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ORIGINAL RESEARCH

Transdiagnostic cognitive behavioural therapy (CBT): case reports from Saudi Arabia

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Abstract. Transdiagnostic cognitive behavioural therapy (CBT) focuses on the processes shared across disorders and can be applied to a wide range of mental health problems or comorbid conditions. The transdiagnostic approach provides the potential opportunity to improve access to CBT, particularly in countries such as Saudi Arabia, where the number of well-trained therapists is limited. This study aims to examine the feasibility and potential benefit of transdiagnostic CBT for Saudi patients. Case reports describe the outcome of transdiagnostic CBT for four female patients who presented a wide range of symptoms and conditions without conducting any specific diagnostic assessments. The results support the positive effect of this treatment method on depression, anxiety symptoms, and general functioning. Patient feedback and observable improvements also supported these outcomes. However, the results are limited by the small sample size and simple study design. Transdiagnostic CBT is a feasible treatment approach for patients in Saudi Arabia. However, to confirm this preliminary finding, more studies are required.

Key words: Anxiety, CBT, depression, transdiagnostic, Saudi Arabia.

Introduction

Over the last decades, numerous research and clinical trials have established that cognitive behavioural therapy (CBT) is a highly effective treatment for emotional disorders and other mental-health problems. The well-established CBT protocols are based on disorder-specific theories and treatment models. The evidence of CBT's efficacy was primarily based on the results from randomized control trials with homogenous samples. However, in everyday clinical practice, patients can present a wide range of symptoms or comorbid conditions to which these disorder-specific treatment models are difficult to apply. For example, patients can present comorbid depression, social anxiety, and obsessive thoughts. Planning and conceptualizing a suitable treatment plan for such cases requires therapists who are well trained in treatment models of depression, social anxiety, and obsessive-compulsive disorder. Familiarity with different models of obsession may also be required. This is more challenging

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in countries such as Saudi Arabia, where CBT training and the number of competent CBT therapists are limited.

In recent years, a major shift in CBT research and practice has emerged. This shift involved viewing psychological disorders in an integrated way by identifying the cognitive processes that are shared across disorders (Harvey *et al.* 2004). The goal has been to develop an effective transdiagnostic and evidence-based treatment protocol that could be applied to a wide range of problems and conditions (for a review on transdiagnostic CBT, see Clark & Taylor, 2009; Mansell *et al.* 2009). For example, evidence indicates that the common features of emotional disorders account for more variance than disorder-specific characteristics (Barlow *et al.* 2004). This evidence has resulted in the development of transdiagnostic treatment protocols for emotional disorders (Barlow *et al.* 2011). Similar transdiagnostic models have been developed for eating (Fairburn *et al.* 2003) and anxiety (Norton, 2008) disorders. This line of research is continuing to evolve by assessing the core cognitive processes, or 'higher order latent processes', that emerge from the overlap of various cognitive processes (Bird *et al.* 2013). This progress could lead to more generic transdiagnostic approaches, such as the currently existing mindfulness-based cognitive therapy (MBCT; Segal *et al.* 2002), acceptance and commitment therapy (ACT; Hayes *et al.* 2006), or the recently proposed method of levels therapy (MOL; Mansell *et al.* 2012).

Applying the transdiagnostic approach in clinical practice has a number of advantages. For example, the effectiveness of the approach does not rely on diagnosis (Mansell *et al.* 2009) or require an intensive assessment of clients (Bird *et al.* 2013). Additionally, it facilitates a balance between evidence-based treatment and flexibility in various clinical presentations (McHugh *et al.* 2009). Importantly, access to CBT may be improved by training therapists to become competent in evidence-based models suitable to the wide range of conditions encountered in everyday clinical practice.

