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Model of the cultural competence and cognitive behavioral therapy for drug addiction rehabilitation in the 3 southern border provinces of Thailand

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Abstract

This study aimed to investigate therapists' and clients' experience of Cognitive-Behavioral Therapy and to propose a model of Cultural competence Cognitive-Behavioral Therapy for drug addiction rehabilitation in the southern border provinces of Thailand. A qualitative design was used to create the questionnaire, focus group, and in-depth interview based on Beck's cognitive conceptualization. The cultural competency proposed was based on the Ecological Validity Model [EVM]. It was formulated through clients and therapists experienced in CBT. The study found that clients were satisfied and willing to participate in CBT conducted by a culturally sensitive therapist, particularly a therapist whom they trusted, practiced the same religion and used the same language. Furthermore, clients reported that no activity involving the exploration of more profound life problems influenced sustained drug use. Therapists reported their experience of CBT to the cultural dimension: the CBT was responsive to clients' cultural backgrounds, predominantly in the areas of language, context, contents, concepts, and personal dimensions. Moreover, therapists who conceptualize drug use behaviors have discovered that their judging behaviors have influenced their attitudes and therapeutic relationship style. The result obtained from the second objective showed that culture and religion create trust in the therapeutic relationship, and redesigning CBT activities and skills should be considered. The redesigning should be carried out with the dimensions of EVM together with the therapeutic relationship, case conceptualization, content, rehabilitation goals, understanding the concept of drug use, method of thought stopping, and building the life balance should be aligned with the cultural dimension and the belief in the doctrine.

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Introduction

The spread of drug use in Thailand has long been a problem. The number of drug addicts has not decreased, although various agencies have strategies to solve the problem. Thailand has an increasing number of drug addicts and this is likely to increase. According to Thailand's 2018 drug situation, youths aged between 20–24 years and employed people showed the highest exposure to illicit drugs. (Office of The Narcotics Control Board [ONCB], 2019, p. 24). A similar situation exists in the three southern border provinces of Thailand (Pattani, Yala, and Narathiwat). These provinces, where the majority of the population are Malay Muslims, make up 83 percent of the population. (Southern Border Provinces Strategic Management Group, 2016, p. 7). Muslims' way of life in this area is different from those of other groups in the country. The Islamic way of life is based on religious beliefs. Islam is not only a spiritual guide for its believers but also sets guidelines for speech, manners, and behavior that Muslims should follow in carrying out their daily activities. They still use the Malay language in everyday life. Some even cannot speak Thai. These aspects of culture affect the effectiveness of the treatment of drug addicts, mostly Muslims. United Nations Office on Drugs and Crime (2017, p. 24) stated that developing a multi-level system assessment process to identify the current needs and gaps in drug use prevention, treatment, and recovery in rural areas, and to develop appropriate interventions to address identified gaps, is based on the premise that all residents, regardless of their place of residence in a given country, should benefit from evidence-based prevention programs and policies. The planning of such prevention, treatment and rehabilitation responses should be firmly based on rigorous assessment, taking account of the substance use situation and the related factors influencing it, as well as the existing responses and supportive policy frameworks and gaps in them.

