were diagnosed according to the DSM-IV criteria.

All clients were assessed using the Hamilton Anxiety scale (HAS) or Hamilton Depression scale (HDS) 2 weeks after treatment and three monthly intervals by another psychiatrist who was blind to the clients' diagnosis and treatment modality. One hundred and two clients who had DSM IV depression or anxiety completed assessment until 6 months. 10 clients only completed the assessment until 3 months and 4 clients stopped follow-up before 3 months. Finally the result were only analysed for the 102 clients.

Another group of 72 clients of various diagnoses based on DSM IV criteria who received cognitive behaviour therapy (CBT) only were also analysed separately. In this group the HDS/HAS scores were done weekly as part of CBT procedure but only the initial and final results are included in the study data.

Results

Of the 102 clients, 64 clients fulfilled the DSM-IV criteria for depression without psychotic features of which 25 were mild, 20 moderate, 19 severe (Table I). The remainder (38) clients had generalized anxiety disorder.

The depressed clients were given supportive psychotherapy using the eclectic approach and religious psychotherapy with CBT approach. The clients receiving the religious psychotherapy with CBT approach improved significantly faster then those in the supportive psychotherapy group (Table II).

Table I
Diagnostic profile of clients

Diagnosis	Number	Percentage
1. Depression	64	62.7
mild	25	39
moderate	20	31.3
severe	19	29.7
2. Anxiety	38	37.3

The anxiety disorder clients were treated using supportive psychotherapy and cognitive behaviour therapy. The HAS score of the supportive psychotherapy group was 10.67 and 4.50 at the end of three and six months, respectively. While the cognitive behaviour group had the HAS score of 5.04 and 3.19 at the end of 3 months and six months, respectively. They showed significantly faster improvement than the other group ($p=0.001$) (Table III).

Also the compliance rate of the clients were extremely good i.e. 87.9% of the clients remained in therapy until 6 months.

We also analysed another 72 clients who received CBT alone (altogether 98, i.e. including the 26 anxiety patients) separately. See Table IV.

The drop out rate were highest for social phobia and obsessive compulsive disorder (OCD). The total drop out rate for all clients who received CBT was only 6.12%. Clients with depression, panic, health anxiety, schizophrenia, bipolar disorder, eating disorders and other disorders (mainly those with V code diagnoses) respond favourably to CBT. Some patients with depression respond after only 5 sessions and panic disorder after only 3 sessions.

Discussion

Psychotherapy seeks to relieve suffering caused by psychological stresses arising from a variety of sources. Stresses includes the person's interaction with others as features of the human condition such as death and especially in Kelantan evil spirits. These are also the domain of religion. As such psychotherapy is a sociocultural institution and their issues will inevitably play a major role in the mode and outcome of psychotherapy.

The results of this study essentially indicate that sociocultural issues in psychotherapy can bring about remarkable result. Kelantan clients being more religious responded faster to religious psychotherapy with CBT approach, something they are familiar with and can identify with. Even the families encouraged them to continue with this form of treatment[5,6]. Csordas[7] provides an illmunating description of the role of

Table II
Psychotherapy for depressed clients and their outcome

Psychotherapy	Total patients	HDS mean score 2 weeks	HDS mean score 3 months	HDS mean score 6 months
Supportive	32	20.04	6.75	1.81
Religious with CBT	32	19.06	4.84	1.34
		t = 0.50 p = N.S	t = 3.10 p = 0.001	t = 4.13 p = N.S

Table 2 taken from Reference (6)

Table 3
Psychotherapy for anxiety disorder clients and their outcome

Psychotherapy	Total patients	HDS mean score 2 weeks	HDS mean score 3 months	HDS mean score 6 months
Supportive	12	27.83	10.67	4.50
Cognitive Behaviour	26	27.65	5.04	3.19
		t = 0.15 p = N.S	t = 10.10 p = 0.001	t = 3.41 p = 0.001

Table IV
Analysis of clients who received CBT

Diagnoses	Sex		Age		Min. ses.	Max. ses.	Dropout	Outcome HDS/HAS	
	M	F	M	F				init.	end
Anxiety	12	14	35	38	3	18	2(7.7%)	27.6	3.19
Depression	5	10	42	44	5	12	1(6.7%)	21.8	1.35
Social phobia	4	–	21	–	1	11	2(50%)	35.8	7.2
Panic	5	3	32	35	3	9	–	38.9	4.2
Health anxiety	4	3	33	36	7	15	–	25.2	3.2
OCD	2	–	25	–	3	9	1(50%)	29.6	5.4
Schizophrenia	5	6	34	27	–	8	–	37.8	5.6
BAD	1	3	26	30	3	5	–	23.2	1.6
Eating	1	8	35	30	10	22	–	23.8	2.4
Others	5	7	31	26	2	5	–	29.5	2.3

supernatural forces in causation and treatment by psychotherapy in Catholic charismatic healing. The distinguishing features of charismatic healers according to Csordas is that they accept the reality of evil spirits that, as components of a therapeutic system, manifest themselves as normal human mental or emotional states that are out of control. Charismatic healers view religious healing and naturalistic psychotherapy as complimentary. They distinguish three types of healing: physical for body healing, inner for relief of emotional distress, and deliverance from the adverse effects of demons. Their physical healing differs from the secular counterpart in utilizing prayer, coupled with laying on of hands accompanied by anointing the effected body part with oil that has been blessed. Inner healing is analogous to dynamic oriented psychotherapies.