In Saudi Arabia, the status of mental health services, education, and training remain underdeveloped compared to their status in Western countries. Saudi Arabia's mental health services were not incorporated into the general health services until 1980. These mental health services have been based largely on pharmacotherapy with limited, eclectic forms of psychotherapy. However, in recent years, interest in CBT has emerged primarily because a number of mental health professionals who received CBT training in Europe and North America returned to Saudi Arabia motivated to apply their skills and knowledge. This interest has resulted in a significant movement towards the application of CBT in clinical practice and the development of local CBT training programmes. However, this movement remains in its early stages, and the existing training programmes do not produce a sufficient number of qualified therapists to meet the demand for mental health services.

CBT research in Saudi Arabia is also underdeveloped. Although CBT is well recognized as a treatment model and has been implemented around the world, in Saudi Arabia its efficacy remains empirically untested. To the best of the author's knowledge, no published study has examined CBT's efficacy in a Saudi sample. It has been suggested that cultural differences concerning specific beliefs and values may require modifications of the original treatment model (Naeem *et al.* 2012). However, this question remains for future research. Based on observation and clinical experience, Al-Hadi and colleagues (2012) reported a number of issues that must be considered when applying CBT in Saudi culture or in the Middle East generally. Some of these issues are related with superstitious beliefs regarding the cause of mental disorders, the barriers to expressing emotion, a focus on somatic complaints, and

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imposing psychotherapy on patients by physicians. These issues require increased emphasis on the psychoeducational and socialization aspect of treatment.

According to the author's own clinical experience, the identified transdiagnostic processes proposed by Harvey and colleagues (2004), which includes self-focused attention, negative thinking, perfectionism, rumination, thought suppression, memory biases, avoidance, and safety behaviours, are observed in Saudi patients. Such observation encourages the application of existing treatment models to patients from Saudi Arabia but with special attention to psychoeducation and socialization, as suggested. Therefore, the current study aims to examine the effect of the transdiagnostic CBT protocol on different mental health conditions in a sample from Saudi Arabia.

This study does not argue that the transdiagnostic approach is more effective than disorder-specific models. In fact, studies have demonstrated that treating the primary diagnosis can improve comorbid conditions (Craske *et al.* 2007), which could be possible if we used a disorder-specific rather than a transdiagnostic approach in this study. Importantly, in this study, diagnostic assessment was not conducted. Therefore, an accurate evaluation of diagnoses and comorbid conditions cannot be made. However, the author's primary interest is to adopt the transdiagnostic model in local clinical practice to test its efficacy, which could help improve access to and training in CBT in Saudi Arabia. It is hoped that the results of this study will help attract the attention of local clinicians and researchers to this evolving area of CBT, both theoretically and clinically.

Methods

Design and procedure

In this study, the effect of transdiagnostic CBT was examined using data from four female Saudi patients. The case study design was selected to test the feasibility of this approach using a simple design. The participants were selected from the psychology unit of a general hospital in Riyadh. This clinic provides general psychological services, not only CBT. Therefore, typically, patients undergo assessment on their first visit to determine the type of service they require and that suits their current needs. All four patients were identified as suitable for CBT. None of the patients had previously received any form of psychotherapy except for case 4 ('Maha'), who had received counselling and support a few years earlier.

The author treated all participants using the transdiagnostic protocol described below. A disorder-specific model was not suggested for these patients because they all presented symptoms of emotional disorder, such as anxiety or depression and other significant symptoms, such as hearing voices, dissociation, or flashbacks. Therefore, the transdiagnostic approach was considered suitable. All of the patients were informed that their case reports might be used for research and educational purposes, and their consent was obtained. Names and identifying information in this report were altered to protect confidentiality.

Participants

Case 1: 'Amal'

Amal is a 20-year-old unmarried female referred to this study from the psychiatric clinic with a current diagnosis of depression and the recent development of hallucinations. The

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depression developed over a few years after the sudden death of a close friend. Her symptoms have recently worsened after another close friend became seriously ill. The patient started seeing visions and hearing voices, some of which were her deceased friend. These symptoms significantly impaired her social and academic functioning. The patient and her family preferred psychotherapy to any medication management.