Concerning drug treatments in Thailand, public hospitals have implemented the approaches treatment focused on rehabilitating the addicts utilizing the CBT model and the prevention of relapse. From the CBT model, the rehabilitation stage focuses on their cognitive and behavioral adaption through CBT. A therapeutic model has been found to be highly effective. It prioritizes the individual cognitive process. It was also found that the rate of relapses with a return to substance use rises to 40–60 percent after discharge from treatment. This resulted in the rising number of addicts in therapeutic facilities. Besides, it is also found that many addicts are dismissed from probation, and being outside the therapeutic process, they relapse. Factors leading to an increased risk of relapse include personal characteristics, motivation, cognition, and perception of self- capacities like intolerance, sensitivity, circumstances, or individual circumstances such as not complying with the law and living an unstable lifestyle. For instance, in the southernmost region, a high rate of relapse was found (Thanyarak Pattani Hospital, 2018, p. 1). This relapse is an exciting phenomenon with the process of cognitive and behavioral adaptation, whether there are any factors incongruent to the therapeutic patients disabling them to adapt their cognition and addictive behavior. As such, a study by Naeem, Ayub, Gobi, and Kingdon (2009) found that individually cognitive correction and adaptation efficiency of treatment increases when cultural awareness of therapeutic patients is improved. It was found that the mindset influencing the interpretation of religious culture had to be a primary focus, considering the corrections and help for individual addiction, to instill the idea that the process must be adhered to. There is a systematic review of studies on drug addiction treatment failure due to a lack of review of the cultural background of drug addicts (Brorson, Arnevik, Rand-Hendriksen, & Duckert, 2013, pp. 1010–1024), significantly undermining the treatment and success of multicultural and multilingual groups compared to mainstream groups (Guerrero et al., 2013, pp. 1450–1467). It is also found that the absence of the consciousness of cultures in therapy reduces achieving success with the therapeutic groups characterized by particular cultures. The therapy for multicultural and multilingual groups then becomes the primary goal leading to service equality and alleviating the rising burden of the mental health problem (Gainsbury, 2016, pp. 987–1001).

Even though CBT is a highly efficient therapy, it was developed in the west. It might be incongruent with the culture of the addicts in the three southern border provinces who are mostly Muslims and devoutly practice their unique culture. Consequently, the cognitive adaptation process and the therapeutic perspective are required to access their belief and culture to help raise therapeutic efficiency (Naeem et al., 2009). With the knowledge and understanding through exploration and intervention of the wrong cognitive system and incongruence with their culture, such will influence the ending of drug use because the adaptation of their proper cognitive process will be followed by such cognition. The therapists should consider such an issue as the prime principle associated with the medication. However, such an issue has been least studied in the past, particularly the addicts' experiences on CBT. Such a study has never been

carried out in the three southern border provinces using the CBT assessment. Therefore, the researcher concluded that considering the CBT-based addicts' and therapists' experiences incorporating the therapy associated with other competencies would help enhance the therapeutic efficiency.

Research Objectives

This study aimed to investigate therapists' and addicts' experience of CBT and propose a model of CCBT for drug addiction rehabilitation. This was the initial implementation of CBT in the three southern border provinces of Thailand.

Methodology

This investigation focused on the importance and the cognitive model of automatic thought affecting the emotional expression and the addictive behavior of the addicts by following Beck's Cognitive model. (Beck, Wright, Newman, & Liese, 1993). It also studied the experience of both the therapists and the addicts towards the CBT structure-based application with the therapists' cultural competence based on EVM through non-participatory observation, focus group, interviews on CBT experiences in the six [6] public hospitals in the provinces of Pattani, Yala, and Narathiwat.

This study employed a qualitative and purposive site sampling to choose the site for investigation. This was because the studied groups were particularly addicted and admitted to public hospital's rehabilitation process in the three [3] southern border provinces characterized by their particular culture, being mostly Muslims. The inclusion criteria included 33 hospitals rehabilitating addicts as out-patients in the three [3] southern border provinces. Sites implementing the CBT model and having addicts for therapy under the conditions of convenience in traveling, and safety in their data collection were also selected. It was found that the 33 public hospitals applied the CBT model, and eight therapists with CBT training certificates were willing to participate in the research.

The focus group and interview were conducted ten times: 2 times in the hospitals at Narathiwat, 2 times in the hospitals at Yala, and 6 times in the hospitals at Pattani). The sessions lasted between 1–2 hours.

Beck's Cognitive Model

Beck's cognitive model is useful for CBT and explains that a cognitive model involves the mechanism in which the situation activates automatic thoughts that influence emotions, behaviors, and physiological responses (i.e., reflex responses are governed by the sympathetic nervous system), as Figure 1.

The Structure of Cognitive-Behavioural Therapy

With the non-participatory observation over the structure of the therapy to pinpoint the significant issues and create a therapeutic atmosphere, Beck (2011) suggested the procedure as: (1) Setting the agenda; (2) Mood check; (3) Bridge from last; (4) Discussion of today's agenda; (5) Socratic questioning (guided discovery); (6) Capsule summaries; (7) Homework assignment; and (8) Feedback in the therapy.

