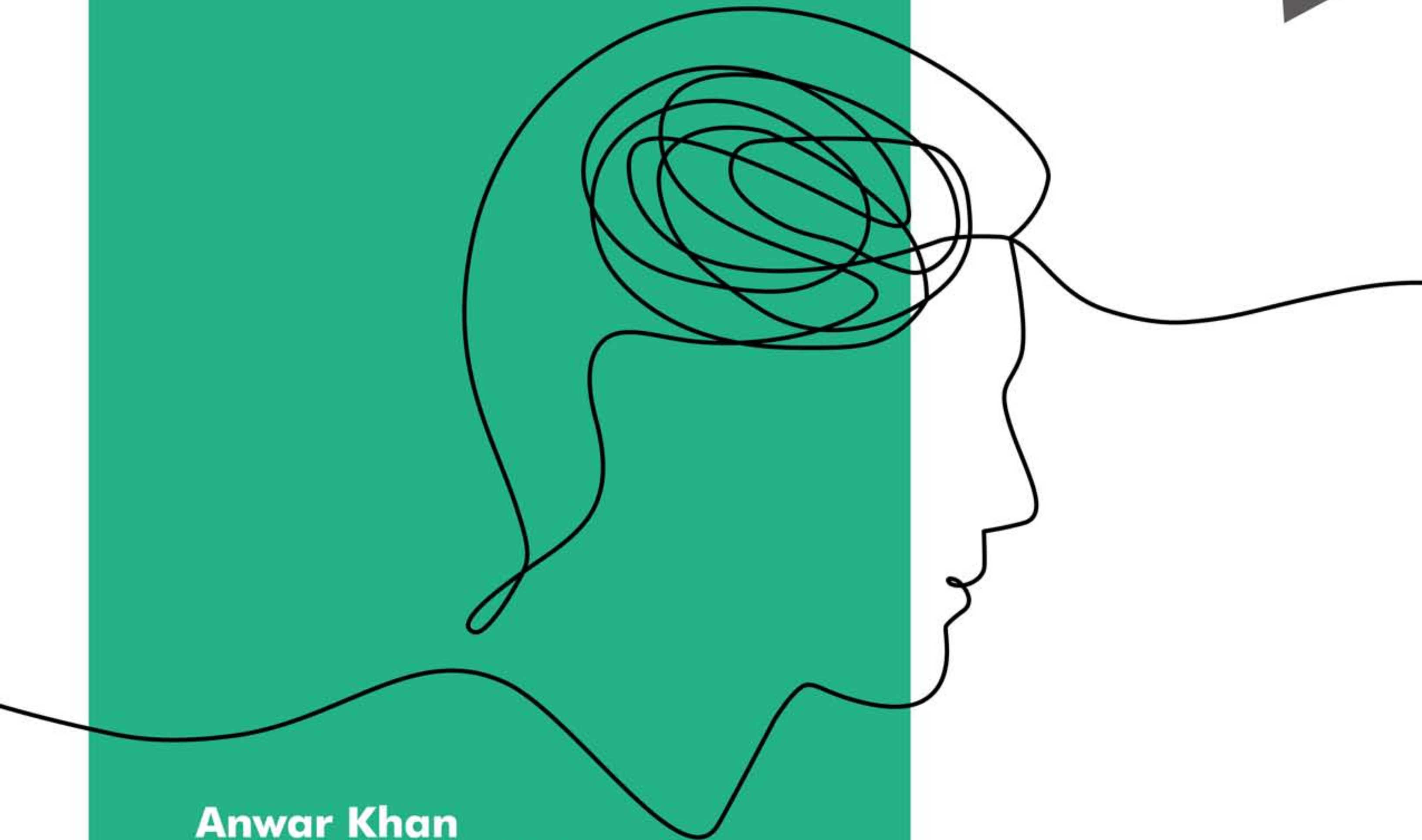
CULTURAL ADAPTATION OF EVIDENCE-BASED PSYCHOTHERAPIES FOR COMMON MENTAL HEALTH DISORDERS IN PAKISTAN



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Cultural Adaptation of Evidence-Based Psychotherapies for Common Mental Health Disorders in Pakistan

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FOREWORD

The quest for psychological well-being is a ubiquitous ambition in the ever-changing universe of Mental Health Sciences. I was ecstatic when Anwar Khan apprised me about his aspirations to write a book about the cultural adaptation of evidence-based psychotherapies in Pakistan. This is the topic that is very dear to my heart. Since we, as mental health practitioners, interact with local patients on a daily basis while adhering to some clinical standards defined and tested by Westerners, the question of how to administer such clinical standards developed by others arose. Keeping this in view, Anwar Khan has embarked on journey of an extensive exploration of the interaction between modern evidence-based psychotherapies and the rich tapestry of Pakistani culture. This narrative has taken place amid the backdrop of practice of relatively new Evidence-Based Psychotherapies in Pakistan, where typical Western-made treatment procedures are used and local modifications in the treatment procedures are a growing requirement.

This book, "Cultural Adaptation of Evidence-Based Psychotherapies for Common Mental Health Disorders in Pakistan," has been meticulously prepared for clinical psychologists, psychiatrists, psychotherapists, mental health counsellors, and academicians. This book gives insightful information about the cultural adaptations of Evidence-Based Psychotherapies in Pakistan, based on an extensive review of the literature, consultations with mental health practitioners, and rigorous research methodologies. The sequence of the book is carefully designed into well-organized chapters in which the readers are guided through a labyrinthine journey of understanding and adapting evidence-based psychotherapies in Pakistani context, beginning with the nature of evidence-based psychotherapy, and continuing with its historical evolution, integration of computer technologies in mental health sciences, and final practical case illustration. Through such comprehensive information, this book not only enlightens its readers but also stimulates their deeper study into the technical aspects of the cultural adaptation of evidence-based psychotherapies, thus making this book as a monument to the unrelenting pursuit of greater mental health for all.

This literary odyssey is much more than a scholastic undertaking; it stands as a monument to teamwork, and an unshakable dedication to improving mental health status of the local people of Pakistan. Anwar Khan and his team cordially welcome readers from across the world to ponder the challenges that are being faced by the mental health practitioners and researchers, just like this book that not only addresses these challenges but also serves as a catalyst to motivate further research towards innovative solutions.

Please join Anwar Khan and his dedicated team on this revolutionary journey and let us work together to achieve a future in which evidence-based psychotherapies are easily accepted within different cultural settings, thus resulting in a more accessible and compassionate system of mental healthcare for the betterment of common people in Pakistan.

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PREFACE

In the realm of Mental Health Sciences, the pursuit of attaining psychological well-being is a universal aspiration. However, the path to achieving psychological well-being is significantly shaped by diverse cultural and societal influences. An examination of the current body of literature reveals that most of the evidence-based psychotherapies, such as eye movement desensitization and reprocessing and cognitive behavioral therapy originated in Western and English-speaking cultures. Consequently, these psychotherapies may require distinct cultural adaptations to ensure their efficacy when applied to populations from varying cultural backgrounds. It is within this intricate interplay between culture and psychological well-being that we embark on a journey through the pages of this book.

The practice of Evidence-Based Psychotherapies in Pakistan is relatively new, and local psychologists apply the standard Western-made treatment protocols, whereas little work has been done on the cultural adaptations of such therapies. "*Cultural Adaptation of Evidence-Based Psychotherapies for Common Mental Health Disorders in Pakistan*" is a profound exploration of the intersection between modern evidence-based psychotherapies and the rich tapestry of Pakistani culture. This book provides valuable insights into the cultural adaptations of evidence-based psychotherapies, with a particular emphasis on adapting these approaches for the treatment of post-traumatic stress disorder, depression, and anxiety in Pakistan. This book has been written keeping in mind readers including clinical psychology researchers, psychotherapists, mental health counselors, academicians, and students of clinical psychology. The language and methodology have been intentionally simplified to cater to the needs of these readers. Furthermore, this book introduces a fresh perspective on Mental Health Counseling, taking into consideration the constantly evolving sociocultural landscape. It constitutes a noteworthy contribution to the current body of literature regarding recent advancements in Evidence-Based Psychotherapies in Pakistan.

As an academic and a student of Mental Health Counseling, my exploration of this field commenced with a fundamental inquiry: How can we effectively implement Western-developed evidence-based psychotherapies within the cultural context of Pakistan? In the quest for answers to this inquiry, I have undertaken a comprehensive study of various facets of mental health issues in Pakistan. This involved an extensive review of the existing literature and consultations with the local mental health practitioners. Furthermore, my colleagues and I conducted a series of rigorous randomized controlled trials to empirically investigate the dynamics of mental health problems in Pakistan. The culmination of these endeavors has resulted in the creation of this book. In order to enhance the reader's experience, we have structured this book into the following chapters:

Chapter One: Nature of Evidence-Based Psychotherapy. The first chapter provides a thorough overview of the field of Evidence-Based Psychotherapy. It begins by elucidating the concept of Evidence-Based Psychotherapy, offering a clear definition. Subsequently, it explores the trilogy of evidence-based psychotherapy, delving into the three foundational components that underpin this approach. The chapter also investigates the robustness of evidence-based psychotherapies, shedding light on their effectiveness and reliability in clinical practice. Moreover, it addresses common misunderstandings that often surround evidence-based psychotherapies, providing readers with clarity on these misconceptions. Lastly, it discusses the challenges faced by practitioners and researchers in the realm of evidence-based psychotherapies, highlighting the obstacles that need to be navigated to advance this field.

Chapter Two: The Development and Evolution of Evidence-Based Practices in Counseling Psychology. The second chapter delves into the historical progression and evolution of evidence-based practices within the field of Counseling Psychology. It encompasses important topics such as the history of evidence-based practice, foundations of counseling psychology prior to the emergence of evidence-based practice, timeline of evidence-based practice in the Western context, and advancement of evidence-based practices in Asia.

Chapter Three: Integration of Computer and Internet Technologies in Evidence-Based Psychotherapies. In the third chapter, the incorporation of computer and internet technologies into the field of mental health sciences has been explored, with a particular focus on their significant roles in diagnosis and treatment. This chapter includes discussions on various aspects of computer and internet technologies, including how modern life is influenced by computers, the ongoing integration of computer technologies into mental healthcare, the relationship between Artificial Intelligence and digital mental healthcare, an overview of existing digital psychotherapeutic interventions, practical recommendations for implementing digital psychotherapeutic interventions, and an examination of the obstacles and challenges associated with implementing these digital mental health interventions.

Chapter Four: Need for Cultural Adaptations in Evidence Based Psychotherapies. This chapter commences by clarifying the concept of culture followed by a comprehensive discussion on various aspects of cultural adaptation such as the cultural adaptation of psychotherapy, the needs for adaptations in evidence-based psychotherapies, challenges encountered in implementing culturally adapted evidence-based psychotherapies, and the evaluation of the effectiveness of culturally adapted evidence-based psychotherapies. This chapter aims to provide readers with a profound understanding of the process of cultural adaptations in evidence-based psychotherapies and the inherent need for such adaptations.

Chapter Five: Approaches for Culturally Adapting Evidence-Based Psychotherapies. This chapter maintains a technical focus as it explains the research methodologies involved in the process of cultural adaptation of evidence-based psychotherapies. This chapter encompasses crucial insights into the selection of research designs and methodologies, techniques for data analysis, and the intricate steps involved in adapting treatment protocols. This chapter presents a detailed map of the labyrinthine journey involved in adapting treatment protocols, ensuring a seamless fusion of science and culture.

Chapter Six: The State of Evidence-Based Mental Healthcare Counseling Systems in Pakistan. Given that the focus of this book is on Pakistan, it is imperative to incorporate insights into the status of the evidence-based mental healthcare counseling system within the country. This chapter illuminates a crucial facet of the status of evidence-based mental healthcare counseling systems in Pakistan by furnishing information pertaining to the situation of the Mental Healthcare System in Pakistan, the Mental Healthcare Counseling System in Pakistan, and the Effectiveness of Evidence-Based Psychotherapies in Pakistan. This chapter is intended to familiarize readers with the intricate dynamics of the evidence-based mental healthcare counseling system in Pakistan.

Chapter Seven: Cultural Adaptations of Evidence-Based Psychotherapies in Pakistan: A Practical Case Illustration. The last chapter of this book is dedicated to illustrating a practical case, aiming to provide readers with a tangible understanding of the entire process of adapting Evidence-Based Psychotherapies to the cultural context of Pakistan. This case is presented by furnishing detailed information about the methodology for cultural adaptation of treatment protocols in Pakistan and the findings obtained after completing a study on the

cultural adaptation of treatment protocols in Pakistan. One of the significant outcomes of this study is the translation of diagnostic tools and treatment protocols. Furthermore, it encompassed the complete cultural adaptation of two treatment protocols, namely Eye Movement Desensitization and Reprocessing and Cognitive-Behavioral Therapy protocols.

Within these chapters, you will find a comprehensive examination of various aspects of cultural adaptation of evidence based psychotherapies. It is our hope that this book not only informs but also inspires further research and practical applications in the field of Mental Health Sciences. Finally, we must express our gratitude to the mental health practitioners who have contributed their expertise and experiences to this work. Your dedication to improving the mental well-being of our society is commendable. "*Cultural Adaptation of Evidence-Based Psychotherapies for Common Mental Health Disorders in Pakistan*" is a testament to the power of collaboration, cultural sensitivity, and the unyielding pursuit of better mental health for all. We invite you all to embark on this enlightening journey, and together, let us work towards a more mentally healthy and culturally enriched Pakistan.

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DEDICATION

Dedicated to those who illuminate the paths of healing, bringing solace to those in need of mental and emotional respite. Your unwavering commitment to the art of psychotherapy is a beacon of hope in the darkest of times

CHAPTER 1

An Introduction to Evidence-based Psychotherapies

Abstract:
Problem Domain: The landscape of psychotherapy is constantly evolving, with practitioners seeking to align their methods with empirical evidence. However, navigating the complexities of evidence-based psychotherapy requires a clear understanding of its foundational principles and challenges.

Goal of this Chapter: This chapter aims to provide a comprehensive introduction to evidence-based psychotherapy, elucidating its core concepts, addressing common misconceptions, and exploring the challenges faced by practitioners and researchers in this field. Subsequently, it delves into the three foundational components that underpin this approach. The chapter also explores the robustness of evidence-based psychotherapies by shedding light on their effectiveness and reliability in clinical practice.

Selling Points and Contributions of this Chapter: By providing a precise definition and elucidating the triad of evidence-based psychotherapy, this chapter serves as an essential guide for both novice and experienced practitioners aiming to incorporate evidence-based practices into their clinical endeavors. Specifically, this chapter has made significant contributions in the following areas:

i) This chapter offers a concise yet comprehensive definition of evidence-based psychotherapy, laying the groundwork for further exploration.

ii) It delves into the three foundational components of evidence-based psychotherapy, this chapter provides readers with a nuanced understanding of its underlying principles.

iii) By debunking common misconceptions, this chapter promotes clarity and informed decision-making among practitioners.

iv) By acknowledging and discussing the challenges faced by practitioners and researchers, this chapter fosters dialogue and encourages innovative solutions.

Short Results: Through its exploration of the robustness of evidence-based psychotherapies and its discussion of the challenges ahead, this chapter sets the stage for further advancements in the field, ultimately aiming to enhance the quality and effectiveness of psychotherapeutic interventions in clinical practice.

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Keywords: Evidence-based medicine, Evidence-based practice, Evidence-based psychotherapy, Mental health counseling.

INTRODUCTION

The advent of evidence-based psychotherapies has revolutionized the therapeutic landscape within the field of mental healthcare by supplanting traditional methods with those grounded in scientific rigor. The primary goal of integrating contemporary evidence-based psychotherapies is to discern therapeutic modalities that garner scientific validation for their ability to effectively treat a range of mental health issues.

Evidence-based medicine emerged as a novel concept in the 1990s, attributed to David Sackett, who defined it as the prudent utilization of the most pertinent scientific and clinical evidence in the treatment regimen (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996). Consequently, evidence-based psychotherapy integrates clinical evidence and scientific methodologies to optimize therapeutic results (Rousseau & Gunia, 2016).

It is unfortunate that research on the adaptation of modern evidence-based psychotherapies has not progressed at a rapid pace, particularly in underdeveloped countries such as Pakistan, where mental health practitioners continue to use traditional therapeutic approaches in a strict and rigid manner, allowing no room for innovations (Masud, 2020). The presence of cultural and religious diversities, alongside structural inequalities, within underdeveloped regions presents distinctive obstacles to the effective implementation of evidence-based psychotherapies. Consequently, the true effectiveness and applicability of such psychotherapies in these areas remain uncertain and unexamined.

This chapter explores this perilous terrain by elucidating the conceptual underpinnings of evidence-based psychotherapies through a more comprehensive research agenda. Furthermore, this chapter also attempts to provide a comprehensive overview of the various introductory components of evidence-based psychotherapies for exploring its concepts that underlie them. Through this approach, researchers can tackle this vital therapeutic domain and endeavor towards crafting more inclusive and culturally attuned evidence-based psychotherapies, thereby ensuring accessibility to diverse populations.

DEFINING EVIDENCE BASED PSYCHOTHERAPY

The field of modern mental health counseling encompasses many terminologies that are often unclear to both researchers and practitioners. This lack of understanding arose following the introduction of new concepts, methods, and

procedures in the Counseling Sciences. Evidence-based psychotherapy emerged during a transition from traditional mental health therapy to a more systematic and empirically grounded psychological treatment. The primary aim of this transition was to ensure efficacy of treatment through robust empirical evidence.

Prior to define evidence-based psychotherapy, it is important to clarify that we have employed the term "evidence-based psychotherapy" as a broad category encompassing two specific forms: Cognitive Behavioral Therapy and Eye Movement Desensitization & Reprocessing therapy. Furthermore, it is important to note that individuals who provide treatment may differ in terms of their educational qualifications, clinical experience and expertise; hence, we have utilized the terms psychotherapist and therapist interchangeably to denote them. Lastly, we have also used the terms patients and respondents interchangeably to refer to those receiving the treatment.

Understanding the definitions of "evidence-based medicine" and "evidence-based practice" would be interesting as it would facilitate a deeper comprehension of the principles underpinning evidence-based psychotherapy. Evidence-based medicine emerged as a contemporary concept in the early 1990s, credited to David Sackett and his collaborators. Sackett delineated it as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p.71). This definition essentially underscores the integration of clinical practice with clinical evidence through systematic research. The systematic inquiry into the etiology and treatment of diseases is leveraged to enhance the overall process of disease management (Martini, 2021). David Sackett highlighted this process as a "*patient centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens*" (Sackett *et al.*, 1996, p.72).

An analogous term, evidence-based practice, on the other hand, describes the process of combining the clinical expertise of the therapist with the outcomes of high-quality research while taking the patient's preferences, characteristics, and cultural background into consideration (Levant & Hasan, 2008). This definition of evidence-based practice aligns with the earlier definition of evidence-based medicine proposed by Sackett (2000): "*Evidence-based medicine is the integration of best research evidence with clinical expertise and patient values*" (p.01). The primary goal of evidence-based practice is to deliver efficient psychological services by utilizing scientific techniques for case formulation, psychological assessment, and therapeutic interventions.

CHAPTER 2

Evolution of Evidence-based Practices in Counseling Psychology

Abstract:
Problem Domain: Understanding the historical evolution of evidence-based psychotherapy is crucial for contextualizing its current practices and future directions. This chapter delves into the rich history and evolutionary journey of evidence-based approaches within the realm of Counseling Psychology, shedding light on its origins, development, and global perspectives.

Goal of this Chapter: The second chapter aims to provide a comprehensive overview of the evolution of evidence-based psychotherapy, tracing its historical roots and contextualizing its emergence within counseling psychology. By exploring topics such as the history of evidence-based practice, the foundations of counseling psychology preceding its advent, the timeline of evidence-based practice, and the progress achieved in evidence-based practice across Asia, this chapter aims to acquaint readers with the historical context of evidence-based psychotherapies.

Selling Points and Contributions of this Chapter: By offering insights into the evolution and historical context of evidence-based approaches, this chapter provides readers with a deeper understanding of the underpinnings and influences shaping contemporary practices in Counseling Psychology. To be more precise, the following are the areas where this chapter has significantly contributed:

i) This chapter offers a detailed exploration of the historical context surrounding evidence-based psychotherapies, including the origins of evidence-based practice and its integration into Counseling Psychology.

ii) By tracing the timeline of evidence-based practice and highlighting key milestones, this chapter provides a comprehensive overview of its evolution, from inception to present-day practices.

iii) In addition to examining the evolution of evidence-based practice in Western contexts, this chapter explores its progress and adoption in Asia, particularly Pakistan, offering insights into cross-cultural variations and implications.

iv) Through the exploration of historical and cultural factors, this chapter contextualizes the development of evidence-based psychotherapies, enriching readers' understanding of its diverse influences and trajectories.

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Short Results: By acquainting readers with the historical context of evidence-based psychotherapies and their evolution within Counseling Psychology, this chapter lays the groundwork for further exploration and reflection on the past, present, and future of evidence-based practices in psychotherapy.

Keywords: Counseling psychology, Historical context, Evolution, Evidence-based psychotherapy.

INTRODUCTION

The evolution of evidence-based psychotherapies is a continuous narrative—a journey characterized by transformational shifts, scholarly endeavors, and various methodological adaptations that have reshaped the existing therapeutic landscapes across the globe. It implies that, while considering the current status and future orientations of evidence-based psychotherapies, it is critical to evaluate the historical backdrop, continuing scientific contributions, and methodological modifications. This comprehensive understanding allows for a more nuanced appreciation of the complexities and nuances within evidence-based psychotherapies, ultimately leading to more effective and tailored treatment approachess to individuals seeking mental health support. By recognizing the dynamic nature of this field, practitioners can stay informed and adaptable in their therapeutic practices to best serve their clients.

In the field of counseling psychology, the adoption of evidence-based practice dates back almost a century. It is thought that researchers and practitioners initially relied heavily on traditional theoretical frameworks and methodologies to guide their clinical practices. However, in the field of evidence-based psychotherapy, a paradigm shift emerged after the rise of evidence-based medicine. This paradigm shift began in the Western world. The first major advancement in healthcare came about in the United States in the middle of the 20th century. Furthermore, the Evidence-Based Medicine Working Group was established before the end of the twentieth century. In a similar vein, Canada pioneered evidence-based medicine during the early 1990s. The Canadian Task Force on Periodic Health Examination produced the first Canadian clinical preventive care recommendations in 1993.

On the other hand, in the United Kingdom, evidence-based treatment has a comparatively recent history. The Cochrane Collaboration was established in 1993 with the goal of successfully introducing evidence-based psychotherapy to the country. Unlike Western countries, Asian countries have a noticeably brief history of developing a system of evidence-based treatment. Factors such as healthcare infrastructure, resources, and cultural aspects of Asian nations have all influenced the acceptance and use of evidence-based medicine. Evidence-based

techniques are still not widely accepted or used, especially in emerging and underdeveloped countries like Pakistan (Masud, 2020).