Amal described experiencing low moods and felt excessive guilt over her deceased friend. She blamed herself for being the cause of her friend's sudden death because she had offered her friend random health advice only days before she became seriously ill and subsequently died. Additionally, Amal blamed herself for not supporting her friend during her final days. When another close friend became ill, Amal avoided visiting her in the hospital because she was afraid of not being able to handle the situation. This fear subsequently increased her feeling of guilt. She started spending more time in isolation and ruminating on 'what if things were different'. During the time she spent in isolation, Amal started to see visions of her deceased friend, which was terrifying and confusing for her.

Case 2: 'Sara'

Sara is a 19-year-old unmarried female referred from the neurology clinic with symptoms of anxiety and frequent episodes of dissociation (the patient loses consciousness 3–4 times a day). The symptoms developed during a period of highly stressful family conflict. Although the conflict was resolved, the symptoms remained and increased in response to any trigger or sign of stress. Medical evaluation did not reveal any physiological cause for the dissociation. Therefore, her physician referred her for psychological evaluation.

Sara described herself as always on edge and waiting for a disaster to occur. She is highly vigilant for signs that might indicate a new conflict in the family and believes that any conflict will have traumatic consequences. Additionally, she expressed a low tolerance for stress. Therefore, she copes by avoiding family gatherings. Moreover, her dissociative episodes increased her anxiety by causing her to believe that 'there is something wrong with me' and 'I am going crazy'.

Case 3: 'Nora'

Nora is a 42-year-old widowed female with three children. She was referred from the psychiatric clinic with a current diagnosis of depression and post-traumatic stress disorder (PTSD). Her symptoms of depression developed over 15 years while in a highly stressful and abusive marital relationship. During this time, she regularly visited a psychiatrist and she was prescribed an antidepressant. Three years ago, the patient was a victim of a traumatic abusive incident after which symptoms of recurrent intrusive memories and avoidant behaviour emerged. Because medication alone was unsatisfactory, she was referred for psychotherapy.

Nora described experiencing low moods and a loss of interest in social interaction. She started to have flashbacks and intrusive memories of the traumatic incident and began to avoid people and places that might trigger her memory of the event. When discussing her symptoms, she reported feeling responsible for the incident and that somehow 'she deserved it'. Additionally, she expressed various beliefs, such as 'this will never end' and 'I will never be the same', and she reported worrying and ruminating about these beliefs often.

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Case 4: 'Maha'

Maha is a 38-year-old married female with eight children. She was referred from the psychiatric clinic with chronic depression that exhibited no significant response to anti-depressants. She has been suffering from depression for almost 20 years. The symptoms were triggered by a highly stressful event and were maintained by continued struggles with the everyday stresses of having a large family, a sick husband, and a low income. Psychotherapy was recommended to the patient to help her with depression as well as coping with stress.

Maha described feelings of hopelessness concerning her current living status. She blames herself for how her life has turned out. In addition, she consistently worries and ruminates on her current situation becoming worse in the future and wonders 'what if my husband died?' Currently, she copes by avoiding interaction with her family and children and isolating herself in her room to avoid the demands of her family, which increases her guilt and self-blame.

Treatment description

Initial assessments of current and past complaints, were conducted prior to the therapy sessions. These assessments were performed routinely for all of the referred patients to determine their suitability for CBT. After identifying the patients who were CBT candidates, an assessment of the cognitive and behavioural factors that help trigger or maintain symptoms was conducted. Subsequently, a case formulation was shared with the patients. The active therapy sessions ranged from 8 to 15 weekly and bi-weekly sessions. The content of the treatment sessions is described below.

The case formulation was based on a generic formulation model developed by Padesky & Mooney (1990). This model is a simple framework that helps patients understand how different elements interact to create their current difficulties. It is also helpful for introducing the key elements of CBT. One modification was made to this model, which emphasizes cognitive content and cognitive processes. This change was made to incorporate the common cognitive process as suggested by Harvey *et al*. (2004). An example of the formulation is provided for case 1 in Figure 1.