Ecological Validity Model (EVM)

On the other hand, the EVM is useful for developing the tool to assess cultural competence in the intervention. The EVM (Bernal, Bonilla, & Bellido, 1995) comprised of eight dimensions as follows:

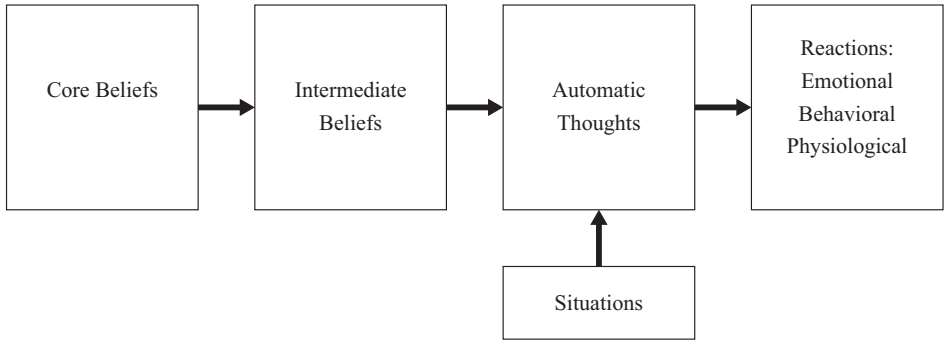

Figure 1 Beck's Cognitive Model

1. Culturally syntonic language; the language used in therapy must be relevant to the client. Language is the carrier of culture. It is needed to consider knowledge about the language and knowledge about the culture when conducting a therapy (Sue & Zane, 1987).

2. Persons; this dimension focuses on the client-therapist relationship variable. Ethnic or racial similarities and differences between the therapist and client are considered necessary.

3. Symbols and metaphors refer to the symbols or metaphors generally used in society. The use of metaphors and slang commonly found among the client group reduced the resistance and increased motivation, such as a waiting room being comfortable and surrounded by a culturally familiar physical environment (Munoz,1982).

4. Contents refer to knowledge about culture and information about values and traditions. Respect for the clients' values, social status, economics, background, and politics, together with facilitating the exchange of experience among the minorities, are considered essential

5. Concepts refer to the structure of psychosocial therapy: understanding and conceptualization of client's presenting issues related to cultures, values, or beliefs' system.

6. Goals are needed to construct the framework to gain access to the client's cultures. The client and the therapist design clear therapy goals relevant to the client's values, culture, and traditions.

7. Methods to increase therapy success; knowledge about culture and therapy instruments relevant to the client's culture are essential.

8. Context refers to the consideration of changing the client's context while gathering information for the therapy, such as interpersonal relationships and social roles or status.

Participants

Participants 1

The 56 clients who were addicts having their domicile in the 3 southern border provinces were admitted to the addictive therapy in the public hospitals with addiction experiences for the past 12 months and at least a week of CBT treatments. 37 clients were from the Pattani hospitals, 14 clients were from the Yala hospitals, and 5 clients were from the Narathiwat hospitals.

Participants 2

The 10 CBT-based therapists in the same hospital and the addicts rehabilitated from the clients passing the CBT model. They included 8 therapists from the Pattani provincial hospitals, 1 therapist from the Yala provincial hospital, and 1 therapist from the Narathiwat provincial hospital.

Data Analysis

In the analysis of characteristics of the demography and various assessment forms, the researcher implemented the computerized analysis using descriptive statistics, which is distributed by percentage, means, and standard deviation to evaluate the demographic characteristics, levels of cognition, belief, and cultural competence. Their congruency was examined with the data from the focus group, interviews, and observation.

The qualitative data analysis involved adopting the recorded data and decoding the tape recordings from the focus group and in-depth interview and adopting data explored from the studies, including the data from non-participatory observation to be processed. Coding involved careful reading and re-reading of the interviews, marking passages, words, or phrases that indicated the client's and therapists' experiences on CBT. This led to identifying preliminary themes, that is, groupings of ideas or phrases that appeared to be related.