This chapter aims to present a complete overview of both past and current global trajectories in the field of evidence-based psychotherapies by examining the development and historical background of these treatments. To help readers understand how evidence-based psychotherapies have changed throughout time, this chapter will take them on a historical tour of these treatments. Readers will gain insight into the evolution of evidence-based psychotherapies and how they have been shaped by several factors, such as research findings, societal changes, and advancements in technology. By exploring the historical context of these treatments, readers will be able to appreciate the progress that has been made in this field and understand the current state of evidence-based psychotherapies.

EVOLUTION OF EVIDENCE BASED PRACTICE: AN UNFINISHED JOURNEY

Evidence-based practice dates to the middle of the 20th century, giving it a brief but significant history. Nonetheless, the chronicles of evidence-based practice remain incomplete, presenting continuous challenges and prospects for advancement. Even with its brief history, evidence-based practice has a significant impact on improving the quality of care and decision-making across several clinical specialties. To comprehend the evolution of evidence-based practice, we must address a few crucial questions, including:

1. When and why was evidence-based practice first implemented?
2. What changes and formalizations did the tenets and procedures of evidence-based practice undergo throughout time?
3. What criticisms and objections did the proponents of evidence-based practice have to deal with?
4. In what ways has evidence-based practice been applied to areas other than medicine, such as clinical psychology and psychotherapy?
5. How can evidence-based practice be developed and applied more effectively in the future?

It is interesting to note that the history of contemporary evidence-based practice is quite new, and many advancements are still to come. Evidence-based medicine essentially gave rise to evidence-based therapies, which eventually moved into Clinical Psychology and related disciplines like counseling science. This is the reason behind the historically radical shift in evidence-based practice in Clinical Psychology—from “naive empiricism” to “systematic empiricism” (Houston, 2020). Furthermore, the development of scientific “randomization” techniques in

CHAPTER 3

Integration of Computer and Internet Technologies in Evidence-based Psychotherapies

Abstract:
Problem Domain: The integration of computer and internet technologies into mental health sciences represents a significant advancement with profound implications for diagnosis and treatment. Understanding the role of these technologies in modern evidence-based psychotherapies is essential for leveraging their potential to enhance mental healthcare delivery. One of the critical issues within this domain is the potential lack of familiarity and understanding of these technologies among psychotherapists. If psychotherapists are not adequately trained or educated about computer and internet technologies, it can hinder their ability to leverage these tools effectively in diagnosis and treatment.

Goal of this Chapter: The third chapter aims to explore the integration of computer and internet technologies into the field of mental health sciences, with a particular focus on their significance in the diagnosis and treatment of mental health problems. By discussing various aspects such as the influence of computers and the internet on modern evidence-based psychotherapies, the integration of computer technologies into mental healthcare, and the relationship between Artificial Intelligence and digital mental healthcare, this chapter seeks to provide readers with a comprehensive understanding of the intersection between technology and mental health.

Selling Points and Contributions of This Chapter

By offering insights into the integration of computer and internet technologies into mental health sciences, this chapter highlights their transformative potential in revolutionizing mental healthcare delivery and improving patient outcomes. A few contributions from this chapter are listed below:

i) This chapter explores how computers and the internet impact modern evidence-based psychotherapies, shedding light on the role of technology in enhancing therapeutic interventions and patient outcomes.

ii) By examining the integration of computer technologies into mental healthcare, this chapter elucidates the evolving landscape of digital interventions and their implications for clinical practice.

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iii) This chapter delves into the relationship between Artificial Intelligence and digital mental healthcare, exploring the potential synergies and challenges in leveraging AI for improving mental health services.

iv) Its presentation of existing digital psychotherapeutic interventions and practical recommendations for implementation, this chapter equips readers with valuable insights and resources for incorporating technology into clinical practice.

Short Results: By providing an overview of the integration of computer and internet technologies into mental health sciences and offering practical recommendations for implementing digital psychotherapeutic interventions, this chapter paves the way for the advancement of technology-driven approaches in mental healthcare, ultimately aiming to enhance accessibility, effectiveness, and efficiency in delivering evidence-based psychotherapies.

Keywords: Computer, Digital mental health, Evidence-based psychotherapies, Internet technologies, Technological integration.

INTRODUCTION

The advent of computer and internet technology at the end of the 20th century caused a dramatic change in the field of mental health research. More computerized and mechanical procedures replaced the conventional clinical procedures. Words like teletherapy and digital therapy emerged. Hence, a paradigm change in the provision of mental healthcare was marked by the integration of computer and internet technologies into evidence-based psychotherapies. These advancements allowed for increased accessibility to mental health services, particularly for those in remote or underserved areas. Additionally, the use of technology in mental health research has opened new possibilities for personalized treatment approaches.

The third chapter delves into the dynamic intersection of computer technology and evidence-based psychotherapies. This chapter not only highlights the revolutionary impact of advancements in computer technology, but also skillfully negotiates the tricky space where innovation and therapeutic efficacy collide. This chapter dissects the mutually beneficial relationship between computer technology and evidence-based psychotherapies in an effort to illuminate the changing landscape of mental health. There is plenty to learn, from delving into the applications of artificial intelligence and machine learning in diagnostic and therapeutic processes to examining the intricacies of internet-based therapies in therapeutic modalities. Thus, this chapter acts as a guide for understanding the enigmatic channels that connect clinical effectiveness and creativity. By exploring the intersection of technology and psychotherapy, professionals can enhance their practice and improve patient outcomes. This comprehensive analysis offers

insights into how advancements in computer technology can revolutionize the field of mental health treatment.

LIFE IN THE AGE OF COMPUTERS AND INTERNET

The use of computers has completely changed how people connect with the outside world. People may now communicate with each other from anywhere on the globe because of the advent of computers, cell phones, and the internet. People may now connect with each other and get information in ways that were before impossible because of these technologies. Over the coming years, there will be an increase in the number of internet users. Internet users climbed steadily from 3.9 billion in 2018 to 5.3 billion at the beginning of the year, according to historical statistics on the rise of Internet users globally from the year 2018 to the year 2023 (Statista, 2023). Many factors, including the expansion of mobile devices, the availability of broadband access, and the growing appeal of social media and online video, can be blamed for this growth.

The contemporary computer era is defined by the swift progression of technological advancements, innovations, and their pervasive integration into nearly every facet of our daily routines. The significance of computer and internet technologies can be assessed through their fundamental characteristics:

1. Computer processors have evolved to be faster, smaller, and more efficient, thereby enabling greater computing power and speed. Consequently, this progression has facilitated the creation of more intricate yet user-friendly applications.
2. The internet has permeated modern society as an omnipresent entity, accessed by individuals through an array of devices including smartphones, tablets, laptops, and desktop computers.
3. Mobile devices like smartphones and tablets have experienced a surge in capabilities, empowering users to execute tasks that were traditionally exclusive to desktop computers.
4. The advent of artificial intelligence and machine learning has precipitated the automation of numerous tasks previously performed by humans.
5. The burgeoning availability of data has spurred the development of novel tools and methodologies for scrutinizing and deciphering it, such as machine learning algorithms and predictive analytics.
6. Virtual and augmented reality technologies are actively employed to craft immersive experiences tailored for entertainment, education, and training endeavors.

CHAPTER 4

Need for Cultural Adaptations in Evidence Based Psychotherapies

Abstract:
Problem Domain: Cultural adaptation of psychotherapy is a critical area within evidence-based practice that addresses the complex interplay between culture and mental health. Understanding the significance of cultural factors in psychotherapeutic interventions is essential for ensuring their effectiveness and relevance across diverse populations. One prominent issue is the lack of cultural competence among psychotherapists, which may impede their ability to effectively engage with and address the diverse cultural backgrounds of their clients. Additionally, there is a gap in understanding the nuanced ways in which culture influences mental health beliefs, behaviors, and help-seeking preferences. Failure to consider these cultural factors in psychotherapeutic interventions can lead to disparities in access to and outcomes of mental healthcare services. Moreover, the existing evidence base for culturally adapted psychotherapies may be limited, highlighting the need for further research to validate and refine these interventions across diverse populations.

Goal of this Chapter: The fourth chapter delves into the cultural adaptation of psychotherapy, aiming to elucidate the importance of cultural considerations in evidence-based psychotherapies. Through a comprehensive exploration of cultural frameworks and the process of cultural adaptation, this chapter seeks to equip readers with the necessary understanding and skills to navigate cultural diversity in psychotherapeutic practice.

Selling Points and Contributions of this Chapter: By highlighting the centrality of cultural adaptation in evidence-based psychotherapies, this chapter serves as a guiding compass for practitioners and researchers, emphasizing the indispensable role of cultural sensitivity and responsiveness in delivering effective mental healthcare. In particular, the following are some notable contributions this chapter has made:

i) This chapter provides a nuanced examination of the concept of culture, unpacking its multifaceted layers and exploring its relevance in the context of evidence-based psychotherapies.

ii) By delving into the process of cultural adaptation, this chapter underscores its pivotal role in ensuring the applicability and efficacy of psychotherapeutic interventions across diverse cultural contexts.

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iii) The chapter navigates through the necessary prerequisites for cultural adaptations within evidence-based psychotherapies, highlighting the critical considerations and steps involved in this process.

iv) Through a thoughtful discussion, this chapter examines the challenges encountered during the implementation of culturally adapted evidence-based psychotherapies, offering insights into potential barriers and strategies for overcoming them.

v) Finally, the chapter explores the elements that may ultimately determine the success of culturally adapted evidence-based psychotherapies, shedding light on key factors contributing to their effectiveness and sustainability.

Short Results: In summary, this chapter serves as a comprehensive guide to understanding the process of cultural adaptations in evidence-based psychotherapies. By emphasizing the evident necessity for such adaptations and providing insights into their implementation and evaluation, this chapter empowers readers to navigate the complexities of cultural diversity in psychotherapeutic practice effectively.

Keywords: Culture, Cultural adaptation, Cross-cultural interventions, Evaluation of cultural adaptations, Evidence-based psychotherapies.

INTRODUCTION

Culture refers to a system of shared opinions, beliefs, standards, morals, behaviors, and traditions (Trend, 2015). So, the question is raised: Why and how does culture play such a significant part in mental health sciences? The reality is that culture has an indisputable influence on the dynamic field of psychotherapy. The way that people see and understand their surroundings is shaped by their culture, and this has a direct impact on how well therapeutic treatments work in clinical settings. This emphasizes how important it is to investigate the complex interaction that exists between social factors and the application of evidence-based psychotherapies in counseling psychology. Understanding how culture influences mental health practices is crucial for providing effective and culturally sensitive therapy to diverse populations. By acknowledging the role of culture in shaping individuals' experiences and beliefs, therapists can tailor interventions to better meet the needs of their clients.

This chapter takes the reader on an engrossing journey through the methodical examination of the complex web of cultural adaptations in the field of evidence-based psychotherapies. It begins by laying the foundation for explaining the complex idea of culture and revealing its many elements within the framework of psychotherapy treatments. Expanding on this fundamental knowledge, the chapter explores the indispensable importance of culture and emphasizes how it shapes successful psychotherapy treatments in a variety of cultural contexts. Thus, this chapter's main goal is to provide readers with a thorough grasp of the complex

process of cultural adaptations in research-based psychotherapies. It also aims to close the gap between theory and practice in order to develop therapeutic techniques that are more sensitive to cultural differences.

CULTURE AND ITS COMPONENTS

Culture simply refers to a system of common ideas, values, norms, habits, traditions, and practices that characterize a certain group of people, like any ethnic, racial, or religious group (Trend, 2015). In essence, culture is a broad concept that encompasses many facets of human civilization. A certain group of people's shared customs, beliefs, norms, values, activities, and behaviors are referred to as their culture. Because of this, culture has an impact on how individuals perceive and understand their surroundings. Although there are many other components that make up culture, the following fundamental components offer a way to comprehend what culture is all about. (Andreatta & Ferraro, 2012):

1) Beliefs and Values: Culture encapsulates fundamental human beliefs, norms, values, and ideologies. This system forms the bedrock of a culture and provides a framework for interpreting the world. Additionally, culture shapes attitudes, guides behaviors, and influences decision-making practices.

2) Customs and Traditions: Culture finds expression through various customs, traditions, and rituals passed down through generations. These practices often hold historical, religious, and social significance, serving to provide identity and cohesion within a social context.

3) Language: Language stands as a crucial component of culture, facilitating the sharing of ideas, knowledge, feelings, and norms among people. The language used by individuals often reflects their unique cultural perspectives.

***4)* Social Organization:** Culture impacts the social structure of a society, encompassing elements such as family structures, social hierarchy, kinship systems, and norms governing interpersonal relationships.

5) Material Culture: Culture is also manifested through a range of material objects and artifacts associated with a society. These may include food, clothing, architecture, and other tangible elements that represent cultural preferences and practices of a community.

CULTURE AND ITS ASPECTS

The world has undergone a major transformation in the twenty-first century. The concept of culture has changed and became more complex in the modern day due to several variables such as internationalization, globalization, technological

CHAPTER 5

Methodologies for Cultural Adaptation of Evidence Based Psychotherapies

Abstract:
Problem Domain: This chapter revolves around the selection and implementation of research methodologies for the cultural adaptation of evidence-based psychotherapies. One significant challenge is the lack of consensus on the most effective methodologies for conducting culturally sensitive research in this domain. This gap in understanding may result in inconsistencies in study designs, data collection procedures, and data analysis approaches, ultimately hindering the validity and reliability of research findings. Additionally, there is a need for guidance on navigating the complexities of adapting evidence-based psychotherapies to diverse cultural contexts, as well as a lack of resources and frameworks to support researchers and practitioners in this endeavor.

Goal of this Chapter: The fifth chapter maintains a technical focus as it outlines the different research methodologies employed in the cultural adaptation of evidence-based psychotherapies. By providing critical insights into methodologies for cultural adaptation, such as the selection of study designs and procedures, data analysis approaches, and the various stages involved in modifying treatment protocols, this chapter aims to equip readers with the necessary tools and strategies for conducting rigorous and culturally sensitive research in this field.

Selling Point and Contributions of this Chapter: This chapter offers a comprehensive overview of the arduous process of adapting evidence-based psychotherapies, emphasizing the synthesis of science and culture. By highlighting the importance of research methodologies in cultural adaptation, this chapter serves as a valuable resource for researchers and practitioners seeking to enhance the cultural relevance and effectiveness of psychotherapeutic interventions. This chapter offers insightful information about the methodological aspects of the cultural adoption of evidence-based psychotherapies:

1) Selection of Study Designs and Procedures: This chapter provides guidance on selecting appropriate study designs and procedures for conducting culturally sensitive research in the adaptation of evidence-based psychotherapies, emphasizing the importance of methodological rigor and cultural sensitivity.

2) Data Analysis Approaches: By discussing various data analysis approaches, this chapter offers insights into analyzing and interpreting research findings within diverse cultural contexts, enhancing the validity and generalizability of study results.

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3) Modification of Treatment Protocols: The chapter navigates through the various stages involved in modifying treatment protocols to accommodate cultural diversity, highlighting key considerations and strategies for ensuring cultural relevance and effectiveness of adapted interventions.

Short Results: In summary, this chapter offers a thorough overview of the methodologies for cultural adaptation of evidence-based psychotherapies, providing valuable insights and guidance for researchers and practitioners alike. By bridging the gap between research and practice, this chapter contributes to the advancement of culturally sensitive psychotherapeutic interventions, ultimately aiming to improve mental health outcomes for diverse populations.

Keywords: Cultural adaptation, Data analysis approaches, Evidence-based psychotherapies, Research methodologies, Study designs, Treatment protocol.

INTRODUCTION

The process of cultural adaptation is intricate and multifaceted, necessitating rigorous research methodologies. Throughout history, researchers have employed a diverse array of research designs and methods to undertake this endeavor. These include exploratory designs, ethnographic surveys, focus groups, theme analysis, and content analysis, all integral to the cultural adaptation of various psychotherapies (Healey *et al.*, 2018).

The complexity inherent in the cultural adaptation of evidence-based psychotherapies arises from the intricate nature of the psychotherapeutic process and the subjective nature of culture itself. Consequently, unique subjective elements such as cultural and religious considerations, as well as technical factors like clinical efficacy and treatment adherence, come into play. This chapter provides a comprehensive examination of the technical procedures involved in the cultural adaptation of evidence-based psychotherapies, which includes a meticulous selection of research designs and data analysis methodologies.

This chapter elucidates the methodological procedures essential for the cultural adaptation of psychotherapies. Through this exploration, it aims to shed light on the intricate yet indispensable task of seamlessly merging science with diverse cultural elements. By comprehending and applying these methodologies, mental health professionals can guarantee that psychotherapies are adeptly tailored to address the varied needs of clients from diverse cultural backgrounds.

WHICH RESEARCH DESIGNS TO CHOOSE?

Research design is the plan and structure of a research study that guides researchers on how to conduct research. Research design acts as a blueprint that

guides researchers on how to choose the most appropriate methods for data collection, analysis and interpretation of results for reaching at any conclusion (Bukve, 2019). In the process of culturally adapting evidence-based psychotherapies, researchers encounter a critical decision regarding research design due to the involvement of both qualitative and quantitative data. They frequently opt for exploratory and mixed-mode research designs to adeptly manage these diverse data types. These designs prove invaluable for synthesizing various forms of data within the realm of psychotherapy, facilitating comprehensive investigations in the field.

Selecting appropriate research designs and methodologies for cultural adaptation in psychotherapies depends on several factors such as the specific context, goals of the study, available resources, and the nature of the psychotherapy being adapted. Here are some commonly used research designs and methodologies:

Exploratory Research Design

Exploratory research is carried out to develop an in-depth understanding of undiscovered research problems. When there is little information available and no established hypothesis surrounding the topic of interest, exploratory research is employed (Swedberg, 2020). Exploratory research plays a pivotal role in the cultural adaptation process by delving into different facets of a culture to facilitate necessary modifications. In the context of psychotherapy cultural adaptation, conducting exploratory research entails exploring methods to tailor psychotherapeutic practices to align with the cultural backgrounds, beliefs, and values of patients. (Sit *et al.*, 2020).

Researchers typically recommend employing the following exploratory research methodologies to carry out the cultural adaptation of psychotherapies:

1) Structured Interviews: Structured and in-depth interviews conducted with a panel of experts can significantly aid in gathering comprehensive and detailed insights into the diverse cultural dimensions inherent in any psychotherapy. This approach empowers researchers to delve deeply into the intricate cultural nuances intertwined within the therapeutic journey (Rimal *et al.*, 2021).

2) Focus Group Discussion: Focus group discussions assemble a small cohort, typically comprising three to five experts, for a guided discourse on a specific topic. By facilitating these discussions, researchers can explore various perspectives and shared experiences pertinent to the subject under study, thereby enriching the depth of understanding (Barbour & Barbour, 2018). Experts engage in interactive discussions, often facilitated by a moderator, to share their perspectives and offer qualitative insights either verbally or in written form.

CHAPTER 6

Status of Evidence-based Mental Healthcare Counseling System in Pakistan

Abstract:

Problem Domain: This chapter discusses the challenges and gaps in the evidence-based mental healthcare counseling system in Pakistan. Despite growing recognition of mental healthcare in the country, significant hurdles impede the effective provision of evidence-based psychotherapies and counseling services. These obstacles include limited resources, inadequate infrastructure, and cultural stigmatization surrounding mental health, which collectively hinder access to quality mental healthcare interventions for Pakistani individuals. Furthermore, there is a notable lack of awareness and understanding of evidence-based practices among mental health professionals and policymakers, exacerbating the disparities in mental healthcare access and quality across the country.

Goal of this Chapter: The sixth chapter specifically focuses on discussing the important aspects of evidence-based mental healthcare counseling systems and the effectiveness of evidence-based psychotherapies in Pakistan. By providing insights into the complex dynamics of the Pakistani mental healthcare system, this chapter aims to educate readers on the challenges and opportunities in improving mental healthcare delivery in the country.

Selling Points and Contributions of this Chapter: This chapter offers a comprehensive overview of the status of evidence-based mental healthcare counseling systems in Pakistan, highlighting the need for enhanced resources, infrastructure, and awareness to address the growing mental health needs of the population. By shedding light on the effectiveness of evidence-based psychotherapies in the Pakistani context, this chapter serves as a valuable resource for policymakers, healthcare providers, and researchers seeking to improve mental healthcare outcomes in the country. More specifically, this chapter has made a substantial contribution in the following ways:

i) This chapter assesses the current status of evidence-based mental healthcare counseling systems in Pakistan, identifying key challenges and opportunities for improvement.

ii) By evaluating the effectiveness of evidence-based psychotherapies in the Pakistani context, this chapter provides insights into the applicability and relevance of these interventions in addressing mental health issues in the country.

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iii) The chapter offers recommendations for enhancing the effectiveness and accessibility of evidence-based mental healthcare counseling systems in Pakistan, including strategies for increasing awareness, building capacity, and improving infrastructure.

Short Results: In summary, this chapter serves as a crucial resource for understanding the status of evidence-based mental healthcare counseling systems in Pakistan. By identifying key challenges and opportunities, and offering recommendations for improvement, this chapter contributes to ongoing efforts to strengthen mental healthcare delivery and improve outcomes for individuals with mental health issues in Pakistan.

Keywords: Evidence-based psychotherapies, Mental health interventions, Pakistani mental healthcare counseling system, Pakistani mental healthcare system, Pakistani cultural dynamics.

INTRODUCTION

The mental healthcare system in Pakistan is still in its formative stages and is characterized by a dearth of licensed clinical psychologists and psychiatrists. Pakistan has just 0.19% psychiatrists per population, which is one of the lowest rates in the World Health Organization's Eastern Mediterranean Region (WHO, 2024). Similarly, another recent report states that in 2022, there were less than 500 psychiatrists in Pakistan who served a population of 220 million in the country (Rifat, 2022). The Government of Pakistan acknowledges the imperative to enhance the country's mental healthcare system. However, upgrading mental healthcare faces formidable challenges such as political instability, economic crises, terrorism, and social issues.

The primary focus of this chapter is to offer detailed insights into understanding the complex nuances of the mental health system in Pakistan. It begins by delineating the present condition of the mental healthcare system and elucidating the socioeconomic context of the country to explain the pervasive occurrence of mental health disorders. This chapter further delves extensively into the status of the mental healthcare system in Pakistan. As per the literature review, mental health professionals in Pakistan are actively endeavoring to tailor psychotherapies to align with the local cultural context. However, due to various impediments, such as poor infrastructure and a lack of research funds, the local researchers encounter challenges in conducting studies on adapting existing treatment protocols. In Pakistan, most research studies on mental health are based on surveys carried out in certain cities at microlevel. It is imperative that the country intelligentsia in academic institutions conduct research at macro levels. Prioritizing cooperation with research organizations such as the Pakistan Psychiatric Research Center is also important (Siddiqui, 2021).