Psychoeducation is an educational component that aims to increase patients' understanding of their symptoms in relation to psychological factors. In addition, it aims to introduce the cognitive behavioural model of how symptoms are developed and maintained. The aim is to provide an understanding of the treatment model and the components of the therapy and their purposes as well as to ensure appropriate treatment socialization.

The *cognitive approach* focuses on two aspects of the treatment. The first aspect involves identifying the content of thoughts and is executed by discussing the patterns of errors and misinterpretations of thought. The participants were encouraged to identify their maladaptive beliefs and misinterpretations by monitoring their thoughts. Then, cognitive restructuring and working towards more adaptive alternative interpretations were introduced and worked through in session using Socratic questioning dialogues.

Second, the cognitive processes that maintain the symptoms were identified by discussing the role of thought suppression, rumination, and self-focused attention. The aim is to encourage patients to observe and monitor the effect of such processes on their current mood and symptoms to develop more adaptive cognitive responses. Such responses are achieved by using mindfulness techniques to view thoughts as mental events rather than reality and to facilitate acceptance and letting go as opposed to rumination and suppression.

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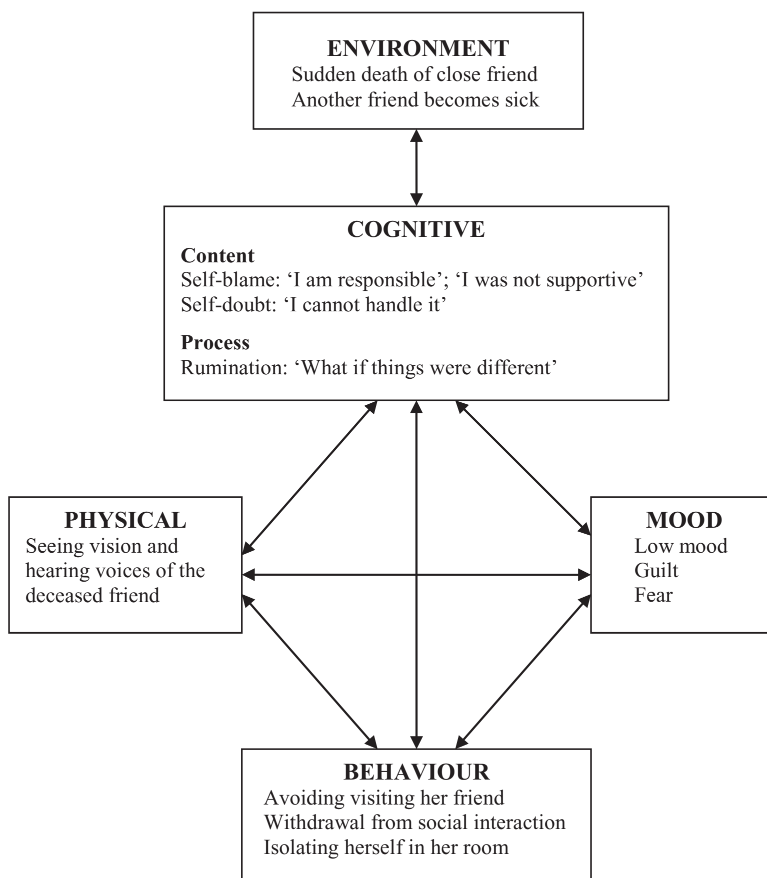

Fig. 1. Case formulation of 'Amal'. Based on Padesky & Mooney's (1990) five aspects model.

The *behavioural approach* focuses on identifying safety behaviour and the role played by escape and avoidance in maintaining symptoms and their underlying thoughts and beliefs. In addition, behavioural experiments were used to examine and test alternative thoughts and behaviours.

Termination and relapse prevention is the treatment's final part. It focuses on termination issues, the identification of the treatment's successful aspects, and the development of a relapse prevention plan. Relapse prevention involves the identification of triggers and other factors that might suggest relapse and the development of an effective action plan.