Results and Discussion

The results and discussions are based on the research objectives (RO1 and RO2) given below

RO 1: To Investigate Therapists' and Clients' Experience of CBT

Therapists' experience of CBT

All 10 therapists were nurses trained in CBT. 70 percent were female, aged 35–55 years old and 43 years old by average. The majority experienced CBT for more than 3 years. CBT was used at least once a week.

The therapists' experience and opinions found that: (1) the problems and barriers of applying CBT, including the content of CBT, were somewhat difficult to understand. In the therapists' words, the addicts could not exchange opinions with the therapists when using the Thai language as a means of communication. Also, some parts of the content were irrelevant to the addicts' culture. Therefore, the addicts attending the CBT rehabilitation should be educated to understand CBT knowledge and structure as CBT is difficult for the addicts.; (2) The relationship was the most critical element of CBT; (3) Partially, culture induces addiction, and; (4) Understanding the culture of the addict benefits imposing CBT.

Clients' experience of CBT

100 percent (56) of the clients were male, aged 28–52 years old, and 38 years by average 62.5 percent, or the majority, earned less than 10,000 Baht/month followed by 26.78 percent earning 10,000–15,000 Baht/month. 64.28 percent, or the majority, were common laborers, followed by 28.57 percent traders. 96.43 percent, or the majority, were taking CBT for the first time, and all 100 percent underwent a 4-week therapeutic period.

It was found that the clients' experience was: (1) Addictive substance benefits oneself; for example, the client owning the automatic thought of substance use thought it benefited their own life in many areas, the addictive substance helped relieve stress, and addictive substance enabled them to work; (2) The addicts could not complete the homework assignment and pass the behavioral test because they had to work to earn a living; (3) No activity involved the exploration of more profound dimensions of life problems influencing sustained drug use; (4) The therapists typically applied religious principles to teach/explain in the therapy; (5) The language the addicts thought they were literate in and which was easy to understand was Malayu/Yawi to access the addicts well; (6) The therapists who practiced the same religion with the drug addicts provided better treatment; and (7) Thought stopping skill cannot work when facing a stimulus.

RO 2: To Propose a Model of CCBT for Drug addiction Rehabilitation in The Southern Border Provinces of Thailand

The activities using CBT as in this model have been organized with experiences towards the CBT based on the therapists' perception and the addicts emphasizing the cognitive proof with 11 criteria: (1) Build a therapeutic relationship to create trust: therapists express their competence to create collaboration and acceptance, create a climate of warmness and care, respect challenging ideas, be adaptable and flexible, and help relax the addicts; (2) Evaluate the culture of substance use and the culture of life among the individual addicts, create understanding with each addict under their cultural context; (3) Analyze and process individual problems of the addicts and process the problems responsive to the addicts' values and cultural values; (4) Collaborate in analyzing problems among the therapists and the addicts through the focus group of mental therapy associated with analyzing causes leading to substance use; (5) Explain the cognitive behavioral therapy by imposing the archetype chart to ease understanding; (6) Target for rehabilitation and seek the automatic negative thought on problem-making; (7) Prove the automatic negative thought leading to substance use through imposing techniques of Socratic Questioning; (8) Collaborate to seek ways to address impulses and problems responsive to the addicts' values or cultural values; (9) Knowledge contents are necessary for real-life practices among the addicts responsive to their values or cultural values; (10) Assign homework responsive to the addicts' values or cultural values; and (11) Evaluate the ongoing therapy for confidence that the addicts and the therapists still communicate with understanding, from 11 criteria leading to create the 3–steps of CCBT model as shown in Figure 2.

The First Step: Building relationships and acquaintances, understanding and knowing oneself, and self-evaluation. Building relationships to gain trust. TRUST, which should be built up and established between the therapists and clients, is essential in initiating therapy:

Communicating in the same language as drug addicts can build more trust in therapy and allow addicts to use their language to make the treatment process more efficient. This is to construct the readiness and case conceptualization. At the beginning of attending rehabilitation this is essential because the therapists have to create a shared understanding, and the addicts have to see their problems. In contrast, the techniques found in the rehabilitation have to be responsive to their cultural values. This is to build an understanding of addiction affecting the brain, body, and mind or the addicted brain and its nature of addiction. The nature of addiction might use the addictions from direct experience before and admissions to therapy without recidivism, including the issues of the impact of drug use and religion-related to drug use. The therapists prepare the contents for the clients to learn and exchange until reaching consciousness and understanding the consequences of addictions. This is to explain the holistic views of CBT and link it with the faith of the addicts associated with building an understanding of the daily living culture of the addicts. The therapists encourage the addicts to discuss problems and what stimulant leads to individual addiction.