The last section of the chapter discusses the effectiveness of various evidence-based psychotherapies in Pakistan. Current literature evidence indicates that psychotherapies such as Cognitive Behavioral Therapy and Eye movement Desensitization and Reprocessing therapy have been found efficacious in addressing a spectrum of mental health concerns in the country. It implies that despite presence of various challenges, the prospects for evidence-based psychotherapies in Pakistan remain promising.

SITUATION OF MENTAL HEALTHCARE SYSTEM IN PAKISTAN

Pakistan, the fifth most populous nation in the world (Qureshi, 2020), grappled with a myriad of challenges including inadequate infrastructure, and governance inefficiencies. Additionally, it contends with issues such as terrorism, poverty, educational deficiencies, corruption, and unequal resource allocation (Nawaz, Khan, Batool, & Rasool, 2021). These challenges have severely hindered the daily lives and mental health of ordinary people in Pakistan (Javed, Khan, Nasar, & Rasheed, 2022). In Pakistan, the government provides mental health facilities, but these are insufficient. A recent survey highlighted the stark reality: a mere 400 psychiatrists serve a population requiring care numbering in the thousands (Siddiqi, 2021). On the other side, the private sector offers mental health treatment; however, access to these facilities is restricted to those residing in the capital cities of the country. Majority of the psychiatrists are employed in large hospitals situated in the big towns, so very handful number are available in the rural area of Pakistan. This creates a significant disparity in access to mental health services between the wealthy and the general population (Noorullah, Asad, Pirani, Iqbal, & Khan, 2024).

Due to the absence of adequate mental health services, a wide spectrum of psychological diseases have been plaguing people in Pakistan. Existing literature documents a wide range of mental health conditions, including Schizophrenia and Psychotic Disorders (Khattak *et al.*, 2022), Depressive Disorders (Haider, Wei, Parveen, & Mehmood, 2023), Obsessive Compulsive Disorders (Shoaib *et al.*, 2023), Anxiety Disorders (Aqeel *et al.*, 2022) and Psychosomatic Disorders (Qayyum *et al.*, 2021). Surprisingly, post-traumatic stress disorder exhibits a notably high incidence rate among the spectrum of mental health disorders, as evidenced by its prevalent occurrence in recent research studies. For instance Shah *et al.* (2022) reported 48.61% prevalence of post-traumatic stress disorder among the journalists. Similarly, Hosseinnejad *et al.* (2022) reported 49.20% prevalence among the victims of natural disasters. Post-traumatic stress disorder is more prevalent in Pakistan and is mostly linked to acts of torture, violence, deprivation, and war on terrorism. These factors have created a widespread sense of unease, anxiety, and stress among the local population (Khan, 2023).

CHAPTER 7

Cultural Adaptations of Evidence Based Psychotherapies in Pakistan: A Case Illustration

Abstract:

Problem Domain: The last chapter of this book addresses the practical challenges and complexities involved in culturally adapting evidence-based psychotherapies to the cultural setting of Pakistan. One significant challenge is the lack of practical guidance on how to adapt treatment protocols effectively while considering the cultural nuances and sensitivities specific to Pakistan. Additionally, there is a notable gap in comprehensive information regarding the cultural adaptation of specific treatment protocols, such as Eye Movement Desensitization and Reprocessing and Cognitive-Behavioral Therapy, for addressing prevalent mental health issues in Pakistan, including post-traumatic stress disorder, anxiety, and depression. Moreover, there is limited research on the efficacy and feasibility of culturally adapted treatment protocols in real-world settings within the Pakistani context, leaving a gap in understanding the practical implications and outcomes of these interventions.

Goal of this Chapter: The last chapter of this book aims to provide readers with a concrete grasp of the complete process of culturally adapting evidence-based psychotherapies in Pakistan. Through a practical case illustration, this chapter offers insights into the methods for cultural adaptation of treatment protocols and presents the results of an experiment on cultural adaptation conducted in Pakistan. The last chapter has endeavored to address the previously mentioned research gaps by furnishing readers with a solid understanding of the entire process involved in culturally adapting evidence-based psychotherapies within the context of Pakistan.

Selling Points and Contributions of this Chapter: This chapter serves as a valuable resource for practitioners and researchers seeking to enhance the efficacy and cultural relevance of psychotherapeutic interventions in Pakistan. By offering a practical demonstration of the cultural adaptation process and presenting experiment results, this chapter provides actionable insights for improving mental healthcare delivery in the country. This chapter has augmented the existing body of knowledge in the following ways:

i) The chapter presents a practical scenario illustrating the complete process of culturally adapting evidence-based psychotherapies in the cultural setting of Pakistan by providing readers with a detailed understanding of the adaptation process.

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ii) Thorough information is provided on the cultural adaptation of treatment protocols of Eye Movement Desensitization and Reprocessing and Cognitive-Behavioral Therapy for addressing Post-Traumatic Stress Disorder, anxiety, and depression in Pakistan, highlighting the importance of tailoring interventions to meet the cultural needs of the population.

iii) The chapter unveils the outcomes of a randomized controlled trial conducted on cultural adaptation in Pakistan, providing valuable insights into the effectiveness and viability of modified treatment protocols in practical settings. The results of this trial have yielded significant insights, manifesting in the development of translated assessment tools like CAPS-5 and culturally adapted trauma-focused psychotherapy protocols. These customized tools and protocols hold promise for utilization by subsequent researchers in Pakistan.

Short Results: In summary, this chapter offers a practical demonstration of culturally adapting evidence-based psychotherapies to the cultural settings of Pakistan by providing valuable insights into the translation of treatment protocols and their efficacy in addressing mental health issues prevalent in the country.

Keywords: Post-traumatic stress disorder, Anxiety, Case illustration, Cognitive-behavioral therapy, Depression, Eye movement desensitization and reprocessing, Evidence-based psychotherapies, Pakistan, Treatment protocols.

INTRODUCTION

Psychotherapy is a therapeutic approach that employs psychological strategies to help people overcome mental health issues, including emotional problems (Wampold, 2019). Psychotherapy professionals use the term “cultural adaptation” for the process of incorporating cultural components into any kind of psychotherapy with the goal of enhancing its effectiveness for patients from various cultural backgrounds (Sit *et al.*, 2020). The process of cultural adaptation in any psychotherapy acknowledges that the cultural backgrounds of patients significantly influence their perspectives, experiences, and methods of coping with psychological disorders. The cultural adaptations aim to establish a psychotherapy environment that is culturally sensitive to the unique requirements of patients from diverse cultural backgrounds (Hall *et al.*, 2020).

Pakistan, an eastern country, has a rich cultural history made up of many different religious and ethnic groups. This varied tapestry provides a unique background against which to examine the pressing necessity of cultural modifications in psychotherapy procedures carried out by local psychotherapists in Pakistan. The local psychotherapists can improve the efficacy, applicability, and acceptability of any psychotherapy for those in need of psychological support in Pakistan. By incorporating cultural adaptations, such as integrating traditional beliefs and practices into psychotherapy sessions, local psychotherapists can ensure that their

patients feel understood and supported in a way that aligns with their cultural background. This can ultimately lead to more successful outcomes and increased mental health awareness and acceptance within Pakistani society.

This chapter is of significant importance as it presents a comprehensive analysis of the cultural adaptation of two well-established psychotherapy modalities. These culturally adapted psychotherapies are specifically tailored for use by local psychotherapists, aiming to benefit patients in Pakistan and neighboring Asian countries. Given the shared cultural heritage among Pakistan and its neighboring Asian nations, it is expected that these adapted psychotherapy modalities will resonate more effectively with local patients in Pakistan and other Asian countries. In conclusion, this chapter underscores the transformative power of cultural adaptation in psychotherapy. By honoring cultural traditions while embracing innovation, therapists can create meaningful interventions that resonate deeply with their diverse clientele. As we embark on this journey of cultural exploration and adaptation, let us remain steadfast in our commitment to promoting mental well-being for all, transcending boundaries and fostering healing in every corner of the world.

METHODOLOGY FOR CULTURAL ADAPTATION OF PROTOCOLS

Research Design

The study employed Qualitative Exploratory Design by incorporating Delphi Interviews and secondary data analysis techniques. Exploratory designs are particularly beneficial for thoroughly investigating a research problem, especially when the problem cannot be fully comprehended through mere description alone (Swedberg, 2020).

Steps for Culturally Adapting Treatment Protocols

Following the procedural framework established by prior studies such as by Seponski (2011), Damra, Nassar, & Ghabri (2014) and Naeem *et al.* (2016), the following steps were adhered to for the cultural adaptation of Cognitive Behavioral Therapy and Eye Movement Desensitization and Reprocessing Therapy protocols to align with the specific requirements of Pakistani patients:

1) Selection of Treatment Protocols: The first step entails choosing treatment protocols that need to be culturally adapted. Given the emphasis on Post-Traumatic Stress Disorder (PTSD) and its accompanying symptoms of depression and anxiety, two trauma-focused treatment protocols were selected:

APPENDIX A

Protocol One

Eye Movement Desensitization and Reprocessing Therapy Protocol For Post-traumatic Stress Disorder

AN OVERVEIW

The Eye Movement Desensitization and Reprocessing protocol for Post-Traumatic Stress Disorder is a specialized adaptation of the standard protocol. This protocol is designed specifically for individuals who have experienced Post-Traumatic Stress Disorder, with a more focused and intensive approach tailored to target the traumatic memories underlying the patient's symptoms. Implementing this protocol has been shown to effectively reduce the severity of Post-Traumatic Stress Disorder symptoms and enhance the overall well-being of patients.

This protocol has following eight phases:

Phase One: History Taking and Treatment Planning

In this initial step, the therapist collects information about the patient. This information includes symptoms related to trauma (past and present), physical and spiritual performance, and any other relevant factors. Information related to the patient can be obtained through the following methods:

1. Unstructured or free conversation.
2. Structured interview (e.g., Structured Clinical Interview for DSM-5 Disorders).
3. Questionnaire (e.g., Impact of Events Scale).
4. Gathering information from the patient's caregivers or family members.

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The medical history and details of the illness can be helpful to the therapist in the following ways:

1. It helps in deciding whether the patient should be treated with Eye Movement Desensitization and Reprocessing (EMDR) therapy or not.
2. Planning the treatment
3. Identifying specific memories or goals to focus on during the treatment process.

Phase Two: Preparation

This stage, termed "Preparation and Arrangement," involves both the therapist and the patient preparing before the commencement of treatment. Key elements in this stage include:

1. Establishing relationships between the therapist and the patient before starting treatment.

2. Explaining the treatment and its effects.

3. Addressing the patient's concerns.

4. Assessing the patient's readiness for treatment.

5. Enhancing the patient's ability to cope with the illness and strengthening it further.

6. Establishing treatment goals through mutual cooperation between the therapist and the patient.

7. Identifying internal and external resources to assist in the patient's recovery process.

8. Ensuring emotional protection for the patient during treatment and preparing a safety plan.

9. Obtaining informed consent for the treatment process.

Phase Three: Assessment

This step has two main objectives:

1. Accessing important aspects of the damaged and disorganized memory network.
2. Establishing baseline measurements to determine the level of target memory impairment. The therapist identifies specific components of the patient's target memory that will be addressed during treatment, including negative beliefs, emotions, physical sensations, and positive beliefs.

For this purpose, rating scales such as the following can be used:

1. Subjective Units of Disturbance Scale.
2. Validity of Cognition Scale.

Phase Four: Desensitization

In this phase, the patient focuses on their target memory while simultaneously engaging in bilateral stimuli (such as eye movements, body tapping, or auditory cues). These bilateral stimuli are helpful in re-sensitizing and consolidating the memory. The main purpose of this stage is to create a link between the knowledge of non-integrated memory and integrated memory. During this stage, distressing emotions triggered by the trauma begin to decrease in intensity, ultimately leading to a reduction in PTSD symptoms.

This step can be performed in the following sequence:

1. **Preparation:** Before beginning the desensitization phase, the therapist ensures that the patient is fully prepared to re-sensitize the memory.
2. **Target Identification:** The therapist and patient together identify a specific traumatic memory that will be the focus of the desensitization phase. It is a memory that is vividly remembered and causes pain.
3. **Formation and Installation of Resources:** Before re-experiencing the traumatic memory, the therapist helps the patient form, develop, and

strengthen internal resources. These resources include positive beliefs, feelings of safety, and coping strategies. The patient is guided to visualize these resources and experience their positive effects.

4. **Desensitization:** The therapist asks the patient to bring to mind the identified traumatic memory, including any associated negative thoughts, emotions, and physical sensations. While focusing on the memory, the patient simultaneously engages in bilateral stimuli. These can be achieved through eye movements, body tapping, or auditory cues.
5. **Dual Attention and Re-sensitization Process:** During desensitization, the patient is instructed to simultaneously attend to the traumatic memory and engage in bilateral stimuli. This dual attention process reduces the intensity of the traumatic memory.
6. **Conclusion:** At the end of each session, the therapist ensures that the patient is emotionally stable and relatively free of anxiety.

Phase Five: Installation

The goal of the installation phase is to establish a positive belief or cognition that replaces the negative belief or cognition associated with the traumatic memory. This step can be performed in the following sequence:

1. **Identification of Targets:** Initially, the therapist identifies a negative belief in the patient's mind associated with the traumatic event, often referred to as the "negative cognition." Next, the patient selects a positive belief to replace this negative cognition, termed the "positive cognition."
2. **Rating Perceptual Accuracy:** The patient rates how strongly they believe in the positive perception on a scale of 1 to 7, where 1 signifies "completely false" and 7 signifies "completely true."

3. **Bilateral Stimulation:** During bilateral stimulation, the patient focuses on both the negative belief and the chosen positive belief. The therapist guides the patient to prioritize the positive belief. Bilateral stimulation can involve eye movements, body tapping, or auditory cues.
4. **Review of Positive Perception:** After several rounds of bilateral stimulation, the patient reassesses their belief in positive cognition. Ideally, positive cognition should register higher on the belief scale.

Continued Work: If necessary, the therapist and patient continue with bilateral stimulation until the patient fully embraces the positive belief.

Phase Six: Body Scan

The physical examination and evaluation phase is a crucial part of treatment aimed at heightening the patient's awareness of the physical sensations and emotions associated with the traumatic memory.

This step can be performed in the following sequence:

1. **Preparation:** Ensure the patient is comfortably seated or lying down. Explain that this phase focuses on physical sensations and emotions. Encourage the patient to recall the painful memories as vividly as possible.
2. **Measurement of Subjective Units of Disturbance:** Ask the patient to rate their distress level on a scale of 0 to 10, where 0 means no disturbance and 10 indicates the highest disturbance.
3. **Noticing Physical Sensations:** Guide the patient to pay attention to any physical sensations or discomfort in their body as they recall the painful memory. These sensations may include changes in tension, tightness, pain, or discomfort.

4. **Verbal Expression:** Encourage the patient to verbally describe their physical sensations and emotions using specific language to express their feelings.
5. Alleviating Physical Discomfort and Integrating Mind and Body: The therapist may employ various techniques such as progressive muscle relaxation or deep breathing to reduce physical discomfort. The goal is to bridge the gap between physical sensations and emotional experiences.

Phase Seven: Closure

The goal of this phase is to leave the patient in a state of emotional stability and self-discipline, thereby reducing the risk of re-experiencing severe anxiety. It is crucial for the patient to experience a sense of completion at the end of all treatment sessions — feeling confident in their ability to manage any emotional reactions that may arise afterward.

This step involves the following sequence:

1. **Assessment of Emotional State:** The therapist begins by assessing the patient's current emotional state, often by asking the patient to rate their level of discomfort or any physical sensations.
2. **Use of Grounding Techniques:** To promote a sense of calm and safety, the therapist employs grounding techniques such as deep breathing exercises, mindfulness exercises, and guided imagery. The objective is to help the patient focus on the present moment. Feedback: The physician and patient review the completed stages of treatment. The patient shares their experiences, feelings, and any insights gained during therapy. The therapist provides necessary support, validation, and guidance.
3. **Ensuring Stability:** Prior to concluding therapy sessions, the therapist ensures the patient is in a stable and calm emotional state. The therapist

seeks feedback from the patient to confirm their sense of safety and readiness to manage any emotions that may emerge post-treatment.

Phase Eight: Re-evaluation

The purpose of this phase is to review the progress made during previous treatment phases and determine whether further processing of specific memories is necessary. This step involves the following sequence:

1. Assessment of Emotional State: Review progress made during previous treatment stages and identify any remaining troubling memories that may require further processing.
2. Determination Process: Ensure that the patient's anxiety levels regarding previously processed memories have sufficiently reduced. This is typically assessed by measuring subjective units of disturbance.
3. Assessment of Core Beliefs: Identify if any negative core beliefs or self-concepts still persist and require additional attention.

Documentation: Thoroughly document the retesting phase. Include any changes observed in the measurement of subjective units of disturbance.

(آنکھوں کی حرکت، غیر حساسیت، اور دوبارہ زیر حساس لانے والےمعا لجہ کا صا بطہ کار)
[برائے مابعد صدمہ تناؤ کا انتشار]

ایک جائزہ

مابعد صدمہ تناؤ کے انتشار کے لیے آنکھوں کی حرکت، غیر حساسیت، اور دوبارہ زیر حساس لانے والےمعا لجہ کا ضابِطۂ کار، معیاری ضابِطۂ کار کی ایک مخصوص موافقت ہے. یہ ضابِطۂ کارخاص طور پر ان افراد کے لیے تیار کیا گیا ہے جومابعد صدمہ تناؤ کے انتشار کا شکار ہیں . یہ ضابِطۂ کار زیادہ مرکوز اور جامع طریقہ اختیار کرتا ہے، جو مریض کے علامات کی بنیادی وجوہات بننے والی صدمے کی یادوں کو نشانہ بناتا ہے- اس ضابِطۂ کار کے استمال سے ثابت ہوا ہے کہ یہ مابعد صدمہ تناؤ کے انتشار کی شدت کو کم کرنے اور مریضوں کی مجموعی بہبود کو بہتر بنانے میں مؤثر ہے-

اس ضابِطۂ کارمیں درج ذیل آٹھ مراحل ہیں:

مرحلہ نمبر ایک: بیماری کی طبی تاریخ معلوم کرنا اور علاج کی منصوبہ بندی کرنا

اس پہلے مرحلے میں معالج مریض کے بارے میں معلومات جمع کرتا ہے- یہ معلومات صدمے سے متعلق علامات (ماضی اور موجودہ)، جسمانی اور روحانی کارکردگی، اور دیگر متعلقہ عوامل کے بارے میں جمع کی جاتی ہیں-مریض سے متعلقہ معلومات مندرجہ ذیل طریقوں سے حاصل کی جا سکتی ہیں:

١. غیر منظم یا آزاد مکالمہ-
٢. منظم مکالمہ (مثلاً Structured Clinical Interview for DSM-5 Disorders)-
٣. سوالنامہ (مثلاً Impact of Events Scale)-
۴. مریض کی دیکھ بھال کرنے والے یا گھر والوں سے معلومات لینا-

بیماری کی طبی تاریخ اور تفصیلات معالج کے لیے مندرجہ ذیل طریقوں سے مددگار ثابت ہو سکتی ہیں:

١. یہ فیصلہ کرنے میں مدد دیتی ہیں کہ آیا اس مریض کا علاج آنکھوں کی حرکت، غیر حساسیت، اور دوبارہ حساس بنانے والے معالجہ سے ہونا چاہیے یا نہیں-
٢. علاج سے متعلق منصوبہ بندی کرنا-
٣. علاج کے عمل کے دوران توجہ مرکوز کرنے کے لیے مخصوص یادوں یا اہداف کی نشاندہی کرنا-

مرحلہ نمبر دو: تیاری اور آراستگی

جیسا کہ نام سے ظاہر ہے، اس مرحلے کو "تیاری اور آراستگی" کہا جاتا ہے، جس کا مطلب ہے کہ علاج کی شروعات سے پہلے، معالج اور مریض دونوں تیاری کرتے ہیں- اس مرحلے میں زیر ذیل اہم نکات شامل ہیں:

١) معالج اور مریض کے درمیان علاج کے آغاز سے پہلے روابط بنانا-

٢) علاج اور اس کے اثرات کی وضاحت کرنا۔
٣) مریض کے خدشات کو دور کرنا۔
٤) علاج کے لیے مریض کی تیاری کا اندازہ لگانا۔
٥) مریض کی بیماری سے نمٹنے کی صلاحیتوں کو بڑھانا اور مزید مضبوط کرنا۔
٦) معالج اور مریض کے درمیان باہمی تعاون سے علاجی اہداف قائم کرنا۔
٧) مریض کی شفا یابی کے عمل میں معاونت کار اندرونی اور بیرونی وسائل کی مدد حاصل کرنا۔
٨) علاج کے دوران مریض کی جذباتی حفاظت کو یقینی بنانا اور مریض کے لیے حفاظتی منصوبہ تیار کرنا۔
٩) علاج کے لیے باخبر رضامندی حاصل کرنا۔

مرحلہ نمبر تین

مرض کا تعین کرنا اور جائزہ لینا
اس مرحلہ کے دو بنیادی مقاصد ہوتے ہیں:
١) خراب اور نا مربوط یاداشت کے جال کے اہم پہلوؤں تک رسائی حاصل کرنا.
٢) ہدف شدہ یادداشت میں خلل کی سطح کو جاننے کے لیے بنیادی پیمائشیں قائم کرنا. معالج مریض کی ہدف شدہ یادداشت کے مخصوص اجزاء کی نشاندہی کرتا ہے جنہیں علاج کے دوران نشانہ بنایا جائے گا۔ اس میں منفی عقائد، جذبات، جسمانی احساسات اور مثبت عقائد شامل ہو سکتے ہیں۔
اس مقصد کے لیے درجہ بندی کے پیمانے جیسے مثال کے طور پر، مندرجہ ذیل پیمانے کا استعمال کیے جا سکتے ہیں:
١) Subjective Units of Disturbance Scale (موضوعی خلل کی اکائیوں کا پیمانہ).
٢) Validity of Cognition Scale (ادراک کی درستگی کا پیمانہ).

