[COMMENTARY]

AUTHORS
Nicola Ann Plastow[a]
https://orcid.org/0000-0002-3536-9129
Munira Begum Hoosain[a]
https://orcid.org/0000-0003-4664-4832
Mariam Salie[b]
https://orcid.org/0000-0003-4060-4813

AFFILIATIONS
[a]Division of Occupational Therapy, Stellenbosch University, Cape Town, South Africa
[b]Department of Psychology, Stellenbosch University, Cape Town, South Africa

CORRESPONDING AUTHOR
Nicola A Plastow
Email:nap@sun.ac.za

KEYWORDS
conference report, exposure therapy, mental illness burden, interdisciplinary intervention, good health and well-being, mental health, psychotherapy, telerehabilitation

HOW TO CITE THIS ARTICLE
Plastow NA, Hoosain MB, Salie M. *Reflections on the 10th World Congress of Cognitive and Behavioural Therapies: Lessons for African occupational therapists.* South African Journal of Occupational Therapy. Volume 54 No 2. August 2024.
DOI: https://doi.org/10.17159/2310-23833/2024/vol54no2a12

ARTICLE HISTORY
Submitted: 17 November 2023
Reviewed 1st round: 29 November 2023
Revised 1st round: 7 February 2024
Reviewed 2nd round: 15 February 2024
Revised 2nd round: 23 February 2024
Accepted: 25 February 2024

EDITOR
Pam Gretschel
https://orcid.org/0000-0002-7890-3635

DATA AVAILABILITY
Not applicable

FUNDING
Conference attendance was generously supported by the Stellenbosch University Early Career Academic Development Program (ECAD), the Department of Research and Development (DRD) Travel Grant, and the Faculty of Arts and Social Science (FASS) Dean's Conference Support Fund.

ISSN On-Line 2310-3833
ISSN Print 0083-2330

Reflections on the 10th World Congress of Cognitive and Behavioural Therapies: Lessons for African occupational therapists

ABSTRACT

Cognitive behavioural therapy (CBT) is a well-researched and evidence-based psychotherapy that is underutilised in Africa. CBT presents opportunities for occupational therapists to expand their practice, for example by promoting engagement in meaningful and purposeful activity (behavioural activation), engaging with a mental health care user's thoughts during and after participation in activity (cognitive restructuring), and grading exposure to traumatic activities (exposure therapy). However, it is also critical that occupational therapists using CBT techniques culturally adapt these for their practice context and engage in professional development activities to develop their competencies as CBT practitioners. This commentary highlights recent advances in CBT practice and calls for CBT and associated techniques to be made more accessible to mental health care users in Africa.

Implications for practice

- The relationship between participation and mental health is gaining prominence within the field of CBT. Occupational therapists should position themselves as experts in the therapeutic use of activity.
- Occupational therapists using CBT techniques should culturally adapt their practice to meet the mental health needs of people living in Africa.
- Occupational therapists using CBT techniques should follow internationally recognised pathways to CBT professional development, and register as Affiliated Members of the Cognitive Behavioural Therapy Association of South Africa

INTRODUCTION

The cognitive behavioural approach is widely applied in mental health services by a range of health professionals, including occupational therapists and psychologists. To our knowledge, there are few opportunities for formal cognitive behavioural therapy (CBT) training in Africa, although the approach is included as a topic in many undergraduate occupational therapy programmes. As two occupational therapists and one psychologist attending the 10th World Congress of Cognitive and Behavioural Therapies (WCCBT) in Seoul, Korea from 1st to 4th June 2023, we appeared to be the only delegates from the African continent. We were left with a strong sense that CBT needs to be made more accessible to service users in Africa. Several strategies were shared during the conference that could facilitate this process, including cross-cultural translation and adaptation of CBT protocols and techniques, digitisation of services, and improved training of CBT practitioners. The term CBT practitioner is used internationally to refer to any health professional who has formal CBT training. In South Africa, the term CBT practitioner refers to a psychologist trained in CBT. However, occupational therapists are able to register as Affiliated Members of the Cognitive Behaviour Therapy Association of South Africa (see

https://cbtasa.co.za/membership-join-us/ for membership subcategories based on level of training).