Measures

Beck Depression Inventory (BDI). The BDI is one of the most widely used self-report measures of depression. It consists of 21 multiple-choice questions to measure common symptoms of depression (Beck *et al.* 1996). In this case study, the Arabic version of the BDI

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Table 1. *Pre- and post-assessments*

	Case 1	Case 2	Case 3	Case 4	Average
Number of sessions	8	11	10	15	11
Beck Depression Inventory					
Pre	46	30	39	40	38.7
Post	25	19	22	22	22
Beck Anxiety Inventory					
Pre	37	33	36	30	34
Post	20	18	22	17	19.2
Global Assessment of Functioning					
Pre	45	50	45	50	47.5
Post	65	75	75	65	70

was used, which is a common tool in clinical and research settings that has been shown to have reasonable validity and reliability in an Arab sample (Abdel-Khalek, 1998).

Beck Anxiety Inventory (BAI). The BAI is a 21-item self-report questionnaire that measures common features of anxiety (Beck *et al.* 1988). The Arabic version used in this case report was found to be a valid and reliable measure of anxiety (Al-Nehar & Al-Zubaidi, 2000).

Global Assessment of Functioning (GAF). This numeric scale measures global psychosocial functioning as perceived subjectively by the assessors. It is measured on a 0–100 scale, with higher scores representing fewer symptoms and better functioning (Hall, 1995).

Results

Overall, all of the patients reported significant improvements following the treatment. These improvements were also observed by the therapist and members of the patients' families. The following is a brief description of each patient's subjective improvement, feedback, and pre- and post-assessment measures.

Case 1: 'Amal'

At the end of the treatment, Amal's feelings of guilt and self-blame concerning her deceased friend declined significantly. She no longer believed that her health advice had caused her best friend's sudden death. Additionally, she realized that not being available to support her friend was not her mistake but the result of her family's decision to shield her from the sad news. Amal was able to visit her sick friend in the hospital and confront her fear that she might collapse, which increased her confidence in her ability to manage her symptoms. The recurrent visions of her friend started to decline as Amal spent more time with her family and friends and less time ruminating. Her visions disappeared completely by the end of her treatment.

As shown in Table 1, Amal's scores on all of the outcome measures indicated improvement. Her scores decreased from 46 to 25 on the BDI and from 37 to 20 on the BAI, which indicate moderate symptoms compared to the severe symptoms that she exhibited prior to treatment. Her GAF score improved from 45, which indicates serious impairment in functioning, to 65, which indicates only mild difficulties.

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Case 2: 'Sara'

At the end of her treatment, Sara was able to tolerate family conflicts and challenge her pessimistic beliefs regarding family arguments and conflicts. Sara reported that understanding that her dissociation is a psychological reaction to stress and that thoughts and behaviour can exasperate these episodes was a major factor in the success of her treatment. Her dissociation declined markedly, and at the end of the last session she reported having no dissociation for a few weeks. She gradually became less vigilant and more relaxed around her family.

Table 1 shows Sara's pre- and post-treatment scores, which agree with the improvement described. Her scores decreased from 30 to 19 on the BDI and from 33 to 18 on the BAI, which indicates mild to moderate symptoms compared to the severe symptoms that were measured prior to her treatment. On the GAF, her score improved from 50, which indicates serious impairment in functioning, to 75, which indicates transient difficulties.

Case 3: 'Nora'

Following her treatment, Nora reported significant changes in her beliefs that 'this will never end' and that 'I deserve it'. She was able to challenge her avoidance by intentionally visiting places and people who might remind her of the previous incident. By the end of her treatment, she was able to visit the site where the incident had occurred. Nora reported that this was a success that 'I never thought I would be able to achieve'. The flashbacks and intrusive memories have improved also. Although episodes of low mood occasionally recur, she was able to accept these episodes as normal mood fluctuations as opposed to her previous tendency to exaggerate or dwell on them.