مرحلہ نمبر چار: غیر حساسیت

اس مرحلے میں، مریض اپنی ہدف شدہ یادداشت پر دھیان مرکوز کرتا ہے جبکہ بیک وقت دو طرفہ محرکات (جیسے آنکھوں کی حرکت، جسم کو تھپتھپانا، یا سمعی اشارے) میں مشغول ہوتا ہے۔ یہ دو طرفہ محرکات یادداشت کو دوبارہ زیر حساس کرنے اور اس کا انضمام کرنے میں مددگار ثابت ہوتے ہیں۔ اس مرحلے کا بنیادی مقصد نا مربوط یادداشت کی جانکاری اور مربوط یادداشت کے درمیان جوڑ پیدا کرنا ہے۔ اس مرحلے کے دوران، صدمے کی وجہ سے ابھرنے والے پریشان کن جذبات کی شدت میں کمی ہونا شروع ہو جاتی ہے، جس سے بالآخر مابعد صدمہ تناؤ کی علامات میں کمی آتی ہے۔
اس مرحلے کو مندرجہ ذیل تسلسل سے انجام دیا جا سکتا ہے:
١) تیاری: حساسیت کا مرحلہ شروع کرنے سے پہلے، معالج اس بات کو یقینی بناتا ہے کہ مریض یادداشت کو دوبارہ زیر حس کرنے کے لیے پوری طرح تیار ہے۔
٢) ہدف کی شناخت: معالج اور مریض مل کر ایک مخصوص تکلیف دہ یادداشت کی نشاندہی کرتے ہیں جو غیر حساسیت کے مرحلے کا مرکز ہوگی۔ یہ وہ یادداشت ہوتی ہے جو صاف طور پر یاد رہتی ہے اور تکلیف کا باعث بنتی ہے۔

۳) وسائل کی تشکیل اور تنصیب: تکلیف دہ یادداشت کو دوبارہ زیر حس میں لانے سے پہلے، معالج مریض کو اندرونی وسائل کی تشکیل، نشوونما، اور مضبوط بنانے میں مدد کرتا ہے۔ ان وسائل میں مثبت اعتقادات، تحفظ کے احساسات، اور بیماری سے نمٹنے کی حکمت عملی شامل ہوتی ہیں۔ مریض کو ان وسائل کا تصور کرنے اور ان کے مثبت اثرات کو محسوس کرنے میں رہنمائی کی جاتی ہے۔
۴) غیر حساسیت: معالج مریض سے کہتا ہے کہ وہ شناخت شدہ تکلیف دہ یادداشت کو ذہن میں لائے، بشمول کسی بھی منسلک منفی خیالات، جذبات، اور جسمانی احساسات۔ یادداشت پر توجہ مرکوز کرتے ہوئے، مریض بیک وقت دو طرفہ محرکات میں مشغول ہوتا ہے۔ یہ دو طرفہ محرکات آنکھوں کی حرکت، جسم کو تھپتھپانے، یا سمعی اشاروں کے ذریعے کیے جاتے ہیں۔
۵) دوہری توجہ اور دوبارہ زیر حساس کرنے کا عمل: غیر حساسیت کے دوران، مریض کو ہدایت کی جاتی ہے کہ وہ بیک وقت تکلیف دہ یادداشت کو ذہن میں رکھے اور دو طرفہ محرکات میں مشغول رہے۔ اس دوہری توجہ کے عمل سے تکلیف دہ یادداشت کی شدت میں کمی آتی ہے۔
٦) اختتام: ہر اجلاس کے اختتام پر معالج اس بات کو یقینی بناتا ہے کہ مریض جذباتی طور پر مستحکم اور نسبتاً پریشانی سے پاک ہے۔

مرحلہ نمبر پانچ: تنصیب

تنصیب کے مرحلے کا مقصد ایک مثبت یقین یا مثبت ادراک کو قائم کرنا ہے جو تکلیف دہ یادداشت سے وابستہ منفی یقین یا ادراک کی جگہ لے لے۔
اس مرحلے کو مندرجہ ذیل تسلسل سے انجام دیا جا سکتا ہے:
۱) اہداف کی شناخت:
معالج ابتدائی طور پر مریض کے ذہن میں منفی عقیدے کی نشاندہی کرتا ہے، جس کا تعلق تکلیف دہ واقعے سے ہوتا ہے۔ اس عقیدے کو اکثر "منفی ادراک" کہا جاتا ہے۔ اگلے مرحلے میں، مریض سے کہا جاتا ہے کہ وہ ایک مثبت عقیدہ منتخب کرے جسے وہ منفی عقیدے کی جگہ ذہن میں رکھنا چاہے گا۔ اس مثبت عقیدے کو "مثبت ادراک" کہا جاتا ہے۔
۲) ادراک کی درستی کی درجہ بندی:
پھر مریض سے کہا جاتا ہے کہ وہ ۱ سے ۷ کے پیمانے پر مثبت ادراک پر کتنا پختہ یقین رکھتا ہے، جس میں ۱ "مکمل طور پر غلط" اور ۷ "مکمل طور پر سچ" ہے۔
۳) دوطرفہ محرکات:
دوطرفہ محرکات کے دوران، مریض منفی عقیدے پر توجہ مرکوز کرتا ہے جبکہ مثبت عقیدے پر بھی توجہ مرکوز رکھتا ہے۔ معالج مریض کو مثبت عقائد پر زیادہ توجہ مرکوز رکھنے کی ہدایت کرتا ہے۔ یاد رہے کہ دوطرفہ محرکات آنکھوں کی حرکت، جسم کو تھپتھپانے، یا سمعی اشاروں کے ذریعے کیے جا سکتے ہیں۔
٤) مثبت ادراک کا جائزہ:
متعدد بار دوطرفہ محرکات کرنے کے بعد، مریض سے کہا جاتا ہے کہ وہ مثبت ادراک پر اپنے اعتقاد کا دوبارہ جائزہ لے۔ مثبت ادراک مثالی طور پر مثبت عقیدے کے پیمانے پر زیادہ ہونا چاہئے۔
٥) مستقل طور پر کام کرنا:
اگر ضرورت ہو، تو معالج اور مریض دوطرفہ محرکات کو جاری رکھتے ہیں جب تک کہ مریض مثبت عقیدے کو مکمل طور پر قبول نہ کر لے۔

مرحلہ نمبر چھ: جسمانی معائنہ اور جانچ

جسمانی معائنہ اور جانچ کا مرحلہ علاج کا ایک لازمی جزو ہے جس کا مقصد مریض کو تکلیف دہ یادداشت سے وابستہ جسمانی احساسات اور جذبات کے بارے میں آگاہی فراہم کرنا ہے۔

اس مرحلے کو مندرجہ ذیل تسلسل سے انجام دیا جا سکتا ہے:

۱) تیاری:

اس مرحلے کا آغاز اس بات کو یقینی بنا کر کیا جانا چاہئے کہ مریض آرام سے بیٹھا یا لیٹا ہوا ہے۔ مریض کو اس مرحلے کے آغاز میں بتا دیا جاتا ہے کہ اس مرحلے میں جسمانی احساسات اور جذبات پر توجہ دینی ہو گی۔ مریض کو تکلیف دہ یادوں کو ہر ممکن حد تک ذہن میں لانے کی ترغیب دیں۔

۲) خلل ڈالنے کی موضوعی اکائیوں کی پیمائش:

مریض سے کہیں کہ وہ 0 سے ۱۰ تک کے اسکیل پر خلل ڈالنے کی موضوعی اکائیوں پر اپنی پریشانی کی سطح کی درجہ بندی کرے، جہاں 0 کوئی خلل نہیں ہے اور ۱۰ خلل کی اعلی سطح ہے۔

۳) جسمانی احساسات پر غور کریں:

معالج مریض کو یہ ہدایت کرے کہ جب وہ تکلیف دہ یادداشت کے بارے میں سوچنا شروع کرے تو وہ اپنے جسم میں کسی بھی جسمانی احساس یا تکلیف کے رونما ہونے پر توجہ دے۔ یہ احساسات جسمانی تبدیلیاں، تناؤ، جکڑن، درد یا تکلیف کی صورت میں ظاہر ہو سکتے ہیں۔

٤) زبانی اظہار:

مریض کو اپنے جسمانی احساسات یا جذبات کی وضاحت کرنے کی ترغیب دیں۔ مریض اپنے جذبات کے اظہار کے لئے مخصوص زبان استعمال کرسکتا ہے۔

٥) جسمانی تکلیف کو کم کریں اور جسم و دماغ کو مربوط کریں:

معالج جسمانی تکلیف کو کم کرنے کے لیے مختلف طریقوں کا استعمال کر سکتا ہے، جیسے کہ بتدریج پٹھوں میں نرمی پیدا کرنا، یا گہری سانس لینا۔ اس طرح، معالج جسمانی احساسات اور جذباتی تجربات کے مابین فرق کو ختم کرنے کی کوشش کرتا ہے۔

مرحلہ نمبر سات

اختتام

اس مرحلے کا مقصد مریض کو جذباتی استحکام اور خود نظم و ضبط کی حالت میں چھوڑنا ہے ، اس طرح شدید پریشانی کا دوبارہ تجربہ کرنے کے خطرے کو کم کرنا ہے۔ مریض کے لئے یہ ضروری ہے کہ علاج کے تمام اجلاسوں کے اختتام کے بعد اس کو "علاج کے اختتام کا احساس" ہو۔ مریض کو یہ محسوس ہونا چاہئے کہ اگر اجلاسوں کے اختتام کے بعد کوئی جذباتی رد عمل رونما ہوا تو وہ اس کو قابو کرسکتا ہے۔

اس مرحلہ کو مندرجہ ذیل تسلسل سے کیا سکتا ہے:

۱) جذباتی حالت کا اندازہ:

معالج مریض کی موجودہ جذباتی حالت کا اندازہ لگا کراختتام کی طرف بڑھتا ہے۔ اس حوالے سے معالج مریض سے اس کی تکلیف کی سطح یا کسی بھی جسمانی احساسات کی درجہ بندی کرنے کے لیے کہہ سکتا ہے۔

۲) گراؤنڈنگ تکنیکوں کا استعمال:

مریض کو پرسکون اور محفوظ محسوس کرنے میں مدد کرنے کے لیے، معالج گراؤنڈنگ تکنیک استعمال کر سکتا ہے۔ ان میں گہرا سانس لینے مشقیں، ذہن سازی کی مشقیں، اور گائیڈڈ امیجری

(ہدایت یافتہ تصویر کشی) شامل ہو سکتی ہیں۔ اس مرحلہ کا مقصد مریض کی توجہ کو موجودہ لمحے پر واپس لانا ہے۔

۳) تاثرات:

معالج اور مریض علاج کےمکمل شدہ مراحل پر تبادلہ خیال کرتے ہیں۔ مریض اپنے تجربات، جذبات، اور علاج کے دوران سامنے آنے والی کسی بھی بصیرت کا اشتراک کر سکتا ہے۔ معالج ضرورت کے مطابق مدد، توثیق اور رہنمائی فراہم کرتا ہے۔

٤) استحکام کو یقینی بنانا:

معالجہ کی اجلاسوں کو ختم کرنے سے پہلے، معالج اس بات کو یقینی بناتا ہے کہمریض ایک مستحکم اور پرسکون جذباتی حالت میں ہے۔ معالج اس بات کی تصدیق کرنے کے لیےمریض سے رائے طلب کرتا ہے کہ وہ محفوظ محسوس کر رہا ہے اورعلاج ختم ہونے کے بعد پیدا ہونے والے کسی بھی جذبات کو سنبھالنے کے قابل ہے۔

مرحلہ نمبر آٹھ

دوبارہ سے جانچ کرنا

اس مرحلے کا مقصد علاج کے پچھلے مراحل کے دوران کی جانے والی پیشرفت کا جائزہ لینا ہے اور اس بات کا تعین کرنا ہے کہ آیا مخصوص یادوں کی مزید پروسیسنگ کی ضرورت ہے یا نہیں۔

اس مرحلہ کو مندرجہ ذیل تسلسل سے کیا سکتا ہے:

١) جذباتی حالت کا اندازہ:

اس مرحلہ میں علاج کے پچھلے مراحل کے دوران ہونے والی پیشرفت کا جائزہ لینا اور باقی ماندہ پریشان کن یادوں کی نشاندہی کرنا شامل ہے جن پر مزید کارروائی کی ضرورت ہو سکتی ہے۔

٢) تعین کا عمل

اس بات کو یقینی بنا لیں کہ پہلے پروسیس شدہ یادوں کے حوالے سے مریض کی پریشانی کی سطح مناسب حد تک کم ہو گئی ہے۔ یہ عام طور پرخلل ڈالنے کی موضوعی اکائیوں کی پیمائش کے ذریعے معلوم کیا جاتا ہے.

٣) بنیادی عقائد کا اندازہ:

دریافت کرلیں کہ کیا کوئی منفی بنیادی عقائد یا خود خیالی اب بھی برقرار ہے اور ان پر مزید توجہ کی ضرورت ہے یا نہیں ۔

٤) دستاویز سازی:

مناسب انداز اور طریقے سے دوبارہ سے جانچ کرنے کے مرحلے کے دستاویز سازی کر لیں. خلل ڈالنے کی موضوعی اکائیوں کی پیمائش میں اگر کوے تبدلی آئی ہو تو اس کو دستاویز کر لیں.

Protocol Two
Trauma-Focused Cognitive Behavioral Therapy Protocol

AN OVERVIEW

Trauma-focused cognitive behavioral therapy is a standardized, evidence-based treatment method primarily used to help individuals who have experienced traumatic events. This therapeutic approach is rooted in cognitive behavioral therapy principles, focusing specifically on mitigating the effects of trauma. It utilizes a range of techniques such as relaxation exercises, cognitive restructuring, and exposure to trauma-related memories to assist patients in processing their traumatic experiences. The goal of this therapy is to reduce trauma-related symptoms and promote the emotional well-being of the patient.

This protocol has following ten phases:

Phase One: Assessment

In this initial step, the physician gathers information about the patient's trauma-related symptoms (past and present), physical and mental functioning, and any other pertinent factors. Information is collected through interviews, questionnaires, and input from the patient's caregivers.

Phase Two: Psychoeducation (Providing Trauma-related Information to the Patient)

Before commencing treatment, the therapist educates the patient about the trauma, its effects, and the treatment objectives. This phase aims to ensure that both the patient and caregivers understand trauma symptoms, coping strategies, and the treatment process.

Phase Three: Caregiver Involvement and Education

During this phase, caregivers are actively engaged in the treatment process. Educating caregivers about the treatment aims to support the patient's healing and recovery. This phase often involves joint sessions where the therapist, patient, and caregivers collaborate.

Phase Four: Enhancing Stress Coping Skills

In this phase, the patient not only learns relaxation techniques but also practices them. Relaxation exercises, such as deep breathing, muscle relaxation, and mental imagery, help patients manage distressing emotions and reactions effectively.

Phase Five: Emotion Regulation

Patients are encouraged to express and manage their feelings and emotions related to the traumatic experience. The therapist assists patients in identifying, understanding, and developing effective strategies for emotion regulation.

Phase Six: Trauma Narrative

During this phase, patients are guided to recount the traumatic event and its aftermath in narrative form. This process helps patients construct a coherent understanding of the trauma and its impact, facilitating further therapeutic work.

Phase Seven: Cognitive Restructuring

Here, the therapist helps patients identify and challenge negative thoughts and beliefs associated with the trauma. By replacing these with more accurate and adaptive beliefs, patients can reframe their understanding and reduce distress.

Phase Eight: *In Vivo* Exposure

In vivo exposure involves safely exposing patients to real-life situations that evoke their traumatic experiences. This exposure helps patients realize that their fears are manageable, thereby reducing anxiety over time.

Phase Nine: Joint Counseling Session (Involving Doctor, Patient, and Caregivers)

If applicable, this phase includes joint counseling sessions where the therapist, patient, and caregivers discuss treatment progress and the patient's needs. This involvement enhances caregivers' understanding and ability to support the patient effectively.

Phase Ten: Ensuring Safe Treatment

The last step ensures that the entire treatment process was conducted safely and without harm to the patient. The therapist promotes overall well-being, fosters a positive therapeutic relationship, and addresses any lingering concerns the patient may have.

(صدمے پر مرکوز شعوری کرداری معالجہ کا ضابطہ کار)
ایک جائزہ

صدمے پر مرکوز شعوری کرداری معالجہ کا ضابطہ کار سائنسی ثبوت اور مشائدے کی بنیاد پر مبنی علاج کا طریقہ ہے جو بنیادی طور پر ایسے افراد کے علاج کے لیے استعمال ہوتا ہے، جنہوں نے تکلیف دہ واقعات کا تجربہ کیا ہو۔
یہ ضابطہ کار اصل میں شعوری کرداری معالجہ کے بنیادی اصولوں پربنایا گیا ہے جو خاص طور پر صدمے کے اثرات کو زائل کرنے پر توجہ مرکوز کرتا ہے. اس میں مختلف اقسام کی اقدامات اور طریقے شامل ہوتے ہیں، جیسا کہ سکون حاصل کرنے کی مشقیں، علمی تنظیم نو، اور صدمے سے متعلقہ یادوں کا انکشاف، وغیرہ، جس کی مدد سے مریض اپنی تکلیف دہ تجربات اور یادوں کو پراسیس کرلیتا ہے. اس معالجہ کا مقصد صدمے سے متعلقہ علامات کو کم کرنا اور مریض کی جذباتی بہبود کو فروغ دینا ہے۔

اس ضابِطَۂ کارمیں درج ذیل دس مراحل ہیں:

مرحلہ نمبر ایک

مرض کا تعین کرنا اور جائزہ لینا
اس پہلے مرحلے میں معالج مریض کے بارے میں معلومات اکٹھی کرتا ہے. یہ معلومات صدمے سے متعلقہ علامات (ماضی اور موجودہ)، جسمانی اور روحانی کارکردگی، اور کسی دوسرے متعلقہ عوامل کے بارے میں اکٹھی کی جاتین ہیں۔
مریض سے متعلق معلومات انٹرویوز، سوالناموں، اور مریض کی دیکھ بھال کرنے والوں سے حاصل کردہ معلومات کی صورت میں حاصل کی جا سکتیں ہیں۔
مرحلہ نمبر دو

نفسیاتی تعلیم (مریض کو صدمے سے متعلق معلومات فراہم کرنا)
علاج شروع کرنے سے پہلے معالج مریض کو معلومات فراہم کرتا ہے صدمے، اس کے اثرات، اور علاج کے مقصد کے بارے میں ۔
اس مرحلے کا مقصد مریض اور ان کی دیکھ بھال کرنےوالے صدمے سے متعلقہ علامات، نمٹنے کی حکمت عملیوں اور علاج کے عمل کو سمجھ لیں ۔

مرحلہ نمبر تین

نگہداشت کرنے والے کی شمولیت اور تعلیم
اس مرحلے میں دیکھ بھال کرنے والا علاج کے عمل میں شامل ہوتا ہے۔ اس مرحلے میں دیکھ بھال کرنے والے کی شمولیت کو یقینی بنایا جاتا ہے جس کا مقصد دیکھ بھال کرنے والوں کو علاج کے عمل کے بارے میں آگاہ کرنا ہے۔
علاج کے عمل میں دیکھ بھال کرنے والے کی شمولیت مریض کی شفا یابی اور صحت یابی میں
اس مرحلے میں عام طور پر سب ایک مشترکہ اجلاس میں شامل ہوتے ہیں، جہاں معاون ہوگی۔
معالج، مریض اور اس کی دیکھ بھال کرنے والے سب مل کر ایک ساتھ کام کرتے ہیں۔

مرحلہ نمبر چار

تناؤ کا سامنا اور مقابلہ کرنے کی صلاحیت کو اُبھارنا
اس مرحلے میں مریض کو سکون حاصل کرنے کی مشقیں کرنے کا نہ صرف طریقہ کارسکھایا جاتا ہے بلکہ عملی طور پر مشقیں کرائی جاتی ہیں۔
سکون حاصل کرنے کی مشقیں مریض کو اپنے پریشان کن جذبات اور اس کے نتیجے میں ہونے والے رد عمل کو کنٹرول کرنے میں مدد گار ثابت ہو سکتیں ہیں۔ سکون حاصل کرنے کی مشقوں میں مریض کو گہری سانس لینے کی مشقیں،عضلا کو آرام دینے کی مشقیں، اور ذہنی تصویر بنانے کی مشقیں سکھائی جاتی ہیں۔

مرحلہ نمبر پانچ

جذبات کو اعتدال میں لانا
اس مرحلے میں مریضوں کو حوصلہ افزائی کی جاتی ہے کہ وہ تکلیف دہ تجربے سے متعلق اپنے احساسات اور جذبات کا اظہار کریں۔ معالج مریضوں کو ان کے جذبات کو پہچاننے، سمجھنے اور ان کا نظم کرنے کے لیے موثر حکمت عملی تیار کرنے میں مدد کرتا ہے۔

مرحلہ نمبر چھ

صدمے کی داستان کا بیان
اس مرحلے میں مریض سے کہا جاتا ہے کہ وہ تکلیف دہ واقعات اور اس کے نتیجے میں پیدا ہونے والے صد مے کو یاد کرنے کے بعد ایک داستان کی صورت میں بیان کر لیں۔
معالج اس سارے عمل میں مریض کی رہنمائی کرتا ہے تا کہ مریض تکلیف دہ واقعات اور اس کے نتیجے میں پیدا ہونے والے صد مے کا مربوط خاکہ اپنے دماغ میں بنا لیں اور بعد میں اس کو تفصیلاً بیان کر لیں۔

مرحلہ نمبر سات

شعوری عمل کرنا
اس مرحلے میں معالج پہلے مریض کے دماغ میں موجود منفی خیالات اور عقائد کو معلوم کر لیتا ہے . ، اور پھر ان منفی خیالات اور عقائد کو ختم کرنے میں مریض کے مدد کرتا ہے۔
معالج کے مدد سے مریض منفی خیالات کی شناخت کرتا ہے اور پھر انہیں زیادہ درست اور موافق عقائد سے تبدیل کرتا ہے، اور صدمے کے بارے میں اپنی سمجھ کو ازسر نو تشکیل کرتا ہے۔

مرحلہ نمبر آٹھ

ان ویوو ایکسپوزر

ان ویوو ایکسپوزر ایک طریقہ علاج ہے جو مریضوں میں حقیقی زندگی میں خوف کا سامنا اور مقابلہ کرنے کی صلاحیت پیدا کرتا ہے- اس طریقہ کار میں عمداً اور محفوظ طریقے سے مریضوں کو ان حالات سے آشنا کرایا جاتا ہے جو انہیں تکلیف دہ تجربات یا صدمے کی یاد دلاتے ہیں۔

ان ویوو ایکسپوزر کا مقصد یہ ہے کہ مریضوں مدد کی جائے یہ سمجھنے میں کہ ان کے تکلیف دہ تجربات یا صدمے اتنےخوفناک نہیں جتنا وہ سمجھ رہے ہیں. مریضوں کو جب اس بات کا احساس ہو جاتا ہے کہ ان کے تکلیف دہ تجربات یا صدمے اتنےخوفناک نہیں، تو پھر وقت کے ساتھ ساتھ ان کے خوف اور اضطراب میں کمی ہو جاتی ہے –

مرحلہ نمبرنو

مشترکہ مشاورتی اجلاس (معالج ، مریض اور دیکھ بھال کرنے والوں کے درمیان)

اگر قابل اطلاق ہو تو، اس مرحلے میں معالج ، مریض اور دیکھ بھال کرنے والوں کے درمیان ایک مشترکہ مشاورتی اجلاس کا اہتمام کیا جاتا ہے- مریض کی دیکھ بھال کرنے والوں کو علاج کے عمل میں اس لیے شامل کیا جاتا ہے تا کہ وہ علاج کے پورے عمل کو سمجھ سکیں- اس کے علاوہ وہ مریض کی ضرورت کو سمجھ سکیں- اس طرح مریض کی دیکھ بھال کرنے والوں کی مریض کو سنبھالنے کی صلاحیتوں میں اضافہ ہوتا ہے-

مرحلہ نمبر دس

محفوظ طریقہ علاج کو یقینی بنانا

اس آخری مرحلہ میں اس بات کو یقینی بنانا جاتا ہے کہ احتتام پذیر علاج محفوظ تھا اور مستقبل میں اس علاج سے مریض کو کوئی مسلہ یا نقصان نہیں ہو گا-

اس مرحلہ میں معالج کی برپور کوشش ہوتی ہے کہ وہ اس علاج کے ذریعے عمومی بہبود کو فروغ دے، مریض کے ساتھ صحت مند تعلقات بنا لےاور مریض کے ذہن میں کسی بھی جاری خدشات کو دورکر لے-

APPENDIX B1

Urdu Translation
Clinician-Administered PTSD Scale for DSM-5 (CAPS-5) Past Month / Worst Month Version

اردو ترجمہ
معالج کے زیر انتظام نافذ العمل مابعد صدمہ تناؤ کے انتشار کا
سوالنامہ برائے
گزشتہ مہینہ / بدترین مہینہ کا نُسخَہ DSM-5

Name:___________________________________

Interviewer:______________________________

Study:____________________________________

ID:_______________________________________

Date:_____________________________________

مریض کا نام:__________________
انٹرویو لینے والا کا نام:_______________
مطالعہ:______________________
شناخت:_____________________
تاریخ:______________________

Instructions

Standard administration and scoring of the CAPS-5 are essential for producing reliable, valid scores and diagnostic decisions. The CAPS-5 should be administered only by qualified interviewers, who have formal training in structured clinical interviewing, differential diagnosis, a thorough understanding of the conceptual

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basis of PTSD and its various symptoms, and detailed knowledge of the features and conventions of the CAPS-5 itself.