Key principles of CBT for practice

CBT is based on the theory that thoughts, feelings, and behaviour influence each other[1]. CBT uses a range of specific techniques to change unhelpful thoughts (e.g. identifying cognitive distortions, thought stopping), feelings (e.g. emotional diaries), and behaviour (e.g. behavioural activation) to improve the person's mental health symptoms and function, otherwise known as occupational performance[2].

In the opening keynote presentation, Judith Beck, daughter of Aaron Beck, the founder of cognitive behavioural therapy, outlined the key tenets or principles of CBT[3]. These principles, and their implications for clinicians using a CBT approach are:

1. Therapy should focus on the relationship between thinking and behaviour: In occupational therapy, the focus of a cognitive behavioural approach is on how the person's thinking and occupational performance influence each other.
2. Therapy should be goal-directed: After the initial assessment, it is essential to spend time collaboratively setting goals with mental health care users (MHCUs). This ensures that the person's goals are achievable, and that therapy sessions are more meaningful. In occupational therapy, collaborative goals should focus on desired improvements in occupational performance and participation.
3. Outcomes should be measurable: It is essential to choose outcomes that can be measured before, during, and at the end of therapy. This ensures that the MHCU can track their progress and see improvement. Occupational therapists should select outcome measures at the level of occupational performance, participation, or quality of life.
4. Therapy should be structured: It is important to have a clear and structured plan of action from the beginning of therapy. If the MHCU makes less progress than expected, this plan can be modified in collaboration with the Mental Health Care User (MHCU). In occupational therapy, the collaborative goals set will inform the intervention plan.

The key principles of CBT are applied during the use of CBT strategies in therapy. Some of the CBT strategies highlighted by Stephanie Oluku, in her presentation at this congress, on supporting health professionals experiencing secondary traumatic symptoms, are already used by clinicians in Africa. According to Oluku, *psychoeducation* helps people to understand their experiences and develop coping strategies. It is important to provide information about the mental health problem, its symptoms, and its causes. She said that *problem solving skills* development enables people to identify and solve problems that contribute to their symptoms or reduced participation. This helps to develop a structured approach to solving problems and managing symptoms and performance deficits. Oluku also highlighted that *relaxation techniques* can be taught to reduce stress and anxiety, and manage symptoms. She said it is important to develop a personalized relaxation plan to meet the person's specific needs. A local example of occupational therapy-led relaxation in South Africa is our progressive muscle relaxation program for garment workers[4].

Techniques recommended by Oluku, that we believe may be less familiar to occupational therapists, include *cognitive restructuring*, exposure therapy, and behavioural activation. According to Oluku, cognitive restructuring is a technique where the therapist helps the person identify and challenge negative thoughts and beliefs that contribute to symptoms, such as feeling overwhelmed, guilty or helpless. The aim is to develop a more balanced and rational perspective on the person's participation and experiences. While this technique is more appropriate in a psychology consultation, we would suggest that occupational therapists could use activity participation as a tool to make these thoughts and beliefs more salient or noticeable to the person. Oluku presented *exposure therapy* which is used to gradually expose the person to the traumatic experiences that contribute to their symptoms, in a controlled and safe environment, to reduce anxiety and desensitize them to the traumatic content. We would suggest that exposure therapy is within the scope of occupational therapy when the activating condition is participation in a particular occupation, such as shopping. In this case, occupational therapists could plan gradual exposure to that occupation. *Behavioural activation* was the third strategy mentioned by Oluku, Judith Beck, and a number of other presenters at this congress, which we found less familiar. We interpreted behavioural activation as the use of meaningful activity participation by a different name.