The Second Step: The rehabilitated group collaborates to analyze problems and the negative automatic thought [NAT] leading to substance use and imposes the techniques of Socratic questioning and Downward Arrow. Setting clear rehabilitation goals is imperative. A collaborative goal-setting through discussion in exchanging opinions among the therapists and the clients will help them understand the rising consequences specified by oneself, seeking NAT as the troublemaker. The therapists should

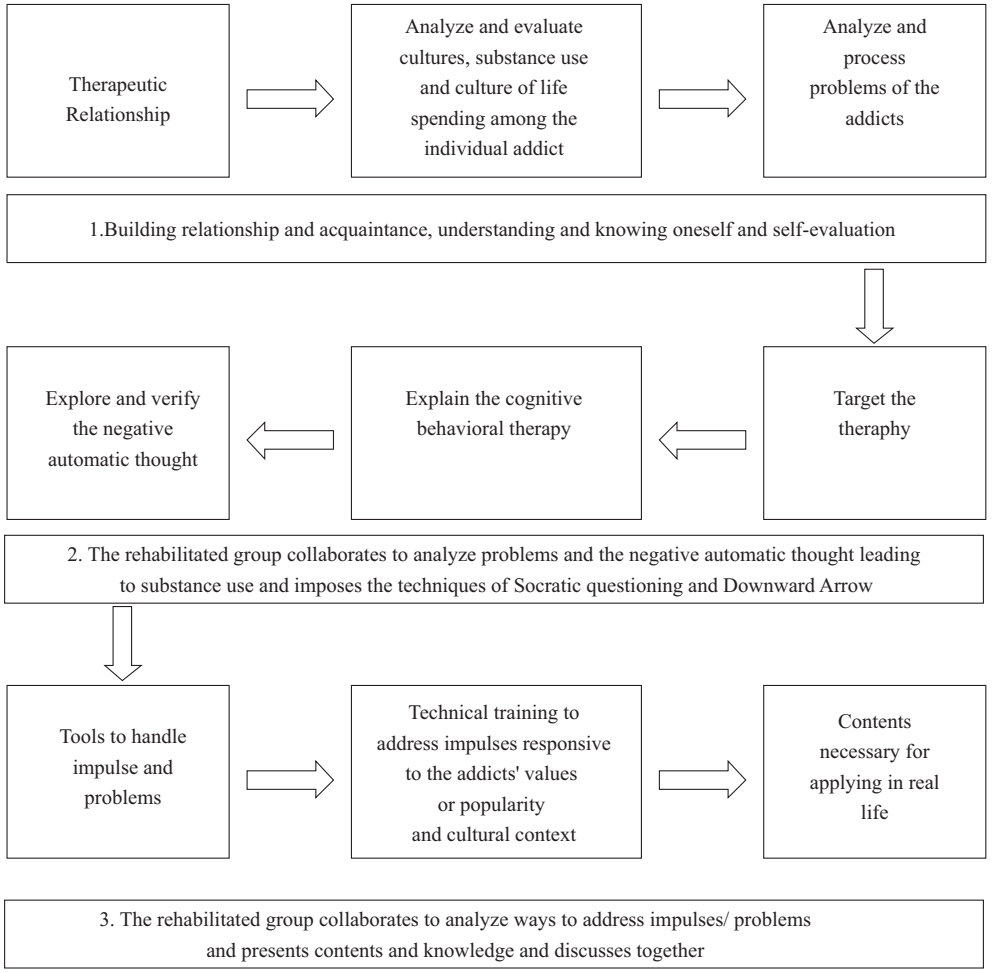

Figure 2 The model of the cultural competence and cognitive behavioral therapy for drug addiction rehabilitation in the three southernmost provinces [of Thailand]

consider and adhere to this step. Handling addicts' NAT, especially proper drug use, is not sinful, thinking to be free from addiction, coercion rehabilitation, and freedom of thought. Having the target responsive to the addicts' culture will enhance rehabilitation efficiency even though it is subject to coercion rehabilitation. In addition, building an understanding of the concept of homework is an important activity in CBT. At this stage, homework is an activity that addicts must return to do in order to prove NAT by the therapists to mockup a scenario and put it into practical training during the therapy.