ہدایات

قابل اعتماد، درست نتایج اورصحیح تشخیصی فیصلے کے لیے اس سوالنامے یعنی
CAPS-5 کا معیاری انداز میں نافذ اور شمار ہونا ضروری
ہے. اس سوالنامے کو صرف تربیت یافتہ مُذاکرہ لینے والے افراد نافذ العمل میں لایں،
جِنھوں نے منظم مُذاکرہ، اورتفریق تشخیص کی باقاعدہ تربیت حاصل کی ھو. اس
کے علاوہ ان کو مابعد صدمہ تناؤ کے انتشار اور اس کی مختلف علامات کی سمجھ
بوجھ حاصل ھو اور CAPS-5
خصوصیات او روایت ضابطہ کا تفصیلی علم حاصل ھو.

Administration

1. Identify an index traumatic event to serve as the basis for symptom inquiry.
2. When assessing both past month (current) and worst month (lifetime) trauma:
    a. First, administer the time frame prompt, which appears under the **Criterion A** assessment box. If the respondent reports that her/his symptoms have been as bad in the past month as they have been at any point since the index event, then the past month can also be considered the worst month. In that case there is no need to assess worst month; past month ratings will serve as the basis for both current and lifetime diagnostic status.
    b. Second, administer all items with respect to the past month and establish current diagnostic status.
    c. Third, if necessary, re-orient the respondent to the worst month time frame, and then re-administer all items with respect to worst month and establish lifetime diagnostic status.

3. Read prompts verbatim, one at a time, and in the order presented, EXCEPT:
    a. Use the respondent's own words for labeling the index event or describing specific symptoms.
    b. Rephrase standard prompts to acknowledge previously reported information, but return to verbatim phrasing as soon as possible. For example, inquiry for item 20 might begin: "You already mentioned having problem sleeping. What kinds of problems?"
    c. If you don't have sufficient information after exhausting all standard prompts, follow up ad lib. In this situation, repeating the initial prompt often helps refocus the respondent.
    d. As needed, ask for specific examples or direct the respondent to elaborate even when such prompts are not provided explicitly.

4. In general, DO NOT suggest responses. If a respondent has pronounced difficulty understanding a prompt it may be necessary to offer a brief example to clarify and illustrate. However, this should be done rarely.

5. DO NOT read rating scale anchors to the respondent. They are intended only for you, the interviewer, because appropriate use requires clinical judgment and a thorough understanding of CAPS-5 scoring conventions.

6. Move through the interview as efficiently as possible to minimize respondent burden. Some useful strategies:
    a. Be thoroughly familiar with the CAPS-5 so that prompts flow smoothly.
    b. Ask the fewest number of prompts needed to obtain sufficient information to support a valid rating.
    c. Minimize note-taking and write while the respondent is talking to avoid long pauses.
    d. Take charge of the interview. Be respectful but firm in keeping the respondent on task, transitioning between questions, pressing for examples, or pointing out contradictions.

سوالنامہ کو نافذ کرنا

1. تکلیف دہ واقعات کی فہرست کی شناخت کرکے ان کو علامات کی تفتیش کی بنیاد رکھ لیں.
2. پچھلے مہینے (موجودہ) اور بدترین مہینے (زندگی بھر) کے صدمے تشخیص کرتے وقت:
   a. سب سے پہلے، وقت کی حد مختص کر لیں، جو کہ جانچ کے اصول (A) کےتشخیصی خانہ میں ظاہر کیا گیا ہے. اگر جواب دہندہ (مریض) یہ بتاتا ہے کہ اس کی علامات پچھلے مہینے میں اتنی ہی خراب تھیں جتنی کہ تکلیف دہ واقعات کی فہرست میں کسی بھی موقع پر تھیں، تو پچھلے مہینے کو بھی بدترین مہینہ تصور کیا جا سکتا ہے۔ اس صورت میں بدترین مہینے میں ہونے والےتکلیف دہ واقعات کا اندازہ لگانے کی ضرورت نہیں ہے اور پچھلے مہینے کی درجہ بندی دونوں یعنی موجودہ اور تاحیات تشخیصی حیثیت کی بنیاد کے طور پر کام کرے گی۔
   b. دوسرا، پچھلے مہینے کے حوالے سے سوالنامے کی تمام جز(مد) پہ معلومات حاصل کر لیں اور موجودہ تشخیصی حیثیت قائم کریں۔
   c. تیسرا، اگر ضروری ہو تو، جواب دہندہ (مریض) کو بدترین مہینے کی وقت کی حد کے متعلق دوبارہ ترتیب دیں، اوربدترین مہینے کے حوالے سے سوالنامے کی تمام جز(مد) پہ دوبارہ معلومات حاصل کر لیں اور تاحیات تشخیصی حیثیت قائم کریں۔
3. ایک وقت میں ایک، اور پیش کردہ ترتیب میں، لفظ بہ لفظ پڑھیں،(جیسا کہ سوالنامے میں الفاظ موجود ہیں) سوائے:
   a. جواب دہندہ(مریض) کے اپنے الفاظ کو استعمال کرنا تکلیف دہ واقعات کی فہرست کی نشان دہی یا مخصوص علامات کو بیان کرنے کے لیے۔
   b. پہلے سے موصول شدہ (مُطلع شدہ) معلومات کو تسلیم کے لیے معیاری اشاروں اور الفاظ کو دوبارہ بیان کریں۔ مثال کے طور پر، جز(مد) ۲۰ کے متعلق معلومات حاصل کرتے ہوے آپ اس طرح سوال پوچھیں: "آپ نے پہلے ہی بتایا تھا کہ نیند میں مسئلہ ہے ۔ کس قسم کے مسائل کی وجہ سے آپ کی نیند میں دشواری پیدا ہوئی ہے؟"
   c. اگر تمام معیاری اشارے اور الفاظ ختم کرنے کے بعد آپ کے پاس کافی معلومات نہیں ہیں، تو پچھلی تیاری کے بغیرآگے بڑھیں۔ اس صورت حال

میں، ابتدائی اشارے کو دہرانے سے اکثر جواب دہندہ (مریض) پر توجہ مرکوز کرنے میں مدد ملتی ہے۔

d. ضرورت کے مطابق، جواب دہندہ (مریض) سے مخصوص مثالیں طلب کریں یا جواب دہندہ (مریض) کو وضاحت کرنے کی ہدایت کریں.

4. عموماً ، جوابات تجویز نہ کریں۔ اگر کسی جواب دہندہ (مریض) کو فوری طور پر سمجھنے میں دشواری کا سامنا کرنا پڑا ہے تو اس کو وضاحت دیں اور وضاحت کے لیے ایک مختصر مثال پیش کریں۔ تاہم، یہ شاذ و نادر ہی کیا جانا چاہئے-
5. جواب دہندہ (مریض) کے لیے سوالنامہ میں سوالات کے لیے دی گی درجہ بندی کے نشان نہ پڑھیں- وہ صرف آپ کے لیے ہیں (بطور مُذاکرہ کرنے والا). کیونکہ اس کے مناسب استعمال کے لیے طبی بصیرت اور CAPS-5 کی شمارسازی اور روایت ضابطہ کی مکمل تفہیم کی ضرورت ہوتی ہے۔
6. جواب دہندگان (مریضوں) کے بوجھ کو کم کرنے کے لیے ہر ممکن حد تک مؤثر انداز سے مُذاکرہ کو آگے بڑا ہیں. کچھ مفید حکمت عملیاں یہ ہیں:

a. CAPS-5 کے متعلق اچھی طرح واقفیت حاصل کر لیں تا کہ اس کو آسانی سے استعمال کیا جا سکے.

b. ایک درست درجہ بندی اور کافی معلومات حاصل کرنے کے لیے کم تعداد میں اشارے یا سوال پوچھیں-

c. نوٹ لینے کے عمل کو کم سے کم کریں اور صرف اس وقت نوٹ لیں جب جواب دہندہ (مریض) بات کر رہا ہو. اس طرح طویل وقفوں سے بچا جا سکتا ہے.

d. اانٹرویو کا انتظام خود سنبھال لیں۔ عزت سے پیش آییں- جواب دہندہ (مریض) کو کام پر لگایں اس طرح کہ وو سوالوں میں مشغول ہو، اور اس کو کہا جائے کہ وہ سوال کرے یا مثال دے، تضادات کی نشاندہی کرے، اورایک سوال سے دوسرے سوال درمیان منتقلی کے عمل سے آسانی سے گرزے.

Scoring

1. CAPS-5 items are rated with a single severity score. The clinician combines information about frequency and intensity before making a single severity rating. Depending on the item, frequency is rated as either the number of occurrences (how often in the past month) or percent of time (how much of the time in the past month). Intensity is rated on a four-point ordinal scale with ratings of *Minimal, Clearly Present, Pronounced*, and *Extreme*.
2. Severity refers to the total symptom load over a given time period, and is a combination of intensity and frequency. The five-point CAPS-5 symptom severity rating scale is used for all symptoms. Rating scale anchors should be interpreted and used as follows:
    - *Absent*
    - *Mild / subthreshold*
    - *Moderate / threshold*
    - *Severe / markedly elevated*
    - *Extreme / incapacitating*
3. In general, make a given severity rating only if the minimum frequency and intensity for that rating are both met.
4. You need to establish that a symptom not only meets the *DSM-5* criterion phenomenologically, but is also functionally related to the index traumatic event, i.e., started or got worse as a result of the event. CAPS-5 items 1-8 and 10 (reexperiencing, effortful avoidance, amnesia, and blame) are inherently linked to the event. Evaluate the remaining items for trauma-relatedness (TR) using the TR inquiry and rating scale. The three TR ratings are:
    - *Definite*
    - *Probable*

- *Unlikely*

5. CAPS-5 total symptom severity score is calculated by summing severity scores for items 1-20.
6. CAPS-5 symptom cluster severity scores are calculated by summing the individual item severity scores for symptoms contained in a given *DSM-5* cluster.

PTSD diagnostic status is determined by first dichotomizing individual symptoms as *Present* or *Absent*, then following the *DSM-5* diagnostic rule. A symptom is considered present only if the corresponding item severity score is rated 2=*Moderate / threshold* or higher.

شمار سازی

1. CAPS-5 کے اجزا کی درجہ بندی شدت کی واحد شمار سازی کے تحت کی جاتی ہے. ایک واحد شدت کی درجہ بندی کرنے سے پہلے معالج تعدد اور شدت کے بارے میں معلومات کو یکجا کرتا ہے. سوالنامہ کے اجزا پر منحصر ہے، تعدد کی درجہ بندی یا تو واقعات کی تعداد (گزشتہ مہینے میں کتنی بار) یا وقت کے فیصد (گزشتہ مہینے میں کتنے وقت کے لیے) کے لحاظ سے کی جاتی ہے. شدت کو چار نکاتی (کم سے کم، واضح طور پر مجود ہونا، اعلان کرنا، انتہائی) آرڈینل پیمانے پر درجہ بند کیا جاتا ہے.
2. شدت سے مراد ایک مقررہ مدت کے دوران علامات کا کل بوجھ ہے، اور یہ شدت اور تعدد کا مجموعہ ہے.اس طرح، تعدد کو مدنظر رکھنے سے پہلے، کم سے کم کی شدت کی درجہ بندی ہلکی/ ذیلی حد کی شدت کی درجہ بندی کے مساوی ہے، واضح طور پر موجودہ اعتدال پسند/ حد سے مساوی ہے. پانچ نکاتی CAPS-5 علامات کی شدت کی درجہ بندی کا پیمانہ تمام علامات کے لیے استعمال کیا جاتا ہے. درجہ بندی کے پیمانے کے نشانات کو مندرجہ ذیل کے طور پر تشریح اور استعمال کیا جانا چاہئے:

0 موجود نہیں.
1 ہلکا / درمیانی.
2 معتدل / درمیانی حد.
3 شدید / واضح طور پر زیادہ.
4 انتہائی / نا کا رہ کر دینے والی.

3. عام طور پر، دی گئی شدت کی درجہ بندی صرف اس صورت میں بنائیں جب اس درجہ بندی کے لیے کم از کم تعدد اور شدت دونوں پوری ہوں۔
4. آپ کو یہ ثابت کرنے کی ضرورت ہے کہ مابعد صدمہ تناؤ کی کوئی علامت نہ صرف DSM-5 کے معیار پر پورا اترتی ہے، بلکہ اس کا تکلیف دہ واقعات کی فہرست میں بھی ہے، یعنی علامت واقعہ کے نتیجے میں شروع ہوئی یا خراب ہوئی۔CAPS-5 کی اجزا 1-8 اور 10 تکلیف دہ واقعات سے جڑ ی ہوئی ہیں۔ صدمے سے متعلق درجہ بندی کے پیمانے کا استعمال کرکے صدمے سے متعلق باقی اجزا قدرپیمائی کریں. تین صدمے سے متعلق درجہ بندیاں یہ ہیں:
   قطعی-
   امکانی -
   نا ممکن ہے-
5. CAPS-5 کل علامات کی شدت کا شمارا جزا 1 سے لے کر 20 کو جمع کرکے حاصل کیا جاتا ہے۔
6. CAPS-5 کی علامات کےخوشہ کی شدت کا شمار انفرادی اجزا کی شدت کے شمار کا خلاصہ کرکے حساب لگایا جاتا ہے ان علامات کے لیے جو DSM-5 خوشہ میں موجود ہیں.
7. مابعد صدمہ تناؤ کی تشخیصی حیثیت کا تعین پہلے انفرادی علامات کو "موجود" یا "غیرموجود" کے طور پر الگ الگ کرکے، پھر DSM-5 تشخیصی اصول کی پیروی کرتے ہوئے کیا جاتا ہے۔ کسی علامت کو صرف اس صورت میں موجود سمجھا جاتا ہے جب متعلقہ جز کی شدت کے شمار کو 2=اعتدال پسند / حد یا اس سے زیادہ درجہ دیا گیا ہو۔

Criterion A:	
A=	**جانچ کا اصول**
Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: 1. Directly experiencing the traumatic event(s). 2. Witnessing, in person, the event(s) as it occurred to others.	

(Table) cont.....

3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

مندرجہ ذیل طریقوں میں سے ایک (یا زیادہ) میں حقیقی یا ہولناک موت ،سنگین چوٹ ،یا جنسی تشدد کا انکشاف	
صدمے سے متعلق واقعہ (واقعات) کا براہ راست سامنا کرنا۔	١
ذاتی طور پر خود دیکھنا واقعہ (واقعات) جوجیسے دوسروں کو پیش آئے۔	٢
یہ جان لینا کہ تکلیف دہ واقعہ (واقعات) کسی قریبی رشتہ دار یا قریبی دوست کے ساتھ پیش آئے ہیں . قریبی رشتہ دار یا دوست کی حقیقی یا ہولناک موت کی صورت میں ، واقعہ پرتشدد یا حادثاتی رہا ہوگا-	٣
تکلیف دہ واقعہ (واقعات) ، مثال کے طور پر، (انسانوں کی باقیات کو جمع کرنے والے سب سے پہلے لوگ)، یا (وہ پولیس افسران جن کو بار بار بچوں سے بدسلوکی کی تفصیلات منکشف ہوتی ہیں) کی تفصیلات کا بار بار تجربہ کرنا یا انکا انکشاف ہونا. نوٹ: جانچ کا اصول نمبر= 4 الیکٹرانک میڈیا ، ٹیلی ویژن ، فلموں ، یا تصاویر کے ذریعہ منکشف ہوئی واقعہ (واقعات) پر لاگو نہیں ہو گا.	۴

[Administer Life Events Checklist or other structured trauma screen]

I’m going to ask you about the stressful experiences questionnaire you filled out. First I’ll ask you to tell me a little bit about the event you said was the worst for you. Then I’ll ask how that event may have affected you over the past month. In general I don’t need a lot of information – just enough so I can understand any problems you may have had. Please let me know if you find yourself becoming

(Table) cont.....

upset as we go through the questions so we can slow down and talk about it. Also, let me know if you have any questions or don't understand something. Do you have any questions before we start?
[زندگی کے واقعات کی چیک لسٹ یا کوئی اور منظم صدمے کی جانچ پڑتال کے سوالناموں کانفاذ کریں] میں آپ سے تناؤ بھرے تجربات کے بارے میں معلومات حاصل کرنے والے سوالنامے کے بارے میں پوچھنے جا رہا ہوں جسے آپ نے پُر کیا ہے۔ سب سے پہلے میں آپ سے پوچھوں گا کہ مجھے اس واقعہ کے بارے میں تھوڑا سا بتائیں جو آپ نےبتایا تھا کہ آپ کے لیے سب سے برا واقعہ تھا۔ اور پھر مجھ کو بتایں کہ پچھلے مہینے سے کیسے اس واقعہ نے آپکو متاثر کیا ہے-عام طور پر مجھے بہت سی معلومات کی ضرورت نہیں ہے - بس اتنا معلومات چاہے کہ میں آپ کو پیش آنے والے کسی بھی مسئلے کو سمجھ لوں- براہ کرم مجھے بتا دیا کریں اگر آپ اپنے آپ کو پریشان محسوس کرتے ہیں جسے کہ ہم تکلیف دہ واقعہ (واقعات) کی متعلق سوالات پر بات کریں. تاکہ ہم اس سوالات کے عمل کو توڑا سست کر لیں ۔ اس کے علاوہ، اگر آپ کے کوئی سوالات ہیں یا کچھ سمجھ نہیں آرہا ہے تو مجھے بتائیں۔ ہم شروع کرنے سے پہلے کیا آپ کے پاس کوئی سوال ہے؟ اس کے علاوہ، اگر آپ کے ذہن میں کوئی سوالات ہیں یا آپکو کچھ سمجھ نہیں آرہا ہے تو مجھے بتائیں۔ شروع کرنے سے پہلے کیا آپ کے ذہن میں کوئی سوال ہے؟

The event you said was the worst was (EVENT). What I'd like for you to do is briefly describe what happened.
آپ نے جس واقعہ کو بدترین کہا تھا. میں چاہتا ہوں کہ آپ مختصراً بیان کریں کہ اس واقعہ میں کیا ہوا تھا؟

What happened? (*How old were you? How were you involved? Who else was involved? Was anyone seriously injured or killed? Was anyone's life in danger? How many times did this happen?*)

(Table) cont.....

کیا ہوا تھا؟ آپ کی عمر کتنی ہے ؟ آپ اس واقعہ میں کیسے ملوث تھے؟ اور کون ملوث تھا؟ کیا کوئی شدید زخمی یا ہلاک ہوا تھا؟ کیا کسی کی جان کو خطرہ تھا؟ ایسا کتنی بار ہوا-
Exposure type: Experienced ___________ Witnessed ____________ Learned about __________ Exposed to aversive details_______________
انکشاف کی قسم: خود کا تجَربَہ ہونا. عینی شاہد ہونا- اسکے بارے میں جانا. ضرر رساں تفصیلات کا کا سامنا ہونا.

Life threat? YES/NO (self or other). Serious injury? YES/NO (self or other). Sexual Violence? YES/NO (self or other). Criterion A met? YES/NO/ PROBABLE.
زندگی/ جان کو خطرہ؟ ہاں/نہیں (خود یا دوسرے کے لئے)- شدید چوٹ؟ ہاں/نہیں (خود یا دوسرے کے لئے)- جنسی زیادتی؟ ہاں/نہیں (خود یا دوسرے کے لئے)- جانچ کے اصول نمبر=A پر پورا اترا ؟ ھاں/نہیں/ممکن ہے-

(Table) cont.....