The importance of engagement in positive activities

People with depression and other long-term mental health problems are less likely to engage in activities that provide positive reinforcement. Many conference presenters emphasised the importance of engaging in meaningful activity to promote mental health. Within CBT this is referred to as "behavioural activation"[(5)]. Within behavioural activation, meaningful activity is defined as positive activities that are most likely to enable people to experience happiness and mastery, and that reflect their values and goals[5]). The core principle of behavioural activation is that the therapist facilitates identification of meaningful activities with the MHCU. The person participates in these activities (with or without the therapist). The person then reflects on how participation has influenced their thinking and behaviour. Although much of this process is consistent with occupational therapy, when working in a cognitive behavioural framework it is important to link behaviour or participation to thoughts and emotions. Application of CBT principles means that during or after activity participation, the therapist should facilitate reflection on thoughts and emotions that were experienced during and after the activity.

Questions suggested by presenters, that we believe clinicians can ask people when using a cognitive behavioural approach during activity participation, include:

- What does your participation in this activity say about you?
- Did this activity show that you are capable?
- Did you enjoy doing this activity more than you expected?
- Did you have enough energy to do this activity?
- Were you able to make other people happy from doing this activity?
- How did others treat you or see you when you shared the product of the activity with them?
- What could this mean for you in the future?

Western and non-western societies

As a precursor to the discussion on cross-cultural adaptations, several presentations highlighted the differences between 'western' and 'non-western' societies. The mismatch between the mental healthcare workers and communities in need was one such highlighted fact. These presenters reiterated that in non-western societies, psychoeducation is vital before any interventions can take place. Globally there remains a shortage of trained mental health care workers, a lack of awareness around mental health in general,

and a lack of understanding about psychotherapy. This lack of understanding and awareness often results in inappropriate treatments. After attending a few presentations on the cultural adaptation theme, this appeared to be the case for many different countries.

Some recommendations were made to address the mental health literacy problem as well as the stigma around mental health treatment seeking. One suggestion to move towards accessibility and appropriate care was to integrate CBT treatment at primary healthcare level. Given that people typically seek out physicians for any health issue, the presenters said it may be useful to offer basic CBT treatment as part of physical care. This integration could additionally help destigmatise mental healthcare and provide appropriate interventions to those who need it. For occupational therapists working in community-based physical rehabilitation in Africa, this recommendation would mean routinely including assessment for mental health problems, and then using CBT and other strategies in a holistic intervention package that addresses both physical and mental health needs.

Another recommendation was to move towards group-based rather than individual interventions as this has a wider reach and will likely be more acceptable than individual interventions. Included in this discussion were suggestions for community-focused interventions and prevention strategies, such as CBT-based psychoeducation.

Cross-cultural Practice

In a session on cross-cultural adaptation of treatments for anxiety, Ardian Praptomojati, Diana Setiawati, Shin-ichi Ishikawa, and Cecilia Essau all spoke to the importance of considering culture during CBT. Mental health problems are experienced differently by people with different cultural backgrounds[6,7,8,9]. CBT includes a range of standardized treatment protocols that have been developed in WEIRD (Western, Educated, Industrialized, Rich, Democratic) countries. Cultural adaptation is the systematic modification of an evidence-based intervention protocol to consider culture, language and context in such a way that it is compatible with the individual's cultural patterns, meanings and values[10]. Cultural adaption can be understood on a continuum that ranges from delivering treatment "Western Style" (hardly any adaptation) to starting from scratch by developing new indigenous way of doing. The cross-cultural adaptation framework for psychological interventions, mentioned by Praptomoiati and Setiyawati suggests three ways in which health care practitioners can adapt therapy[11].

Understanding the cultural concept of distress: This is about understanding what people think is the cause or origin of the mental health problem being experienced, and the cultural relevance or salience of symptoms addressed in therapy. When people present with mental health problems, therapists should spend time finding out how the person understands their emotional or cognitive difficulties, and the core difficulties they experience as a result. Therapy can be culturally adapted by including interventions the person believes will address their most important problems, and what they believe will be effective. In occupational therapy, this could mean using the occupations a person believes are most likely to help in their recovery, rather than having a pre-determined set of activities in a ward program.