In our clients we also practice religious healing in psychotherapy but the concept is different. We operate more on a cognitive approach of religious healing rather than dynamic. The hypothesis is that an individual will experience dissonance with resultant guilt, anxiety or alienation if the individual act contrary to personal values. If unresolved, these feeling may manifest as mental illness. Values are ideals that we have learned from childhood through parents and later on becomes more defined as one picks up ideals from other sources and in Kelantan the religious teachers or preachers. Clear values are relevant to mental health because if the intentions and actions are in accordance with the personal value system, there is no conflict. Self esteem is reinforced, there is satisfaction in chosen endeavours, there is harmony with the environment. But if actions are contrary to personal values there is dissonance, self esteem is lowered and there may be feelings of shame, guilt, or anxiety. In this hypothesis, the conflict between the actions and the personal values is understandable i.e. there is no need to look for a conflict, it is there. What is required is to have a relook at the personal value system, to analyse and understand it and ultimately to modify or change it to suit the environment, social situation and personal ideal. As such it is not a "conflict search" but a "value search"- to find an alternative usually more logical way of developing a value system for the patient and in our patients using religious modalities as complement to the secular method of psychotherapy. This approach is very similar to the technique of cognitive therapy by Beck[8]

Koltko[9] states that ideally, psychotherapists should be able to take into account the impact on therapy of religious beliefs and practices, especially those that play powerful roles in client's lives. Koltko clearly illustrates how religious beliefs are relevant to many issues in psychotherapy, such as receptivity to psychotherapy in general, or relative accessibility to different specific approaches. He further describes how a client's religious beliefs help to form attitudes about the self and its worth. Highly religious clients become dissonant when their actions do not match their values. It is best and easiest to look at the values and analyse why his behaviour sway from the values rather than to explain it in terms of "sexual deprivation" or other conflicts.

The result of the anxiety patients clearly indicate that in Kelantan, the cognitive behavioural approach is more acceptable. They significantly improve faster with this approach. The method is also akin to the religious healing mentioned above. The ideas that bring about the anxiety are analysed and clients are taught to give alternative logical ideas instead of negative ones. Usually the logical alternative ideas relate to religious and cultural beliefs that the clients can relate to. Hunt and Singh[10] have stated that cognitive behaviour therapy appears to be the treatment of choice in generalized anxiety disorder. The result is even more significant in panic disorder patients where some patients respond after only 3 sessions. We have shown in another study[11] that panic patients can significantly improve after only three sessions on CBT. Overall most clients showed improvement but the religious psychotherapy with CBT approach and cognitive behaviour therapy significantly seem to have better results in the depressed clients and anxious clients, respectively in Kelantan. Besides being therapeutic, cognitive behaviour therapies are also cost-effective. These therapies are brief, 10 to 30 hours for most problems. Andrews[12] has pointed out that the essential task of psychiatry is to deliver care to 2700 per 100,000 population who are being treated for their psychiatric disorder.

He calculated that dynamic psychotherapists can only see 0.5% and even if there are 6 cognitive-behaviour therapists per 100,000 this would allow an extra 20% of clients to be treated appropriately.

The cognitive-behaviour approach encourages one to

analyse the major problem, identify the axis I & II diagnoses present and develop a therapy plan that specifies the goals of therapy and the treatments to be used, as well as evaluating outcome. This seems to be ideal for the religious clients of Kelantan. Their conflicts are well recognized, their goals modest and easily achievable with incorporation of religious sociocultural factors in the cognitive-behaviour therapy approach.

Table IV further adds to the fact that CBT seems very useful for this group of clients. Almost all common diagnoses seem to benefit from its use. However, we cannot be absolutely certain until a proper controlled study is done. At the moment we are trying to show its effectiveness in schizophrenia using controlled trials. It is quite difficult to show its usefulness in other disorders because of infrequency of getting cases at the present moment. The number of sessions are also fairly low even though improvements as shown by the HDS or HAS are quite substantial. This is what Andrews meant by being cost effective[12]. It must however be explained that its use in the psychotic disorders namely schizophrenia and bipolar disorders are not meant as curative but in solving psychological problems faced by the clients as well as in enhancing drug compliance and relapse prevention strategies. They are also useful in reducing positive symptoms in chronic clients[13]. Its usefulness in social phobia and obsessive compulsive disorder (OCD) is still under study at several centres in United Kingdom and the United States. In our small sample, they have the highest drop-out rate. However those that continue treatment had shown rcmarkable improvement.

Conclusion

The cognitive-behaviour approach with the influence of religious sociocultural context seems to favour faster relief in anxious clients as well as clients with other anxiety group of disorders in Kelantan. Depressed clients seem to favour religious psychotherapy over the conventional therapy. Those that received CBT only also improved and some after only three to five sessions. CBT also has shown promise in resolving psychological problems and reducing symptoms of psychotic patients. However more work needs to be done to see if this response is sustained over long periods.

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