Nora's post-treatment measures reflected this improvement. Her BDI scores decreased from 39 to 22, and her BAI scores decreased from 36 to 22. These scores indicate moderate symptoms compared to the severe symptoms prior to her treatment. In addition, her GAF score improved from 45, which indicates serious impairment in functioning, to 75, which indicates transient difficulties.

Case 4: 'Maha'

Following her treatment, Maha's tendency to blame herself for her current situation and her worries regarding what might occur in the future improved significantly. Although she continues to have recurrent negative thoughts, Maha reported being able to view them as *just thoughts* without needing to respond to them with suppression or rumination. Additionally, she reported being able to be involved with and responsive to her children and husband, which was an improvement acknowledged by other family members. She started to become more active with respect to her circumstances by seeking employment to support her family.

The outcome measures also indicated improvement. Maha's scores on the BDI decreased from 40 to 22, and her BAI scores decreased from 30 to 17. These scores indicate moderate symptoms compared to the severe symptoms that she exhibited prior to her treatment. She received a score of 65 on the GAF, which indicates improvement in overall functioning compared to her score of 50 at the start of her treatment.

Discussion

In this study, the feasibility and potential benefit of transdiagnostic CBT were examined in a sample of four female patients from Saudi Arabia. The transdiagnostic CBT focused on the

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cognitive and behavioural processes that have been found to be common across disorders. Therefore, transdiagnostic CBT is suitable for patients with a wide range of symptoms. The results support the positive effect of treatment on patients with various conditions. The effect was based on subjective reports by the patient, measures of depression and anxiety, and improvement in daily functioning.

It could be argued that such improvement can be achieved using a disorder-specific model. However, in this study, no specific diagnostic assessment was conducted, and a disorder-specific treatment protocol was not offered to the patients. Therefore, it is important to mention that this report does not argue that the transdiagnostic approach is more effective than disorder-specific models. In fact, the transdiagnostic approach is not intended to replace the disorder-specific models (Clark & Taylor 2009). Nevertheless, there are many practical reasons that suggest the potential for the transdiagnostic approach to improve access to CBT, particularly in Saudi Arabia. The majority of patients in daily clinical practice present a wide range of symptoms and conditions, such as the patients discussed in this paper. The transdiagnostic approach spares clinicians the effort of determining the diagnosis or the primary condition, which is required for the selection of a disorder-specific treatment model appropriate for a given patient. This sparing of effort is particularly important in countries in which the number of specialized and competent CBT therapists is limited.

Although the participants in this study presented a wide range of symptoms, their difficulties involved common cognitive processes, which justified the application of the transdiagnostic approach. *Avoidance* is an important cognitive process that was used by all four of the participants to control their difficulties. Amal avoided visiting her friend to prevent collapse, Sara avoided family gatherings to prevent witnessing a catastrophe, Nora avoided places and people to prevent remembering, and Maha avoided family to prevent stress. Avoidance has been identified as one of the core cognitive processes for maintaining psychopathology (Hayes *et al*. 1996). Therefore, a treatment approach that targets avoidance is expected to result in significant improvement, as noted in this study.

The other important cognitive process observed in this sample is *rumination,* which is a recurrent negative thought that can be observed in a number of psychological disorders (Ehring & Watkins, 2008). Although the participants differed with respect to the content of their ruminations, they all had negative recurrent thoughts that maintained their difficulties. For example, Amal ruminated about doing things differently, which maintained her feelings of guilt. Nora ruminated about things that she believed would never change, which maintained her low mood. Thus, targeting rumination in therapy is expected to improve symptoms. All patients reported a decline in rumination. One participant, Maha, continued to have recurrent negative thoughts. However, she was able to change her view and become more accepting of these thoughts.

Initially, Harvey *et al*. (2004) identified a number of transdiagnostic maintenance processes across five domains. Since then, researchers have made efforts to identify additional processes that underlie psychological disorders. However, a shift occurred in the identification of the commonalities, or overlaps, between these processes, which could represent core processes (Mansell, 2011). Rumination, avoidance, and thought suppression are some of the identified core processes, and evidence suggests that these processes represent one latent factor proposed as ‘inability to control negative thinking’ (Bird *et al.* 2013). Therefore, treatment that targets these core processes could have substantial benefits.