Since (EVENT) has there been a time when it was causing you more problems than it has over the past month? [If yes:] When was (EVENT) causing you the most problems? [If not clear:] Did it last at least a month?
واقعہ کے بعد، کیا کوئی ایسا وقت آیا ہے جب اس نے آپ کو موجودہ مہینے کے مقابلے میں زیادہ مشکلات پیدا کی ہیں؟ [اگر ہاں:] تو (واقعہ) آپ کو سب سے زیادہ مشکلات کب پیدا کر رہا تھا؟ [اگر غیر واضح:] کیا یہ کم از کم ایک مہینہ تک جاری رہا؟
For the rest of the interview, I want you to keep (EVENT) in mind as I ask you about different problems it may have caused you. You may have had some of these problems before, but for this interview we're going to focus just on the [past month / worst month]. For each problem I'll ask if you had it at all, and if so, how often and how much it bothered you.
بقیہ مُذاکرَہ کے لیے، میں چاہتا ہوں کہ آپ (واقعہ) کو ذہن میں رکھیں کیونکہ میں آپ سے مختلف مسائل کے بارے میں پوچھتا ہوں۔ آپ کو پہلے بھی ان میں سے کچھ مسائل درپیش ہوں گے، لیکن اس مُذاکرَہ کے لیے ہم صرف [پچھلے مہینے / بدترین مہینے] پر توجہ مرکوز کرنے جا رہے ہیں۔ ہر مسئلے کے لیے میں پوچھوں گا کہ اگر آپ کو یہ مسائل درپیش تھے، اور اگر ایسا ہے تو، ان مسائل نے آپ کو کتنی بار اور کتنا پریشان کیا۔

Criterion B:	
B=	جانچ کا اصول
Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:	
تکلیف دہ واقعہ (واقعات) کے ساتھ منسلک درج ذیل تجاوزی علامات (مداخلت کرنے والی علامات) میں سے ایک (یا زیادہ) کی موجودگی، جو کہ تکلیف دہ واقعہ (واقعات) کے پیش آنے کے بعد شروع ہُوِیں:	

<table>
<tr><td colspan="2">Item 1 (B1): Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic events) are expressed.</td></tr>
<tr><td colspan="2">(B1) 1 آئٹم
بار بار، غیرضروری اور پریشان کن یادیں جو کہ تکلیف دہ واقعہ (واقعات) سے جڑی ہوئی ہیں-نوٹ: وہ بچے جو ٦ سال سے زیادہ عمر کے ہوں ان کا بار بار اس کھیل کھیلنا جس میں تکلیف دہ واقعات (واقعات) کے مرکزی خیالات اورپہلوؤں کا اظہار ہو.</td></tr>
<tr><td>In the [past month / worst month], have you had any <u>unwanted memories</u> of (EVENT) while you were awake, so not counting dreams? (Rate 0=Absent if only during dreams)</td><td>0 Absent
1 Mild / subthreshold
2 Moderate / threshold
3 Severe / markedly elevated
4 Extreme / incapacitating
Past Month ________________
Worst Month _______________</td></tr>
<tr><td>[پچھلے مہینے / بدترین مہینے] میں، کیا آپ کے ذھن میں (واقعہ) کی کوئی ناپسندیدہ یادیں آئی ہیں جب آپ جاگ رہے تھے، اس لیے خوابوں کی گنتی نہیں کریں- (درجہ بندی=0 موجود نہیں، اگر صرف خوابوں کے دوران موجود ہو)-</td><td>0 موجود نہیں
1 ہلکا / درمیانی
2 معتدل / درمیانی حد
3 شدید / واضح طور پر زیادہ
4 انتہائی / نا کا رہ کر دینے والی
پچھلا مہینہ ____________
بدترین مہینہ____________</td></tr>
</table>

(Table) cont.....

How does it happen that you start remembering (EVENT)?
یہ کیسے ہوتا ہے کہ آپ (واقعہ) کو یاد کرنا شروع دیتے ہیں-
How much do these memories bother you?
یہ یادیں آپ کو کتنا پریشان کرتی ہیں؟
Are you able to put them out of your mind and think about something else?
کیا آپ انہیں اپنے دماغ سے نکال کر کسی اور چیز کے بارے میں سوچ سکتے ہیں؟
Circle: Distress = *Minimal*_____ *Clearly Present*_____ *Pronounced*_______ *Extreme*_______
دائرہ لگائیں : رنج کا باعث= کم سے کم ____ واضح طور پر موجود ____ نُمایاں ____ انتہائی____
How often have you had these memories in the [past month]. Number of times __________
[پچھلے مہینے / بدترین مہینے] میں آپ کو کتنی بار یہ یادیں آئی ہیں؟ اوقات کی تعداد ________

[If reports not returning to sleep:] (How much sleep do you lose?)

[اگر نیند میں واپس نہ آنے کی شکایت ہو:] (آپ کی کتنی نیند متاثر ہوتی ہے؟)

How much do these dreams bother you?

یہ خواب (یعنی پریشان کن خواب) آپ کو کتنا پریشان کرتے ہیں؟

Circle: Distress = *Minimal*_____ *Clearly Present*_____ *Pronounced*_______ *Extreme*_______

دائرہ لگائیں : رنج کا باعث= کم سے کم ____ واضح طور پر موجود ____ نُمایاں ____ انتہائی____

How often have you had these dreams in the [past month / worst month]? # of times ________

آپ نے [پچھلے مہینے / بدترین مہینے] میں کتنی بار یہ خواب دیکھے ہیں؟ اوقات کی تعداد _______

Item 3 (B3): Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) Note: In children, trauma-specific reenactment may occur in play.

آئٹم 3 (B3):
قطع تعلقی کا رد عمل (مثال کے طور پر: سابقہ منظر کی طرف لوٹنا) جس میں فرد ایسا محسوس کرتا ہے یا اس پر عمل کرتا ہے کہ جیسے تکلیف دہ واقعہ (واقعات) دوبارہ سے ہو رہے ہیں، اس طرح کے رد عمل ایک تسلسل کے ساتھ پیش آسکتے ہیں. جس کا شدید اظہار موجودہ ماحول سے واقفیت کھو دینے کی صورت میں ہو سکتا ہے. نوٹ: بچوں میں، کھیل کے دوران صدمے سے متعلق رد عمل دوبارہ ظاہر ہو سکتا ہے۔

(Table) cont.....

<table>
<tr><td>In the [past month / worst month], have there been times when you suddenly acted or felt as if (EVENT) were actually happening again?</td><td>0 Absent
1 *Mild / subthreshold*
2 *Moderate / threshold*
3 *Severe / markedly elevated*
4 *Extreme / incapacitating*
Past Month _______________
Worst Month _______________</td></tr>
<tr><td>[گزشتہ مہینہ/بدترین مہینہ] میں، کیا ایسا وقت آیا ہے جب آپ نے اچانک عمل کیا ہویا محسوس کیا ہو کہ جیسے (واقعہ) دوبارہ رونما ہوا ہے ؟</td><td>0 موجود نہیں
1 ہلکا / درمیانی
2 معتدل / درمیانی حد
3 شدید / واضح طور پر زیادہ
4 انتہائی / نا کا رہ کر دینے والی
پچھلا مہینہ ___________
بدترین مہینہ___________</td></tr>
<tr><td colspan="2">[If not clear:] (This is different than thinking about it or dreaming about it. Now I’m asking about flashbacks, when you feel like you’re actually back at the time of (EVENT), actually reliving it.)</td></tr>
<tr><td colspan="2">[اگرسوال واضح نہیں ہے:] (یہ اس [واقعہ] کے بارے میں سوچنے یا اس کے بارے میں خواب دیکھنے سے مختلف ہے۔ اب میں فلیش بیکس [سابقہ منظر کی طرف لوٹنا] کے بارے میں پوچھ رہا ہوں، جب آپ کو ایسا لگتا ہے کہ آپ واپس اس وقت کی طرف آگئے ہیں جب یہ [واقعہ] ہوا تھا. اور حقیقتا اس [واقعہ] کا دوبارہ تجربہ کر رہے ہیں.</td></tr>
<tr><td colspan="2">How much does it seem as if (EVENT) were happening again? (*Are you confused about where you actually are?*)</td></tr>
<tr><td colspan="2">ایسا کس حد تک لگتا ہے کہ جیسے [واقعہ] دوبارہ سے رونما ہو رہا ہو؟ (کیا آپ اس بارے میں الجھن میں ہیں کہ آپ اصل میں کہاں ہیں؟)-</td></tr>
<tr><td colspan="2">What do you do while this is happening? (Do other people notice your behavior? What do they say?)</td></tr>
<tr><td colspan="2">جب ایسا ہو رہا ہوتا ہے تو آپ کیا کرتے ہیں؟ (کیا دوسرے لوگ آپ کے رویے کو دیکھتے ہیں؟ وہ کیا کہتے ہیں؟)-</td></tr>
<tr><td colspan="2">How long does it last ?</td></tr>
</table>

(Table) cont.....

یہ کتنے عرصہ تک رہتا ہے؟

Circle: Dissociation = *Minimal____ Clearly Present____ Pronounced______ Extreme______*
دائرہ لگائیں : لا تعلقی= کم سے کم ____ واضح طور پر موجود ____ نُمایاں ____ انتہائی____
How often has this happened in the [past month / worst month]? # of times ________
یہ [پچھلے مہینے / بدترین مہینے] میں کتنی بار رونما ہوا ہے؟ اوقات کی تعداد _____

Item 4 (B4): Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).	
آئٹم 4 (B4): اندرونی یا بیرونی اشارے کے سامنے آنے پر شدید یا طویل نفسیاتی پریشانی جو تکلیف دہ واقعہ (واقعات) کے کسی پہلو کی علامت ہو یا اس سے مشابہت رکھتی ہے۔	
In the past month have you gotten emotionally upset when something reminded you of (EVENT)?	0 Absent 1 *Mild / subthreshold* 2 *Moderate / threshold* 3 *Severe / markedly elevated* 4 *Extreme / incapacitating* *Past Month* _______________ **Worst Month** ______________
پچھلے مہینے میں کیا آپ جذباتی طور پر پریشان ہو گئے تھے جب کسی چیز نے آپ کو (واقعہ) کی یاد دلائی؟	0 موجود نہیں 1 ہلکا / درمیانی 2 معتدل / درمیانی حد

(Table) cont.....

	3 شدید / واضح طور پر زیادہ 4 انتہائی / نا کا رہ کر دینے والی پچھلا مہینہ ________ بدترین مہینہ_______

What kinds of reminders make you upset?
کس قسم کی یادوں نے آپ کو پریشان کیا؟
How much do these reminders bother you?
یہ یادیں آپ کو کتنا پریشان کرتی ہیں؟
Are you able to calm yourself down when this happens? (How long does it take?)
کیا آپ اپنے آپ کو پرسکون کرنے کے قابل ہیں جب ایسا ہوتا ہے؟ (اس میں کتنی دیر لگتی ہے؟)
[If not clear:] (Overall, how much of a problem is this for you? How so?)
[اگر سوال واضح نہیں ہے:] (مجموعی طور پر، یہ آپ کے لیے کتنا بڑا مسئلہ ہے؟ کیسے؟)
Circle: Distress = *Minimal*_____ *Clearly Present*_____ *Pronounced*_______ *Extreme*_______
دائرہ لگائیں : رنج کا باعث= کم سے کم ____ واضح طور پر موجود ____ نُمایاں ____ انتہائی____
How often has this happened in the past month? # of times
پچھلے مہینے میں کتنی بار ایسا ہوا ہے؟ اوقات کی تعداد _____

Item 5 (B5): Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
آئٹم 5 (B5): اندرونی یا بیرونی اشاروں پرقابلِ ذکر جسمانی ردعمل ظاہر کرنا، جو تکلیف دہ واقعہ (واقعات) کے کسی پہلو کی علامت ہو یا ان سے مشابہت رکھتے ہوں-

(Table) cont.....

In the [past month / worst month], have you had any physical reactions when something reminded you of (EVENT)?	0 Absent 1 *Mild / subthreshold* 2 *Moderate / threshold* 3 *Severe / markedly elevated* 4 *Extreme / incapacitating* *Past Month* ________________ **Worst Month** _______________
[پچھلے مہینے / بدترین مہینے] میں، کیا آپ کو کوئی جسمانی ردعمل محسوس ہوا ہے جب کسی چیزنے آپ کواس (واقعہ) کی یاد دلائی؟	0 موجود نہیں 1 ہلکا / درمیانی 2 معتدل / درمیانی حد 3 شدید / واضح طور پر زیادہ 4 انتہائی / نا کا رہ کر دینے والی پچھلا مہینہ ________ بدترین مہینہ_______
Can you give me some examples? (Does your heart race or your breathing change? What about sweating or feeling really tense or shaky?)	
کیا آپ مجھے کچھ مثالیں دے سکتے ہیں؟ (کیا آپ کا دل کی دھڑکن تیز ہوتی ہے، یہسانسیں بدلتی ہیں؟ پسینہ آنے یا واقعی تناؤ یا متزلزل ہونے کے بارے میں کیا خیال ہے؟)	
What kinds of reminders trigger these reactions?	
کس قسم کی یادوں سے یہ رد عمل کو تیز ہو جاتا ہے؟	
How long does it take you to recover?	
آپ کو آپنی اصلی صحت مند حالت میں واپس آنے میں کتنا وقت لگتا ہے؟	
Circle: ___Physiological reactivity = *Minimal___ Clearly Present___ Pronounced__ Extreme___*	
دائرہ لگائیں : جسمانی رد عمل= کم سے کم ____ واضح طور پر موجود ____ نُمایاں ____ انتہائی____	
How often has this happened in the past [past month / worst month]? # of times ___________	

(Table) cont.....

یہ ماضی میں کتنی بار ہوا ہے [پچھلے مہینے / بدترین مہینے]؟اوقات کی تعداد _____

Criterion C:	
C=	جانچ کا اصول
Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:	
تکلیف دہ (واقعہ) واقعات سے وابستہ محرکات سے مستقل اجتناب، یا بچنے کی کوششیں کرنا. یہ اجتناب (واقعہ) واقعات کے پیش آنے کے بعد شروع ہوا. جیسا کہ مندرجہ ذیل میں سے ایک یا دونوں سے ثابت ہے:	
Item 6 (C1): Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).	
آئٹم **6** (C1): تکلیف دہ یادوں، خیالات، یا تکلیف دہ (واقعہ)واقعات کے بارے میں یا اس سے قریب سے جڑے ہوئے احساسات سے گریز کرنا یا ان سے بچنے کی کوشش کرنا.	
In the [past month / worst month], have you tried to <u>avoid thoughts</u> or <u>feelings</u> about (EVENT)?	0 Absent 1 *Mild / subthreshold* 2 *Moderate / threshold* 3 *Severe / markedly elevated* 4 *Extreme / incapacitating* *Past Month* _______________ **Worst Month** ______________
[پچھلے مہینے / بدترین مہینے] میں، کیا آپ نے (واقعہ) کے بارے میں خیالات یا احساسات سے بچنے کی کوشش کی ہے؟	0 موجود نہیں 1 ہلکا / درمیانی 2 معتدل / درمیانی حد 3 شدید / واضح طور پر زیادہ 4 انتہائی / نا کا رہ کر دینے والی

(Table) cont.....

	پچھلا مہینہ ______ بدترین مہینہ______
What kinds of thoughts or feelings do you avoid?	
آپ کس قسم کے خیالات یا احساسات سے اجتناب کرتے ہیں؟	
How hard do you try to avoid these thoughts or feelings? (*What kinds of things do you do?*)	
ان خیالات یا احساسات سے بچنے کے لیے آپ کتنی کوشش کرتے ہیں؟ (آپ کس قسم کے عمل یا کام کرتے ہیں؟)	
[If not clear:] (Overall, how much of a problem is this for you? How would things be different if you didn't have to avoid these thoughts or feelings?)	
[اگرسوال واضح نہیں ہے:] (مجموعی طور پر، یہ آپ کے لیے کتنا مسئلہ ہے؟ اگر آپ کو ان خیالات یا احساسات سے بچنے کی ضرورت نہ ہوتی تو حالات کیسے مختلف ہوتے؟)	
Circle: Avoidance = *Minimal*___ *Clearly Present*___ *Pronounced*__ *Extreme*___	
دائرہ لگائیں : اجتناب= کم سے کم ____ واضح طور پر موجود ____ نُمایاں ____ انتہائی____	
How often in the past [past month / worst month]? # of times __________	
یہ ماضی میں کتنی بار ہوا ہے [پچھلے مہینے / بدترین مہینے]؟اوقات کی تعداد _____	

Item 7 (C2): Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).	
آئٹم **7** (C2): بیرونی یاد دہانیوں جیسے کہ (لوگ ، مقامات، گفتگو، سرگرمیاں، اشیاء، حالات) سے اجتناب یا ان سے بچنے کی کوششیں جو تکلیف دہ یادوں، خیالات، یا جذبات کو جنم دیتی ہیں یا تکلیف دہ واقعہ (واقعات) سے وابستہ ہیں.	
In the [past month / worst month], have you tried to avoid things that remind you of (EVENT), like certain people, places, or situations?	0 Absent 1 *Mild / subthreshold* 2 *Moderate / threshold* 3 *Severe / markedly elevated* 4 *Extreme / incapacitating*

(Table) cont.....

	Past Month ______________ **Worst Month** ______________
[پچھلے مہینے / بدترین مہینے] سے کیا آپ نے ان چیزوں سے بچنے کی کوشش کی ہے جو آپ کو (واقعہ) کی یاد دلاتی ہیں، جیسے کہ کچھ لوگ، جگہیں، یا حالات؟	0 موجود نہیں 1 ہلکا / درمیانی 2 معتدل / درمیانی حد 3 شدید / واضح طور پر زیادہ 4 انتہائی / نا کا رہ کر دینے والی پچھلا مہینہ _______ بدترین مہینہ_______
What kinds of things do you avoid?	
آپ کس قسم کی چیزوں سے اجتناب کرتے ہیں؟	
How much effort do you make to avoid these reminders? (Do you have to make a plan or change your activities to avoid them?)	
ان یاد دہانیوں سے بچنے کے لیے آپ نے کتنی کوشش کی ہے؟ (کیا آپ نے ان سے بچنے کے لیے کوئی منصوبہ بنایا یا اپنی سرگرمیوں کو تبدیل کیا؟)	
[If not clear:] (Overall, how much of a problem is this for you? How would things be different if you didn't have to avoid these reminders?)	
[اگرسوال واضح نہیں ہے:] (مجموعی طور پر، یہ آپ کے لیے کتنا مسئلہ ہے؟ اگر آپ کو ان یاد دہانیوں سے بچنے کی ضرورت نہ ہوتی تو حالات کیسے مختلف ہوتے؟)	
Circle: Avoidance = *Minimal*___ *Clearly Present*___ *Pronounced*__ *Extreme*___	
دائرہ لگائیں : اجتناب= کم سے کم ____ واضح طور پر موجود ____ نُمایاں ____ انتہائی____	
How often in the past [past month / worst month]? # of times __________	
یہ ماضی میں کتنی بار ہوا ہے [پچھلے مہینے / بدترین مہینے]؟اوقات کی تعداد _____	

<table>
<tr><td colspan="2">Criterion D:</td></tr>
<tr><td>D=</td><td>جانچ کا اصول</td></tr>
<tr><td colspan="2">Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:</td></tr>
<tr><td colspan="2">تکلیف دہ واقعہ (واقعات) سے وابستہ ادراک اور مزاج میں منفی تغیرات، جو کہ تکلیف دہ واقعہ (واقعات) کے پیش آنے کے بعد شروع ہوتیں ہیں یا بگڑتی ہیں، جیسا کہ درج ذیل میں سے دو (یا زیادہ) شواہد سے ثابت ہے:</td></tr>
<tr><td colspan="2">Item 8 (D1): Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).</td></tr>
<tr><td colspan="2">آئٹم 8 (D1):
تکلیف دہ واقعہ (واقعات) کے ایک اہم پہلو کو یاد رکھنے میں ناکامی (عام طور پر الگ الگ بھولنے کی بیماری یا غیر منسلک نسیان کی وجہ سے اور دوسرے عوامل جیسے کہ سر کی چوٹ، شراب، یا منشیات کی وجہ سے نہیں)۔</td></tr>
<tr><td>In the [past month / worst month], have you had difficulty remembering some important parts of (EVENT)? (Do you feel there are gaps in your memory of (EVENT)?)</td><td>0 Absent
1 Mild / subthreshold
2 Moderate / threshold
3 Severe / markedly elevated
4 Extreme / incapacitating
Past Month _______________
Worst Month _______________</td></tr>
<tr><td>[پچھلے مہینے / بدترین مہینے] سے، کیا آپ کو (واقعہ) کے کچھ اہم حصوں کو یاد رکھنے میں دشواری ہوئی ہے؟ (کیا آپ کو لگتا ہے کہ (واقعہ) کے حوالے سے آپ کی یادداشت میں کمی رونما ہوئی ہے؟)</td><td>0 موجود نہیں
1 ہلکا / درمیانی
2 معتدل / درمیانی حد
3 شدید / واضح طور پر زیادہ
4 انتہائی / نا کا رہ کر دینے والی
پچھلا مہینہ _______
بدترین مہینہ_______</td></tr>
<tr><td colspan="2">What parts have you had difficulty remembering?</td></tr>
</table>

(Table) cont.....

آپ کو کن حصوں کو یاد رکھنے میں دشواری ہوتی ہے؟
Do you feel you should be able to remember these things?
کیا آپ کو لگتا ہے کہ آپ کو ان چیزوں کو یاد رکھنے کے قابل ہونا چاہئے؟
[If not clear:] (Why do you think you can't? Did you have a head injury during (EVENT)? Were you knocked unconscious? Were you intoxicated from alcohol or drugs?) (Rate 0=Absent if due to head injury or loss of consciousness or intoxication during event)
[اگرسوال واضح نہیں ہے:] (آپ کے خیال میں آپ ایسا کیوں نہیں کر سکتے؟ کیا (واقعہ) کے دوران آپ کے سر پر چوٹ لگی تھی؟ کیا آپ بے ہوش ہو گئے تھے؟ کیا آپ شراب یا منشیات کے نشے میں تھے؟) (درجہ بندی کریں 0 = غیر حاضر اگر سر کے چوٹ کی وجہ سے یا واقعہ کے دوران بےہوشی یا نشہ).
[If still not clear:] (Is this just normal forgetting? Or do you think you may have blocked it out because it would be too painful to remember?) (Rate 0=Absent if due only to normal forgetting)
[اگر اب بھی واضح نہیں ہے:] (کیا یہ صرف عام بھولنا ہے/ معمول کےمطابق بھولنا ہے ؟ یا کیا آپ کو لگتا ہے کہ آپ نے اسے بلاک کردیا ہے/روک دیا ہے، کیونکہ اس کو یاد رکھنا بہت تکلیف دہ ہوگیا ہو گا؟) (درجہ بندی کریں 0 = غیر حاضر اگر صرف عام بھولنے کی وجہ سے ہے).
Circle: ___Difficulty remembering = *Minimal___ Clearly Present___ Pronounced__ Extreme___*
دائرہ لگائیں : یاد رکھنے میں دشواری = کم سے کم ____ واضح طور پر موجود ____ نُمایاں ____ انتہائی____
In the [past month / worst month], how many of the important parts of (EVENT) have you had difficulty remembering? (What parts do you still remember?) Number of important aspects________.
[پچھلے مہینے / بدترین مہینے] سے، آپ کو (واقعہ) کے کتنے اہم حصوں کو یاد رکھنے میں دشواری پیش آئی؟ (کون سے حصے آپ کو اب بھی یاد ہیں؟) اہم پہلوؤں کی تعداد________.
Would you be able to recall these things if you tried?
اگر آپ کوشش کریں گے تو کیا آپ ان چیزوں کو یاد کر سکیں گے؟

Item 9 (D2): Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The

(Table) cont.....