The Third Step: The rehabilitated group collaborates to analyze ways to address problems and presents contents and knowledge and discusses the techniques of Socratic questioning and Downward Arrow. This includes adjusting the wrongful NAT while applying the belief in the doctrines being the prime foundation responsive to the values or cultural values of the addicts. Seeking the principle and method of thought stopping, sentiment, and negative behavior when facing stimulus is the training for handling the craving leading to drug use under the contexts responsive to the principle's cultural values, including cognitive restructuring. This step perceives the craving to be a part of the therapeutic period and emphasizes strategies to manage it. This concept needs to be taught through response during the group therapy and to explore or survey the influential persons to see whether they can support drug craving symptoms. Moreover, it is to use the ability to apply in daily life, among friends, places, or various situations, which are the external stimulants that the addicts have to be careful of. The hardship to refuse is the main goal in developing this step (Hechanova & Waelde, 2017; Tuliao, 2014). The addicts might need to arrange the peer group's score order and

exchange opinions within the group. Later, CBT needs to play a virtual role in avoiding various stimulants. Moreover, building a life balance for good health is necessary. The goal of behavior exchange is to stop drug use, but it is not the last goal of the therapy. Under the core value in the culture, it provides the knowledge contents responsive to the readiness for adjusting self-care covering all aspects of body, emotion, social, environmental spirit and career (Substance Abuse Mental Health Services Administration [SAMHSA], 2016), particularly, faith being the spirit and course of life of the addicts.

The therapist's competence using the model should be: (1) Pass CBT training under a supervisor and develop communication competence; (2) Be able to communicate in Malayu/Yawi during rehabilitation; (3) Identify the local culture of the three southernmost provinces; and (4) Own the skills of group therapy.

Conclusion

The CBT structure designed for each group therapy needs to be conscious of the addicts' cultural values. Existing literature works have found that to derive a more effective intervention for drug addicts, it is essential to apply culturally competent CBT for drug addiction rehabilitation in Thailand's southern border – the area with a distinct culture. CBT emphasizes the modification of internal cognitive elements and outer behaviors by promoting the client's strength and facilitating learning about the association between thinking and problematic behaviors. Therapists must have cultural competencies. TRUST BUILDING is vital to start building trust from the beginning of the relationship and to be consistent. After that, culture and religion create trust in the therapeutic relationship. The knowledge and understanding of the clients' culture that indicates respect for the clients' values are also essential to increase treatment effectiveness as is the ability to collaborate with addicts to set individual therapy goals or agendas that align with their issues. Homework assignments are essential for the therapist in keeping up with the problems and daily life of the addict. The therapist should also assist in the modification of the cognitive structure or the discovery of solutions to the problems relevant to the clients' cultural beliefs. It is required that the therapist has Cultural Competence in drug addiction rehabilitation based on CBT principles to design the treatment. The EVM framework, consisting of eight dimensions of treatment interventions, particularly in person, language, content, and context dimensions, is essential in this area to guide developing culturally sensitive treatments and adapting existing CBT to specific ethnic minority groups.

Recommendations

The result of this study helps elucidate that addict therapy with CBT requires expertise in its process. Therapists have first to pass training from the CBT experts and to understand its concept and principle. These findings are useful in CBT therapy within a unique cultural location. Then, sensitivity to the culture playing the leading role in leveraging the therapeutic efficiency reflects the cultural and related values. For further studies, this study presents a cultural competence model in CBT; its effectiveness should then be investigated.

Conflict of Interest

There is no conflict of interests.

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