Adapting treatment approaches: Cultural adaptation of treatment approaches means choosing the practice approach that is most acceptable to the person and best addresses their needs, adapting the therapeutic use of self to meet the needs of the person, and choosing treatment techniques or modalities that are consistent with the person's culture and are meaningful to them. For example, when choosing a practice approach, an occupational therapist may explain to the person the difference between following a cognitive behavioural versus psychodynamic approach to occupational therapy, and empower the person to choose the approach they believe would work best for them. Similarly using activities as means (e.g. daily crafts groups) versus group psychoeducation sessions could provide the MHCU with two different experiences of occupational therapy.

Adapting treatment sessions: Cultural adaptation can also be applied within individual treatment sessions. Specific techniques may include adjusting treatment to meet the language needs of the person, changing materials and language used to adjust for low levels of literacy and the socio-economic status, using cultural examples and themes (e.g. in education materials and worksheets), adjusting treatment based on the gender of MHCUs, and selecting the treatment environment and other people present (e.g. family, caregivers) to better meet the person's cultural needs.

Another model for cultural adaptation that was presented by Maria Santos from California State University was the Shifting Cultural Lenses (SCL) model[12,13]. In this model, culture is conceptualised as what is at stake for a client, given their lived experiences in local social worlds. When implementing this model, the therapist attempts to view the situation through the 'cultural lens' of the person. In other words, they make a specific attempt to understand the situation from the person's perspective. When communicating their own viewpoint, the therapist does this tentatively. This could be through a phrase like "When I think about your situation, I think….. What do you think about that?". In this way, the therapist shows they remain open to having their viewpoint challenged, so that the person and therapist can reach a common understanding of the problems experienced, and best methods to address them. Dr Santos concluded that the SCL model was useful in assisting clinicians with incorporating client's cultural views into behavioural activation.

Digitisation of Therapy

There has been a rapid increase in the development and use of digital CBT programs, particularly since the Covid-19 pandemic[14,15,16]. Many presenters talked about the potential digital interventions have to increase the accessibility of interventions, particularly in low to middle income countries (LMICs) or low-resourced areas in high income countries. Across the presentations it was highlighted that digital interventions may address other barriers to traditional therapy such as cost, stigma and logistical challenges.

According to an invited talk by Sabine Wilhelm from Harvard University, smartphone penetration in South Africa is 60%, presenting a golden opportunity for digital mental health. She reported that over 20 000 mental health apps are currently available, but many of these are not evidence-based and have not been developed in collaboration with clinicians and MHCUs. Guided use of certain mental health apps has been found to be as effective as in-person CBT with body dysmorphic disorder. This guidance does not need to be done by a mental health professional, but could be facilitated by a trained lay person. Personal guidance makes digital mental health treatment much more effective. Credibility is a challenge to effectiveness, as MHCUs believing that treatment will be ineffective may have a negative effect on their progress. For this reason, it is helpful to use mental health apps in clinical practice, where clinicians can explain the use of the app as well as outcomes data to the MHCU. In occupational therapy, this could mean incorporating the use of a mental health app into the

person's routine, and using the app's outcomes data as a way of monitoring progress towards occupational goals.

The most commonly used mental health apps are those with immediate benefit, e.g. mindfulness apps such as Headspace and Calm, whereas some MHCUs may benefit more from other treatment modalities. It was recommended that practitioners develop digital mental health programs in collaboration with industry partners such as medical insurance companies, in order to obtain funding to support high quality product development. It may also be useful to include software engineers, designers, clinicians and MHCUs in product design.

Some of the new digital mental health programs presented at WCCBT 2023 were:

- Psidamai: an Indonesian mindfulness interventions for students (https://instagram.com/psidamai?igshid=NTc4MTIwNjQ2YQ==)
- COMET: Originally developed in the USA and adapted for the UK, this is a two-hour brief interventions for students (http://essay.utwente.nl/81554/1/Loos_MA_EEMCS.pdf)
- Intellect: A 12-day intervention of 10 minutes per day improved students' self compassion using this app. Available on Google Play and in the App Store (https://play.google.com/store/apps/details?id=co.intellect.app&hl=en&gl=US)

Before using these programs, it is recommended that occupational therapists in Africa carefully consider how the technology was developed (e.g. with clinicians and MHCU's), and whether they are appropriate to context.