<table>
<tr><td colspan="2">world is completely dangerous,” “My whole nervous system is permanently ruined”).</td></tr>
<tr><td colspan="2">آئٹم **9** (D2):
اپنے، دوسروں، یا دنیا کے بارے میں مسلسل اور مبالغہ آمیز منفی عقائد یا توقعات (مثال کے طور پر، "میں برا ہوں،" "کسی پر بھروسہ نہیں کیا جا سکتا،" "دنیا مکمل طور پر خطرناک ہے،" "میرا پورا اعصابی نظام مستقل طور پر تباہ ہو چکا ہے") .</td></tr>
<tr><td>In the [past month / worst month], have you had strong negative beliefs about yourself, other people, or the world?</td><td>0 Absent
1 *Mild / subthreshold*
2 *Moderate / threshold*
3 *Severe / markedly elevated*
4 *Extreme / incapacitating*
Past Month _______________
Worst Month ______________</td></tr>
<tr><td>[پچھلے مہینے / بدترین مہینے] سے، کیا آپ کے اپنے بارے میں، دوسرے لوگوں، یا دنیا کے بارے میں سخت منفی عقائد تھے؟</td><td>0 موجود نہیں
1 ہلکا / درمیانی
2 معتدل / درمیانی حد
3 شدید / واضح طور پر زیادہ
4 انتہائی / نا کا رہ کر دینے والی
پچھلا مہینہ _______
بدترین مہینہ_______</td></tr>
<tr><td colspan="2">Can you give me some examples? (What about believing things like “I am bad,” “there is something seriously wrong with me,” “no one can be trusted,” “the world is completely dangerous”?)</td></tr>
<tr><td colspan="2">کیا آپ مجھے کچھ مثالیں دے سکتے ہیں؟ ("میں برا ہوں"، "میرے ساتھ کچھ سنگین غلط ہے"، "کسی پر بھروسہ نہیں کیا جا سکتا،" "دنیا مکمل طور پر خطرناک ہے" جیسی چیزوں پر یقین کرنے کے بارے میں کیا خیال ہے؟)</td></tr>
</table>

<table>
<tr><td>How strong are these beliefs? (How convinced are you that these beliefs are actually true? Can you see other ways of thinking about it?)</td></tr>
</table>

(Table) cont.....

یہ عقائد کتنے مضبوط ہیں؟ (آپ کتنے قائل ہیں کہ یہ عقائد حقیقت میں درست ہیں؟ کیا آپ کو ان عقائد کے بارے میں سوچنے کے دوسرے طریقےنظر آتے ہیں؟)
Circle: Convictions = *Minimal___ Clearly Present___ Pronounced__ Extreme___*
د ائرہ لگائیں:منفی عقیدے/یقین= کم سے کم ____ واضح طور پر موجود ____ نُمایاں ____ انتہائی____
How much of the time in the past month have you felt that way? As a percentage? % of time____
پچھلے مہینے سے آپ نے کتنا وقت ایسا محسوس کیا ہے؟ وقت کے تناسب کے طور پر؟ وقت کا تناسب ____
Did these beliefs start or get worse after (EVENT)? (Do you think they're related to (EVENT)? How so?) Circle: Trauma-relatedness = Definite Probable Unlikely
کیا یہ عقائد (واقعہ) کے بعد شروع ہوئے یا اور بدتر ہو گئے؟ (کیا آپ کو لگتا ہے کہ ان عقائد کا تعلق (واقعہ) سے ہے؟ ایسا کیسے؟) د ائرہ لگائیں: حادثے سے متعلق= واضح طور پر، ممکنہ طور پر، غالبًا ،ناممکن

Item 10 (D3): Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.	
آئٹم **10** (D3): تکلیف دہ واقعہ (واقعات) کی وجہ یا نتائج کے بارے میں مستقل، مسخ شدہ ادراک, جس کی وجہ سے خود کو یا دوسروں کو قصوروار ٹھہرا نا.	
In the [past month / worst month], have you blamed yourself for (EVENT) or what happened as a result of it? Tell me more about that. (In what sense do you see yourself as having caused (EVENT)? Is it because of something you did? Or something you think you should have done but didn't? Is it because of something about you in general?)	0 Absent 1 *Mild / subthreshold* 2 *Moderate / threshold* 3 *Severe / markedly elevated* 4 *Extreme / incapacitating* *Past Month* ______________ **Worst Month** ______________
[پچھلے مہینے / بدترین مہینے] میں، کیا آپ نے خود کو (واقعہ) کے لیے مورد الزام ٹھہرایا ہے یا اس کے نتیجے میں جو بھی ہوا؟ مجھے اس کے بارے میں	0 موجود نہیں 1 ہلکا / درمیانی 2 معتدل / درمیانی حد

(Table) cont.....

مزید بتائیں۔ (آپ کس معنوں میں اپنے آپ کو (واقعہ) کا موجب/سبب دیکھتے ہیں؟ کیا یہ آپ کے کسی کام کی وجہ سے ہے؟ یا کچھ آپ کو کرنا چاہیے تھا لیکن آپ نے نہیں کیا؟ عام طور پر کیا یہ آپ سے متعلق کسی چیز کی وجہ سے ہے؟)	3 شدید / واضح طور پر زیادہ 4 انتہائی / نا کا رہ کر دینے والی پچھلا مہینہ _______ بدترین مہینہ_______
What about blaming someone else for (EVENT) or what happened as a result of it? Tell me more about that. (In what sense do you see (OTHERS) as having caused (EVENT)? Is it because of something they did? Or something you think they should have done but didn't?)	
کسی اور کو(واقعہ) کے لیے مورد الزام ٹھہرانے کے بارے میں کیا خیال ہے یا اس کے نتیجے میں جو کچھ بھی ہوا؟ مجھے اس کے بارے میں مزید بتائیں۔ (آپ (دوسروں) کو کس معنوں میں (واقعہ) کا مورد الزام ٹھہراتے ہیں؟ کیا یہ ان کے کسی کام کی وجہ سے ہے؟ یا آپ کے خیال میں کچھ انہیں کرنا چاہئے تھا لیکن انہوں نے کیا نہیں؟	
How much do you blame (YOURSELF OR OTHERS)?	
آپ (خود کو یا دوسروں کو) کتنا قصوروار ٹھہراتے ہیں؟	
How convinced are you that (YOU OR OTHERS) are truly to blame for what happened? (Do other people agree with you? Can you see other ways of thinking about it?)	
آپ کتنے قائل ہیں کہ جو کچھ ہوا اس کے لیے آپ (آپ یا دوسرے) واقعی قصوروار ہیں؟ (کیا دوسرے لوگ آپ سے اتفاق کرتے ہیں؟ کیا آپ کو اس کے بارے میں سوچنے کے دوسرے طریقے نظر آتے ہیں؟)	
(Rate 0=Absent if only blames perpetrator, i.e., someone who deliberately caused the event and intended harm)	
(درجہ بندی کریں: 0 = غیر موجودگی اگر صرف مجرم کو موردِ الزام ٹھہرایا جائے، یعنی کوئی ایسا شخص جس نے جان بوجھ کر واقعہ کیا ہو یا نقصان پہنچایا ہو).	
Circle: Convictions = *Minimal___ Clearly Present___ Pronounced__ Extreme___*	
د ائرہ لگائیں: اِرْتِکابِ جُرْم= کم سے کم ____ واضح طور پر موجود ____ نُمایاں ____ انتہائی____	
How much of the time in the past month have you felt that way? As a percentage? % of time____	
پچھلے مہینے سے آپ نے کتنا وقت ایسا محسوس کیا ہے؟ وقت کے تناسب کے طور پر؟ وقت کا تناسب ____	

(Table) cont.....

<table>
<tr><td colspan="2">Item 12 (D5): Markedly diminished interest or participation in significant activities.</td></tr>
<tr><td colspan="2">آئٹم **12** (D5):
اہم سرگرمیوں میں دلچسپی یا شمولیت میں واضح طور پر کمی.</td></tr>
<tr><td>In the [past month / worst month], have you been less interested in activities that you used to enjoy?</td><td>0 Absent
1 *Mild / subthreshold*
2 *Moderate / threshold*
3 *Severe / markedly elevated*
4 *Extreme / incapacitating*
Past Month ________________
Worst Month _______________</td></tr>
<tr><td>[پچھلے مہینے / بدترین مہینے] سے، کیا آپ ان سرگرمیوں میں کم دلچسپی لیتے ہیں جن سے آپ لطف اندوز ہوتے تھے؟</td><td>0 موجود نہیں
1 ہلکا / درمیانی
2 معتدل / درمیانی حد
3 شدید / واضح طور پر زیادہ
4 انتہائی / نا کا رہ کر دینے والی
پچھلا مہینہ ________
بدترین مہینہ________</td></tr>
<tr><td colspan="2">What kinds of things have you lost interest in or don't do as much as you used to? (Anything else?)</td></tr>
<tr><td colspan="2">کس قسم کی چیزوں میں آپ نے دلچسپی کھو دی ہے یا آپ اتنا ان چیزوں کونہیں کرتے جتنا آپ پہلے کرتے تھے؟ (اور کچھ؟)</td></tr>
<tr><td colspan="2">Why is that? (Rate 0=Absent if diminished participation is due to lack of opportunity, physical inability, or developmentally appropriate change in preferred activities).</td></tr>
<tr><td colspan="2">ایسا کیوں ہے؟ (درجہ بندی کریں: 0 = غیر موجودگی، اگر کم ہونے والی شرکت موقع کی کمی کی وجہ سے ہے، جسمانی معذوری ، یا ترجیحی سرگرمیوں میں ارتقائی مناسب تبدیلی)۔</td></tr>
<tr><td colspan="2">How strong is your loss of interest? (Would you still enjoy (ACTIVITIES) once you got started?)</td></tr>
</table>

(Table) cont.....

آپ کی عدم دلچسپی کتنی مستحکم /مضبوط ہے؟ (آپ (سرگرمیوں) سے بدستور لطف اندوز ہونگے؟ ایک بار آپ شروع کردیں؟)
Circle: Loss of interest= *Minimal___ Clearly Present___ Pronounced__ Extreme___*
د ائرہ لگائیں: عدم دلچسپی = کم سے کم ____ واضح طور پر موجود ____ نُمایاں ____ انتہائی____
Overall, in the [past month / worst month], how many of your usual activities have you been less interested in, as a percentage?As a percentage? % of activities
مجموعی طور پر،[پچھلے مہینے / بدترین مہینے] سے، آپ کی معمول کی سرگرمیوں میں کتنی دلچسپی کم ہوئی ہے؟ تناسب کے لحاظ سے؟ سرگرمیاں کا تناسب (٪)------------
What kinds of things do you still enjoy doing?
آپ اب بھی کس قسم کی چیزوں/سرگرمیوں سے لطف اندوز ہوتے ہیں؟
Did this loss of interest start or get worse after (EVENT)? (Do you think it's related to (EVENT)? How so?) Circle: Trauma-relatedness = Definite Probable Unlikely
کیا یہ عدم دلچسپی (واقعہ) کے بعد شروع ہوئی یا بد تر ہوئی؟ (کیا آپ کو لگتا ہے کہ اس کا تعلق (واقعہ) سے ہے؟ کیسے؟ د ائرہ لگائیں: حادثے سے متعلق= واضح طور پر، ممکنہ طور پر، غالبًا ،ناممکن

Item 13 (D6): Feelings of detachment or estrangement from others.	
آئٹم **13** (D6): دوسروں سے لاتعلقی یا دوری کے احساسات.	
In the [past month / worst month], have you felt distant or cut off from other people? Tell me more about that.	0 Absent 1 *Mild / subthreshold* 2 *Moderate / threshold* 3 *Severe / markedly elevated* 4 *Extreme / incapacitating* *Past Month* ______________ **Worst Month** ______________

(Table) cont.....

[پچھلے مہینے / بدترین مہینے] سے، کیا آپ نے لوگوں سے دوری یا لاتعلقی محسوس کی؟ مجھے اس کے بارے میں مزید بتائیں۔	0 موجود نہیں 1 ہلکا / درمیانی 2 معتدل / درمیانی حد 3 شدید / واضح طور پر زیادہ 4 انتہائی / نا کا رہ کر دینے والی پچھلا مہینہ ______ بدترین مہینہ______
How strong are your feelings of being distant or cut off from others? (Who Do you feel closest to? How many people do you feel comfortable talking with about personal things?)	
آپ کے دوسرے لوگوں سے دوری یا لاتعلقی کے جذبات کتنے مضبوط ہیں؟ (کس کو آپ آپنے قریب ترین محسوس کرتے ہیں؟ کتنے لوگوں سے آپ اپنی ذاتی چیزوں کے بارے میں بات کرنے میں راحت محسوس کرتے ہیں؟)	
Circle: Detachment or estrangement = *Minimal__ Clearly Present__ Pronounced__Extreme__*	
د ائرہ لگائیں: دوری یا لاتعلقی = کم سے کم ____ واضح طور پر موجود _____ نُمایاں ____ انتہائی____	
How much of the time in the [past month / worst month] have you felt that way, as a percentage? % of time_______________	
[پچھلے مہینے / بدترین مہینے] سے کتنے وقت کے لیے اپ نے ایسا محسوس کیا، فیصد کے طور پر؟ وقت کا تناسب (٪)--------	
Did this feeling of being distant or cut off start or get worse after (EVENT)? (Do you think it's related to (EVENT)? How so?) started	
کیا (واقعہ) کے بعد دوری یا لاتعلقی کا احساس شروع یا بد ترہوا؟ (کیا آپ کو لگتا ہے کہ اس کا تعلق (واقعہ) سے ہے؟ کیسے؟	
Circle: Trauma-relatedness = Definite Probable Unlikely	
د ائرہ لگائیں: حادثے سے متعلق= واضح طور پر، ممکنہ طور پر، غالبًا ،ناممکن	

Item 14 (D7): Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).
آئٹم **14** (D7):

(Table) cont.....

مثبت جذبات کے تجربہ کرنے میں مستقل نااہلی (جیسے کہ، خوشی ، اطمینان ، یا محبت کے جذبات کا تجربہ کرنے سے قاصر).	
In the [past month / worst month], have there been times when you had difficulty experiencing positive feelings like love or happiness?	0 Absent 1 *Mild / subthreshold* 2 *Moderate / threshold* 3 *Severe / markedly elevated* 4 *Extreme / incapacitating* *Past Month* _______________ **Worst Month** ______________
[پچھلے مہینے / بدترین مہینے] سے، کیا ایسے وقت بھی آیا ہے جب آپ کو محبت یا خوشی جیسے مثبت جذبات کاتجربہ کرنے میں دشواری کا سامنا کرنا پڑا؟	0 موجود نہیں 1 ہلکا / درمیانی 2 معتدل / درمیانی حد 3 شدید / واضح طور پر زیادہ 4 انتہائی / نا کا رہ کر دینے والی پچھلا مہینہ ______ بدترین مہینہ______
Tell me more about that. (What feelings are difficult to experience?)	
مجھے اس کے بارے میں مزید بتائیں. (کونسی احساسات کا تجربہ کرنا مشکل ہے؟)	
How much difficulty do you have experiencing positive feelings? (Are you still able to experience any positive feelings?)	
آپ کو مثبت احساسات کا تجربہ کرنے میں کتنی دشواری ہوتی ہے؟ (کیا آپ اب بھی کسی مثبت جذبات کا تجربہ کرنے کے قابل ہیں؟)	
Circle: Reduction of positive emotions = *Minimal_ Clearly Present__ Pronounced__Extreme_*	
د ائرہ لگائیں: مثبت جذبات میں کمی = کم سے کم ____ واضح طور پر موجود ____ نُمایاں ____ انتہائی____	
How much of the time in the [past month / worst month] have you felt that way, as a percentage? % of time_______________	

(Table) cont.....

[پچھلے مہینے / بدترین مہینے] سے کتنے وقت کے لیے اپ نے ایسا محسوس کیا، فیصد کے طور پر؟ وقت کا تناسب (٪)--------
Did this trouble experiencing positive feelings start or get worse after (EVENT)? (Do you think it's related to (EVENT)? How so?)
کیا (واقعہ) کے بعد مثبت احساسات کا تجربہ کرنے میں دشواری ہونا شروع ہوئی یا بدتر ہو گئی. (کیا آپ کو لگتا ہے کہ اس کا تعلق (واقعہ) سے ہے؟ کیسے؟
Circle: Trauma-relatedness = Definite Probable Unlikely
د ائرہ لگائیں: حادثے سے متعلق= واضح طور پر، ممکنہ طور پر، غالبًا ،ناممکن

Criterion E:	
E=	جانچ کا اصول
Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:	
تکلیف دہ واقعات (واقعہ) سے وابستہ جوش/ وہیجان اور رد عمل میں نشان زد تبدیلیاں، جو کہ تکلیف دہ واقعات (واقعہ) کے پیش آنے کے بعد شروع یا بگڑتی ہیں، جیسا کہ درج ذیل میں سے دو (یا زیادہ) سے ظاہر ہوتا ہے:	
Item 15 (E1): Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.	
آئٹم **15** (E1): چڑ چڑا رویہ اور غصے سے بھڑک اٹھنا (بہت کم یا کسی اشتعال کے بغیر) جو کہ عام طور پر لوگوں یا اشیاء کی طرف زبانی یا جسمانی جارحیت کے طور پر ظاہر ہوتا ہے۔	
In the [past month / worst month], have there been times when you felt especially irritable or angry and showed it in your behavior?	0 Absent 1 *Mild / subthreshold* 2 *Moderate / threshold* 3 *Severe / markedly elevated* 4 *Extreme / incapacitating* *Past Month* ________________

(Table) cont.....

	Worst Month _______________
[پچھلے مہینے / بدترین مہینے] سے، کیا ایسا وقت آیا ہے جب آپ نے خاص طور پر چڑچڑاپن یا غصہ محسوس کیا اور اسے اپنے رویے میں ظاہر کیا؟	0 موجود نہیں 1 ہلکا / درمیانی 2 معتدل / درمیانی حد 3 شدید / واضح طور پر زیادہ 4 انتہائی / نا کا رہ کر دینے والی پچھلا مہینہ _______ بدترین مہینہ_______
Can you give me some examples? (How do you show it? Do you raise your voice or yell? Throw or hit things? Push or hit other people?)	
کیا آپ مجھے کچھ مثالیں دے سکتے ہیں؟ (آپ اسے (چڑچڑاپن یا غصہ) کیسے دکھاتے ہیں؟ کیا آپ اپنی آواز بلند کرتے ہیں یا چیختے ہیں؟ چیزیں پھینکتے ہیں یا مارتے ہیں؟ دوسرے لوگوں کو دھکا دیتے ہیں یا مارتے ہیں؟)	
Circle: Agression = *Minimal_ Clearly Present__ Pronounced__Extreme_*	
د ائرہ لگائیں: جارحیت = کم سے کم ____ واضح طور پر موجود _____ نُمایاں _____ انتہائی____	
How often in the [past month / worst month]. Number of times	
[پچھلے مہینے / بدترین مہینے] میں کتنی بار۔ اوقات کی تعداد-------	
Did this behavior start or get worse after (EVENT)? (Do you think it's related to (EVENT)? How so?)	
کیا یہ رویہ (واقعہ) کے بعد شروع ہوا یا بدتر ہو گیا؟. (کیا آپ کو لگتا ہے کہ اس کا تعلق (واقعہ) سے ہے؟ کیسے؟	
Circle: Trauma-relatedness = Definite Probable Unlikely	
د ائرہ لگائیں: حادثے سے متعلق= واضح طور پر، ممکنہ طور پر، غالبًا ،ناممکن	

Item 16 (E2): Reckless or self-destructive behavior.	
آئٹم **14** (E2): لاپرواہی یا خود کو تباہ کرنے والا سلوک/عمل۔	
In the [past month / worst month], have there been times when you were taking more risks or doing things that might have caused you harm? Can you give me some examples?	0 Absent 1 *Mild / subthreshold* 2 *Moderate / threshold* 3 *Severe / markedly elevated* 4 *Extreme / incapacitating* *Past Month* ______________ **Worst Month** ______________
[پچھلے مہینے / بدترین مہینے] میں، کیا ایسا وقت آیا ہے جب آپ زیادہ خطرہ مول لے رہے تھے یا ایسے کام کر رہے تھے جن سے آپ کو نقصان پہنچا ہو؟کیا آپ مجھے کچھ مثالیں دے سکتے ہیں؟	0 موجود نہیں 1 ہلکا / درمیانی 2 معتدل / درمیانی حد 3 شدید / واضح طور پر زیادہ 4 انتہائی / نا کا رہ کر دینے والی پچھلا مہینہ _______ بدترین مہینہ_______
How much of a risk do you take? (How dangerous are these behaviors? Were you injured or harmed in some way?)	
آپ کتنا خطرہ مول لیتے ہیں؟ (یہ رویے کتنے خطرناک ہیں؟ کیا آپ کسی طرح زخمی ہوئے یا آپ کو نقصان پہنچا؟)	
Circle: Risk = *Minimal_ Clearly Present__ Pronounced__Extreme_*	
د ائرہ لگائیں: خطرہ= کم سے کم ____ واضح طور پر موجود ____ نُمایاں ____ انتہائی____	
How often have you taken these kinds of risks in the [past month / worst month] have you felt that way, as a percentage? % of time_______________	
[پچھلے مہینے / بدترین مہینے] سے آپ نے اس قسم کے خطرات کو کتنی بارلیے ہیں. فیصد کے طور پر؟ اوقات کا تناسب (٪)--	
Did this behavior start or get worse after (EVENT)? (Do you think it's related to (EVENT)? How so?)	

(Table) cont.....

کیا یہ رویہ (واقعہ) کے بعد شروع ہوا یا بدتر ہو گیا؟ (کیا آپ کو لگتا ہے کہ اس کا تعلق (واقعہ) سے ہے؟ کیسے؟
Circle: Trauma-relatedness = Definite Probable Unlikely
د ائرہ لگائیں: حادثے سے متعلق= واضح طور پر، ممکنہ طور پر، غالبًا ،ناممکن

Item 17 (E3): Hypervigilance	
آئٹم **17** (E3): چونکا دینے والا یا مبالغہ انگیز ردعمل	
In the [past month / worst month], have you been especially alert or watchful, even when there was no specific threat or danger? (Have you felt as if you had to be on guard?)	0 Absent 1 *Mild / subthreshold* 2 *Moderate / threshold* 3 *Severe / markedly elevated* 4 *Extreme / incapacitating* *Past Month* _______________ **Worst Month** ______________
[پچھلے مہینے / بدترین مہینے] سے، کیا آپ خاص طور پر چوکس یا ہوشیار رہے ہیں، یہاں تک کہ جب کوئی خاص گھڑکی(خوف) یا خطرہ نہیں تھا؟ (کیا آپ نے ایسا محسوس کیا ہے جیسے آپ کو چوکس رہنا پڑا؟)	0 موجود نہیں 1 ہلکا / درمیانی 2 معتدل / درمیانی حد 3 شدید / واضح طور پر زیادہ 4 انتہائی / نا کا رہ کر دینے والی پچھلا مہینہ _______ بدترین مہینہ_______
Can you give me some examples? (What kinds of things do you do when you're alert or watchful?)	
کیا آپ مجھے کچھ مثالیں دے سکتے ہیں؟ (جب آپ بیدار یا چوکس ہوتے ہیں تو آپ کس قسم کی چیزیں کرتے ہیں؟)	
[If not clear:] (What causes you to react this way? Do you feel like you're in danger or threatened in some way? Do you feel that way more than most people would in the same situation?)	