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Because this approach was developed and investigated in the context of Western culture, its adaptation to another culture requires careful consideration. Naeem *et al*. (2012) reviewed the question of culture and CBT and noted the limited research in this area. Evidence from studies on minority groups who reside in the West has provided a framework for the adaptation of the approach to other cultures. Many proposed considerations, including understanding the religion, spiritual orientation, and culture orientation of patients, which are important for clinicians who provide therapy for patients from various backgrounds. However, such considerations may not be relevant in Saudi Arabia because therapists typically treat patients from the same cultural and religious background.

CBT has not yet been empirically tested in Saudi culture. It has been suggested that psychotherapy must be adjusted to culture at three levels: technical, theoretical, and philosophical (Naeem *et al.* 2012). Based on the author's clinical practice, the emerging CBT practice is promising. Most adaptation requires technical adjustments rather than theoretical or philosophical modifications. In fact, CBT's core theoretical concepts (e.g. the interaction of mood, thoughts, and behaviour with the conscious effort to modify maladaptive patterns) harmonize with the Islamic religion of Saudis, which is believed to facilitate the acceptance of this approach by patients (Al-Hadi *et al.* 2012).

At the technical level, one important adjustment would be to place greater emphasis on the psychoeducational component of the therapy, specifically on increasing patients' understanding of the psychological factors that influence and trigger mental illness as opposed to the superstitious views commonly held by patients. In addition, many patients find it particularly difficult to distinguish thoughts from feelings, and they tend to focus heavily on bodily sensations. Therefore, it is important to spend more time on psychoeducation to facilitate the understanding of the interaction and distinction among thoughts, feelings, and bodily sensations. It is also important to spend more time on encouraging the collaborative aspect of the treatment and persuading patients to be active participants in the process rather than passive recipients of advice and instructions.

Evidence of the applicability of transdiagnostic CBT for Saudi patients will have important implications for clinical practice. It is well known that CBT training is limited in Saudi Arabia and other non-Western countries, which results in a substantial shortage of qualified and competent therapists. This shortage is a challenge because the application of a disorder-specific approach requires training therapists to become competent in multiple disorder-specific models. However, it has been proposed that clinicians who lack experience in disorder-specific models could easily learn to apply a transdiagnostic approach (Erickson *et al.* 2009). Therefore, the potential opportunity to train more therapists to use a transdiagnostic model that can be applied to a wide range of symptoms could help improve access to CBT in Saudi Arabia because it requires less training and produces therapists who are more competent.

Finally, although this study is preliminary, several limitations should be noted. First, the study used a simple study design, which is a valid starting point for this line of research. However, further research using more powerful designs and comparison groups is required for the replication of these results. Second, although the outcome was based on standardized measures and subjective evaluations, the treatment lacks an independent measure of reliability. Supervision, as an important monitoring process, is limited in Saudi Arabia. However, reliability will need to be considered carefully in future research using, e.g. peer-support supervision while applying standardized measures, such as the revised cognitive therapy scale (CTS-R).

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In sum, this paper presents case reports on transdiagnostic CBT in four female Saudi patients. It provides preliminary evidence for the feasibility and potential benefit of this approach. Based on this evidence, it is hoped more clinicians and researchers will be encouraged to investigate this evolving area. However, further studies are required to confirm our findings.

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Declaration of Interest

None.

Recommended follow-up reading

Clark DA, Taylor A (2009). The transdiagnostic perspective on cognitive-behavioral therapy for anxiety and depression: new wine for old wineskins? *Journal of Cognitive Psychotherapy* **23**, 60–66.

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Learning objectives

(1) The transdiagnostic CBT approach demonstrated potential benefits when used with a sample from Saudi Arabia.
(2) CBT practice in Saudi Arabia is increasing despite the limited resources.
(3) The adaptation of CBT to the Saudi culture will be a fruitful line for future research.

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