Education and Training

A highlight of the congress was the presentation by the World Confederation of CBT's (WCCBT) training and education guidelines. This was a historic moment as it is the first set of guidelines to be disseminated for CBT training and education. These guidelines

- are a direct response to the World Health Organisation's call for action on mental health;
- were established to ensure that CBT practitioners have appropriate licensure and registration to practice in their respective region;.
- aim to identify different competencies required for CBT and work towards best practice of CBT amongst various healthcare professionals;
- aim to ensure that minimum requirements are met for now, but eventually work towards an optimum level of practice within CBT;
- use the term "CBT practitioner" to account for the use of CBT across disciplines, including occupational therapy, and across different skill levels; and
- adopt a premise that CBT practitioners are ethical, flexible and able to culturally adapt for their own contexts.

Conference presentations from several countries, including Malaysia, Canada and South Africa[17], demonstrated the current diverse training pathways across institutions and in different countries. The WCCBT guidelines were presented to create a standardised approach, however, acknowledging the various types of cognitive and behavioural therapies used across the globe.

The guidelines, presented by Professor Firdaus Mukhtar, president of the ACBTA (Asian Cognitive Behavioural Therapies Association), included guidelines for selection of trainees, training strategies, and a range of definitions. It was evident that the guidelines apply to post-graduate training in CBT since the guidelines emphasised the selection of trainees qualified to provide mental health services, with basic clinical skills and knowledge as well as an understanding of ethics in healthcare. Prof Mukhtar emphasised that training should be continued until competency and adherence is reached. Adherence is the accuracy with which clinicians implement specific CBT interventions, while competence is described as how well they deliver the intervention across a range of diversities.

Supervision was highlighted as a key teaching strategy, as well as experiential learning for trainees with real cases. Several further strategies such as didactic lectures, readings, webinars, presentations, live observations, demonstrations, group discussions, experiential case conceptualisation, activities, role plays, skills practice and reflection activities were recommended.

Further recommendations included supervision across multiple cases, with trainees having exposure to at least three cases with a minimum of six sessions each. The guidelines also indicated that multiple supervisors (at least two) is best. Supervision should aim to include direct observation, discussion of clinical decisions and implementation, regular feedback on strengths and areas of development and evaluation of specific knowledge and competencies. The interdisciplinary nature of the guidelines means that occupational therapists would need to adhere to these guidelines, to develop their competence. In South Africa, the membership category of the CBTASA is based on the level of training received. This ranges from Open Member, who has an interest in CBT, through to Accredited Members who hold internationally accredited status as a CBT Trainer and Supervisor.

Prof Mukhtar emphasised the importance of developing both knowledge and competency in CBT, while highlighting that these guidelines are not regulations. It was recommended that the guidelines are implemented in the users' own region within their own legal and accreditation frameworks, in order to produce best practice and for the protection of the public or service users.

CONCLUSION

Cognitive behavioural therapy is one of the most widely researched psychotherapies that has the potential to address the burden of mental illness in Africa. This means it is important that occupational therapists develop competencies in CBT through accredited CPD opportunities. An emerging field in CBT is engagement in meaningful activity to promote mental health. Occupational therapists are already experts in the relationship between occupation and health, and so have the opportunity to make a substantial contribution within the CBT community.

In some countries, like Malaysia and South Africa, being a cognitive behavioural therapist is limited to psychiatrists and psychologists. In other countries, such as the United States of America and the United Kingdom, a range of health and social care professionals can gain additional registration as CBT practitioners. Nevertheless, in South Africa there is the opportunity for occupational therapists to gain Affiliated Membership of the CBTASA, and follow a recognised pathway to professional development.

We believe that in Africa, CBT should be used by a range of mental health practitioners including medical doctors, nurses, psychologists, occupational therapists, social workers and counsellors. This will improve access to cognitive behavioural interventions. However, it is essential that CBT is culturally adapted for the African context, whether it is delivered face-to-face or on a digital platform.

Author contributions

All listed authors contributed to the writing of this manuscript and approved the final version.

Conflicts of Interest

There are no conflicts of interest to declare.

REFERENCES

1. Fenn K, Byrne M. The key principles of cognitive behavioural therapy. InnovAiT Educ Inspir Gen Pract. 2013 Sep;6(9):579–85. https://doi.org/10.1177/1755738012471029
2. Cully JA, Teten AL. A therapist's guide to brief cognitive behavioral therapy. Houst Dep Veterans Aff South Cent MIRECC. 2008; (No DOI available)
3. Beck JS. Cognitive behavior therapy: Basics and beyond. Guilford Publications; 2020. (No DOI available)
4. Hoosain M, Dwayi S, Ganie A, Jacobs Z, Prince D, Sokomani Y, et al. The immediate effect of progressive muscle relaxation (PMR-OT) on the pain and wellbeing of garmetn workers. Cape Town; 2022. (No DOI available)
5. Veale D. Behavioural activation for depression. Adv Psychiatr Treat. 2008;14(1):29–36. https://doi.org/10.1192/apt.bp.107.004051
6. Chen SX, Mak WWS. Seeking professional help: Etiology beliefs about mental illness across cultures. J Couns Psychol. 2008;55(4):442. https://doi.org/10.1037/a0012898
7. Swartz L. Culture and mental health in the rainbow nation: transcultural psychiatry in a changing South Africa. Transcult Psychiatr Res Rev. 1996;33(2):119–36. https://doi.org/10.1177/136346159603300201
8. Gopalkrishnan N. Cultural diversity and mental health: Considerations for policy and practice. Front public Heal. 2018;6:179. https://doi.org/10.3389/fpubh.2018.00179
9. Bass JK, Bolton PA, Murray LK. Do not forget culture when studying mental health. Lancet. 2007;370(9591):918–9. https://doi.org/10.1016/S0140-6736(07)61426-3
10. Bernal G, Jiménez-Chafey MI, Domenech Rodríguez MM. Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. Prof Psychol Res Pract. 2009;40(4):361. https://doi.org/10.1037/a0016401
11. Heim E, Kohrt BA. Cultural adaptation of scalable psychological interventions. Clin Psychol Eur. 2019;1(4):1–22. https://doi.org/10.32872/cpe.v1i4.37679
12. López SR, Ribas AC, Sheinbaum T, Santos MM, Benalcázar A, Garro L, et al. Defining and assessing key behavioral indicators of the Shifting Cultural Lenses model of cultural competence. Transcult Psychiatry. 2020;57(4):594–609. https://doi.org/10.1177/1363461520909599
13. Lakes K, López SR, Garro LC. Cultural competence and psychotherapy: Applying anthropologically informed conceptions of culture. Vol. 43. Educational Publishing Foundation; 2006. https://doi.org/10.1037/0033-3204.43.4.380
14. Cheng P, Casement MD, Kalmbach DA, Castelan AC, Drake CL. Digital cognitive behavioral therapy for insomnia promotes later health resilience during the coronavirus disease 19 (COVID-19) pandemic. Sleep. 2021;44(4):zsaa258. https://doi.org/10.1093/sleep/zsaa258
15. Song J, Jiang R, Chen N, Qu W, Liu D, Zhang M, et al. Self-help cognitive behavioral therapy application for COVID-19-related mental health problems: A longitudinal trial. Asian J Psychiatr. 2021;60:102656. https://doi.org/10.1016/j.ajp.2021.102656
16. Korpilahti-Leino T, Luntamo T, Ristkari T, Hinkka-Yli-Salomäki S, Pulkki-Råback L, Waris O, et al. Single-Session, Internet-Based Cognitive Behavioral Therapy to Improve Parenting Skills to Help Children Cope With Anxiety During the COVID-19 Pandemic: Feasibility Study. J Med Internet Res. 2022;24(4):e26438. https://doi.org/10.2196/26438
17. Salie M, Coetzee B. Assessing student clinical psychologists' self-competence in CBT as part of a professional training programme in South Africa. 2023. (DOI not available)