(Table) cont.....

[اگر واضح نہیں ہے تو:] (آپ کا اس طرح کا ردعمل ظاہر کرنے کی کیا وجہ ہے؟ کیا آپ کو ایسا لگتا ہے کہ آپ کسی طرح سے خطرے میں ہیں یا آپکو کسی نے دھمکی دی ہے؟ اس صورت حال میں کیا آپ باقی او زیادہ تر لوگوں کی نسبت اس طرح سے خطرہ زیادہ محسوس کرتے ہیں؟
Circle: Hypervigilance = *Minimal_ Clearly Present__ Pronounced__Extreme_*
د ائرہ لگائیں: ہوشیار ہونا/چوکس ہونا = کم سے کم ____ واضح طور پر موجود ____ نُمایاں ____ انتہائی____
How much of the time in the [past month / worst month] have you felt that way, as a percentage? % of time_______________
[پچھلے مہینے / بدترین مہینے] میں آپ نے کتنی بار ایسا محسوس کیا ہے، فیصد کے طور پر؟ اوقات کا تناسب (٪)--
Did being especially alert or watchful start or get worse after (EVENT)? (Do you think it's related to (EVENT)? How so?)
کیا خاص طور پر بیدار یا چوکنا رہنا (واقعہ) کے بعد شروع ہوا یا بدتر ہو گیا؟ (کیا آپ کو لگتا ہے کہ اس کا تعلق (واقعہ) سے ہے؟ کیسے؟
Circle: Trauma-relatedness = Definite Probable Unlikely
د ائرہ لگائیں: حادثے سے متعلق= واضح طور پر، ممکنہ طور پر، غالبًا ،ناممکن

Item 18 (E4): Exaggerated startle response.	
آئٹم **18** (E4): ہوشیار ہونا/چوکس ہونا (خطرے کے دوران تمام حسوں کا بیدار ہونا)-	
In the [past month / worst month], have you had any strong startle reactions?	0 Absent 1 *Mild / subthreshold* 2 *Moderate / threshold* 3 *Severe / markedly elevated* 4 *Extreme / incapacitating* *Past Month* ________________ **Worst Month** _______________
[پچھلے مہینے / بدترین مہینے] سے، کیا آپ نے کوئی سخت چونکا دینے والا ردعمل کیا تھا؟	0 موجود نہیں 1 ہلکا / درمیانی

(Table) cont.....

<table>
<tr><td></td><td>2 معتدل / درمیانی حد
3 شدید / واضح طور پر زیادہ
4 انتہائی / نا کا رہ کر دینے والی
پچھلا مہینہ _______
بدترین مہینہ_______</td></tr>
<tr><td colspan="2">What kinds of things made you startle?</td></tr>
<tr><td colspan="2">کس قسم کی چیزوں نے آپ کو چونکا دیا؟</td></tr>
<tr><td colspan="2">How strong are these startle reactions? (How strong are they compared to how most people would respond? Do you do anything other people would notice?)</td></tr>
<tr><td colspan="2">یہ چونکا دینے والے ردعمل کتنے مضبوط/قوی ہیں؟ (یہ چونکا دینے والے ردعمل زیادہ تر لوگوں کے ردعمل سے کتنے مضبوط ہیں؟ کیا آپ کوئی ایسا کام کرتے ہیں جسے دوسرے لوگ محسوس/دیکھ سکیں؟)</td></tr>
<tr><td colspan="2">How long does it take you to recover?</td></tr>
<tr><td colspan="2">آپ کو آپنی بحالی/چونکا دینے والے ردعمل سے باہر نکلنے میں کتنا وقت لگتا ہے؟</td></tr>
<tr><td colspan="2"><u>Circle:</u> Startle = Minimal_ Clearly Present__ Pronounced__Extreme_</td></tr>
<tr><td colspan="2">د ائرہ لگائیں: چونکا دینا = کم سے کم ____ واضح طور پر موجود ____ نُمایاں ____ انتہائی____</td></tr>
<tr><td colspan="2">How often has this happened in the [past month / worst month]? Number of times_______________</td></tr>
<tr><td colspan="2">یہ [پچھلے مہینے / بدترین مہینے] میں کتنی بار ہوا ہے؟ اوقات کی تعداد --------</td></tr>
<tr><td colspan="2">Did these startle reactions start or get worse after (EVENT)? (Do you think it's related to (EVENT)? How so?)</td></tr>
<tr><td colspan="2">کیا یہ چونکا دینے والے رد عمل (واقعہ) کے بعد شروع ہوئے یا بدتر ہو گئے؟ (کیا آپ کو لگتا ہے کہ اس کا تعلق (واقعہ) سے ہے؟ کیسے؟</td></tr>
<tr><td colspan="2">Circle: Trauma-relatedness = Definite Probable Unlikely</td></tr>
<tr><td colspan="2">د ائرہ لگائیں: حادثے سے متعلق= واضح طور پر، ممکنہ طور پر، غالبًا ،ناممکن</td></tr>
</table>

<table>
<tr><td colspan="2">Item 19 (E5): Problems with concentration.</td></tr>
<tr><td colspan="2">آئٹم 19 (E5):
توجہ مرکوز کرنے میں مسائل</td></tr>
<tr><td>In the [past month / worst month], have you had any problems with concentration?</td><td>0 Absent
1 Mild / subthreshold
2 Moderate / threshold
3 Severe / markedly elevated
4 Extreme / incapacitating
Past Month ________________
Worst Month _______________</td></tr>
<tr><td>[پچھلے مہینے / بدترین مہینے] سے، کیا آپ کو توجہ مرکوز کرنے میں کوئی پریشانی ہوئی ہے؟</td><td>0 موجود نہیں
1 ہلکا / درمیانی
2 معتدل / درمیانی حد
3 شدید / واضح طور پر زیادہ
4 انتہائی / نا کا رہ کر دینے والی
پچھلا مہینہ _______
بدترین مہینہ_______</td></tr>
<tr><td colspan="2">Can you give me some examples?</td></tr>
<tr><td colspan="2">کیا آپ مجھے کچھ مثالیں دے سکتے ہیں؟</td></tr>
<tr><td colspan="2">Are you able to concentrate if you really try?</td></tr>
<tr><td colspan="2">اگر آپ واقعی کوشش کریں تو کیا آپ توجہ مرکوز کر سکتے ہیں؟</td></tr>
<tr><td colspan="2">[If not clear:] (Overall, how much of a problem is this for you? How would things be different if you didn't have problems with concentration?)</td></tr>
<tr><td colspan="2">[اگرسوال واضح نہیں ہے:] (مجموعی طور پر، یہ (توجہ مرکوزنہ کرنا) آپ کے لیے کتنا مسئلہ ہے؟ چیزیں کیسے مختلف ہوتیں اگر آپ کے ساتھ توجہ مرکوزنہ والا مسلہ نہ ہوتا؟</td></tr>
<tr><td colspan="2"><u>Circle:</u> ___Problem concentrating = Minimal_ Clearly Present__ Pronounced__Extreme_</td></tr>
<tr><td colspan="2">د ائرہ لگائیں: توجہ مرکوزنہ کرنا = کم سے کم ____ واضح طور پر موجود _____ نُمایاں ____ انتہائی____</td></tr>
</table>

How much of the time in the [past month / worst month] have you had problems with concentration, as a percentage? % of time______________
[پچھلے مہینے / بدترین مہینے] میں، کتنے وقت سے آپ کوتوجہ مرکوزنہ کرنے کے مسائل کا سامنا کرنا پڑا ہے؟ فیصد کے طور پر؟ اوقات کا تناسب (٪)----
Did these problems with concentration start or get worse after (EVENT)? (Do you think it's related to (EVENT)? How so?)
کیا یہ توجہ مرکوزنہ کرنے کے مسائل (واقعہ) کے بعد شروع ہوئے یا مزید خراب ہو گئے؟ (کیا آپ کو لگتا ہے کہ اس کا تعلق (واقعہ) سے ہے؟ کیسے؟
Circle: Trauma-relatedness = Definite Probable Unlikely
د ائرہ لگائیں: حادثے سے متعلق= واضح طور پر، ممکنہ طور پر، غالبًا ،ناممکن

<table>
<tr><td colspan="2">Item 20 (E6): Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).</td></tr>
<tr><td colspan="2">آئٹم 20 (E6):
نیند میں خلل (مثلاً، نیند آنے میں دشواری یا سوتے رہنا یا بے چین مضطرب نیند)۔</td></tr>
<tr><td>In the [past month / worst month], have you had any problems falling or staying asleep?</td><td>0 Absent
1 Mild / subthreshold
2 Moderate / threshold
3 Severe / markedly elevated
4 Extreme / incapacitating
Past Month _______________
Worst Month ______________</td></tr>
<tr><td>[پچھلے مہینے / بدترین مہینے] میں، کیا آپ کو نیند آنے میں دشواری یا سونے میں کوئی پریشانی ہوئی ہے؟</td><td>0 موجود نہیں
1 ہلکا / درمیانی
2 معتدل / درمیانی حد
3 شدید / واضح طور پر زیادہ
4 انتہائی / نا کا رہ کر دینے والی
پچھلا مہینہ _______
بدترین مہینہ_______</td></tr>
</table>

What kinds of problems? (How long does it take you to fall asleep? How often do you wake up in the night? Do you wake up earlier than you want to?)
کس قسم کے مسائل؟ (آپ کو نیند آنے میں کتنا وقت لگتا ہے؟ آپ رات میں کتنی بار جاگ جاتے ہیں؟ کیا آپ اپنی مرضی سے پہلےجاگ جاتے ہیں؟)
How many total hours do you sleep each night?
آپ ہر رات کُل کتنے گھنٹے سوتے ہیں؟
How many hours do you think you should be sleeping?
آپ کے خیال میں آپ کو کتنے گھنٹے سوتے رہنا چاہئے؟
Circle: Problem sleeping = *Minimal_ Clearly Present__ Pronounced__Extreme_*
د ائرہ لگائیں: نیند میں مسئلہ/دشواری = کم سے کم ____ واضح طور پر موجود ____ نُمایاں ___ انتہائی____
How often in the [past month / worst month] have you had these sleep problems? Number of times_______________
[پچھلے مہینے / بدترین مہینے] میں کتنی بار آپ کو نیند کے یہ مسائل درپیش ہوئے ہیں؟ اوقات کی تعداد---
Did these sleep problems start or get worse after (EVENT)? (Do you think it's related to (EVENT)? How so?)
کیا یہ نیند کے مسائل (واقعہ) کے بعد شروع ہوئے یا بدتر ہو گئے؟ (کیا آپ کو لگتا ہے کہ اس کا تعلق (واقعہ) سے ہے؟ کیسے؟
Circle: Trauma-relatedness = Definite Probable Unlikely
د ائرہ لگائیں: حادثے سے متعلق= واضح طور پر، ممکنہ طور پر، غالبًا ،ناممکن

Criterion F:	
F=	جانچ کا اصول
Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.	
پریشانی کا دورانیہ (جانچ کے اصول B، C، D ، اورE) ایک (01) ماہ سے زیادہ ہے۔	

Item 21: Onset of symptoms.	
21آئٹم	علامات کا آغاز.
[If not clear:] When did you first start having (PTSD SYMPTOMS) you've told me about? (How long after the trauma did they start? More than six months?)	Total number of months delay in onset _________ With delayed onset (> 6 months)?

	NO or YES
[اگرسوال واضح نہیں ہے:] آپ کو پہلی بار کب (مابعد صدمہ تناؤ کے انتشار کی علامات) ہونا شروع ہویں جس کے بارے میں آپ نے مجھے بتایا تھا؟ (یہ علامات صدمے کے کتنے عرصے بعد شروع ہویں؟ چھ ماہ سے زیادہ؟)	علامات شروع ہونے میں کُل کتنے مہینوں کی تاخیر رہی ________ تاخیر سے شروع ہونے کے ساتھ (> 6 ماہ)؟ نہیں یا ہاں

Item 22: Duration of symptoms.	
22 آئٹم	علامات کا دورانیہ
[If not clear:] How long have these (PTSD SYMPTOMS) lasted altogether?	*Total duration in months* ____ ***Duration more than 01 month? NO or YES***
[اگرسوال واضح نہیں ہے تو:] یہ (مابعد صدمہ تناؤ کے انتشار کی علامات) مکمل طور پر کتنے عرصے تک موجود رہیں ہیں؟	مہینوں میں کُل دورانیہ ____ دورانیہ ایک (01) ماہ سے زیادہ؟ نہیں یا ہاں

Criterion G:	
جانچ کا اصول	**G=**
The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.	
یہ پریشانی سماجی، پیشہ ورانہ یا روز مرہ کے اہم پہلوؤں کی کارکردگی میں طبی لحاظ سے معنی خیزانداز میں رنج کا یا خرابی کا باعث بنتی ہے-	

Item 23: Subjective distress	
23آئٹم	داخلی موضوعی پریشانی/تکلیف
Overall, in the [past month / worst month], how much have you been bothered by these (PTSD	0 *None* 1 *Mild, minimal distress*

SYMPTOMS) you've told me about? [Consider distress reported on earlier items]	2 *Moderate, distress clearly present but still manageable* 3 *Severe, considerable distress* 4 *Extreme, incapacitating distress* *Past Month* _______________ *Worst Month* ______________
مجموعی طور پر، [پچھلے مہینے / بدترین مہینے] سے، آپ ان (مابعد صدمہ تناؤ کے انتشار کی علامات) سے کس حد تک پرشان ہوے، جن کے بارے میں آپ نے مجھے بتایا تھا. (ابتدائی آئٹمز پربیان شدہ تکلیف/رنج پر غور کریں)-	0 کوئی نہیں۔ 1 ہلکی، کم سے کم تکلیف 2 معتدل / درمیانی حد، پریشانی واضح طور پر موجود ہے لیکن پھر بھی سنبھالنے کے قابل ہے 3 شدید، کافی تکلیف 4 انتہائی، ناقابل برداشت تکلیف گزشتہ مہینہ ________ بدترین مہینہ ________

Item 24: Impairment in social functioning	
معاشرتی کام کاج میں خرابی	آئٹم24
In the [past month / worst month], have these (PTSD SYMPTOMS) affected your relationships with other people? How so? [Consider impairment in social functioning reported on earlier items]	0 *No adverse impact* 1 *Mild impact, minimal impairment in social functioning* 2 *Moderate impact, definite impairment but many aspects of social functioning still intact*

	3 *Severe impact, marked impairment, few aspects of social functioning still intact* 4 *Extreme impact, little or no social functioning* *Past Month* _______________ *Worst Month* ______________
[پچھلے مہینے / بدترین مہینے] سے، کیا ان (مابعد صدمہ تناؤ کے انتشار کی علامات) نے دوسرے لوگوں کے ساتھ آپ کے تعلقات کو متاثر کیا ہے؟ کیسے کریں؟ [پہلے آئٹمز پر بیان کردہ سماجی کام کاج میں خرابی پر غور کریں]	0 کوئی منفی اثر نہیں۔ 1 ہلکا اثر، سماجی کام کاج میں کم سے کم خرابی۔ 2 معتدل اثر، قطعی خرابی لیکن سماجی کام کاج کے بہت سے پہلو اب بھی برقرار ہیں۔ 3 شدید اثرات، نمایاں خرابی، سماجی کام کے چند پہلو اب بھی برقرار ہیں۔ 4 انتہائی اثر، بہت کم یا کوئی سماجی کام کرنا پچھلا مہینہ _______ بدترین مہینہ_______

Item 25: Impairment in occupational or other important area of functioning.	
پیشہ ورانہ یا دوسرے اہم کام کاج میں خرابی	آئٹم **25**
Are you working now? [If yes:] In the [past month / worst month], have these (PTSD SYMPTOMS) affected your work or your ability to work? How so? [If unable to work because of PTSD symptoms, rate at least 3=Severe. If unemployment is not due to PTSD symptoms, or if the link is not clear, base rating only on impairment in other important areas of functioning]. Have these (PTSD SYMPTOMS) affected any other important part of your life? [As	0 *No adverse impact* 1 *Mild impact, minimal impairment in social functioning* 2 *Moderate impact, definite impairment but many aspects of social functioning still intact* 3 *Severe impact, marked impairment, few aspects of social functioning still intact*

appropriate, suggest examples such as parenting, housework, schoolwork, volunteer work, etc.] How so?	4 *Extreme impact, little or no social functioning* *Past Month* ______________ **Worst Month** ______________
کیا آپ ابھی کام کر رہے ہیں؟ [اگر ہاں:] [پچھلے مہینے / بدترین مہینے] سے، کیا ان (مابعد صدمہ تناؤ کے انتشار کی علامات) نے آپ کے کام یا آپ کی کام کرنے کی صلاحیت کو متاثر کیا ہے؟ وہ کیسے؟ [اگر مابعد صدمہ تناؤ کے انتشار کی علامات کی علامات کی وجہ سے کام کرنے سے قاصر گئے ہوں تو کم از کم درجہ بندی 3=شدید کریں۔ اگر بے روزگاری مابعد صدمہ تناؤ کے انتشار کی علامات کی وجہ سے نہیں ہے، یا اگربیروزگاری کا تعلّق مابعد صدمہ تناؤ کے انتشارکے ساتھ واضح نہیں ہے تو، صرف کام کے دیگر اہم حصوں میں خرابی کی بنیاد پر درجہ بندی]۔ کیا ان (مابعد صدمہ تناؤ کے انتشار کی علامات) نے آپ کی زندگی کے کسی دوسرے اہم حصے کو متاثر کیا ہے؟ [جیسا کہ مناسب ہے، مثالیں تجویز کریں جیسے والدینیت، گھر کا کام، اسکول کا کام، رضاکارانہ کام وغیرہ] ایسا کیسے؟	0 کوئی منفی اثر نہیں۔ 1 ہلکا اثر، سماجی کام کاج میں کم سے کم خرابی۔ 2 معتدل اثر، قطعی خرابی لیکن سماجی کام کاج کے بہت سے پہلو اب بھی برقرار ہیں۔ 3 شدید اثرات، نمایاں خرابی، سماجی کام کے چند پہلو اب بھی برقرار ہیں۔ 4 انتہائی اثر، بہت کم یا کوئی سماجی کام کرنا پچھلا مہینہ ______ بدترین مہینہ______

Global Ratings	
عالمی درجہ بندی	
Item 26: Global validity.	
	آئٹم26
Estimate the overall validity of responses. Consider factors such as compliance with the interview, mental status (e.g., problems with concentration, comprehension of items,	*0 Excellent, no reason to suspect invalid responses* *1 Good, factors present that may adversely affect validity*

dissociation), and evidence of efforts to exaggerate or minimize symptoms	*2 Fair, factors present that definitely reduce validity* *3 Poor, substantially reduced validity* *4 Invalid responses, severely impaired mental status or possible deliberate "faking bad" or "faking good"* *Past Month _______________* *Worst Month _______________*
جوابات کی مجموعی صداقت کا اندازہ لگائیں۔ انٹرویو کے ساتھ تعمیل، ذہنی کیفیت (مثلاً، توجہ مرکوز کرنے میں مسائل، اشیاء/عناصر کی سمجھ/پہچان، علیحدگی/ تفریق) اور علامات کو بڑھا چڑھا کر پیش کرنے یا کم کرنے کی کوششوں کے ثبوت جیسے عوامل پر غور کریں۔	0 بہترین، غلط جوابات پر شبہ کرنے کی کوئی وجہ نہیں۔ 1 اچھا، ایسے عوامل موجود ہیں جو درستگی کو متاثر کر سکتے ہیں۔ 2 منصفانہ، ایسے عوامل موجود ہیں جو یقینی طور پر درستگی کو کم کرتے ہیں۔ 3 ناقص، کافی حد تک درستگی میں کمی 4 غلط جوابات، شدید طور پر خراب دماغی حالت یا ممکنہ طور پر جان بوجھ کر "برائی کا بہانہ" یا "اچھائی کا بہانہ" گزشتہ مہینہ ________ بدترین مہینہ ________

Item 27: Global severity.	
عالمی شدت	**27**آئٹم
Estimate the overall severity of PTSD symptoms. Consider degree of subjective distress, degree of functional impairment, observations of behaviors	*0No clinically significant symptoms, no distress and no functional impairment*

in interview, and judgment regarding reporting style.	*1Mild, minimal distress or functional impairment* *2Moderate, definite distress or functional impairment but functions satisfactorily with effort* *3Severe, considerable distress or functional impairment, limited functioning even with effort* *4Extreme, marked distress or marked impairment in two or more major areas of functioning* *Past Month* ________________ *Worst Month* _______________
مابعد صدمہ تناؤ کے انتشار کی علامات کی مجموعی شدت کا اندازہ لگائیں۔ موضوعی رنج یا تکلیف کی سطح/مقدار، فعلی خرابی کی سطح/مقدار،انٹرویو میں طرز عمل کے مشاہدات، اور رپورٹنگ (خبر دینے) کے انداز کے بارے میں فیصلے پر غور کریں۔	0 طبی لحاظ سے کوئی اہم علامات نہیں، کوئی تکلیف اور کوئی فعلی خرابی نہیں۔ 1 ہلکی، کم سے کم تکلیف یا کام کی خرابی۔ 2 معتدل، یقینی تکلیف یا فعالی خرابی لیکن کوشش کے ساتھ تسلی بخش کام کرتا ہے 3 شدید، کافی تکلیف یا فعلی خرابی، کوشش کے باوجود محدود کارکردگی 4 نتہائی، کام کاج کے دو یا زیادہ بڑے حصوں میں انتہائی، نشان زدہ پریشانی یا نشان زدہ خرابی گزشتہ مہینہ __________ بدترین مہینہ _________

Item 28: Global improvement	
عالمی بہتری	آئٹم28
Rate total overall improvement since the previous rating. Rate the degree of change, whether or not, in your judgment, it is due to treatment.	*0 Asymptomatic* *1 Considerable improvement* *2 Moderate improvement* *3 Slight improvement* *4 No improvement* *5 Insufficient information*
پچھلی درجہ بندی کے بعد سے مجموعی طور پر بہتری کی شرح نکالیں. تبدیلی کی حد کی درجہ بندی کریں، چاہے یہ آپ کےخیال میں ہو یا نہ ہو یہ تبدیلی علاج کی وجہ سےہے.	0 علامات کی غَیْر مَوجُودْگی/عَدَم مَوجُودْگی 1 قابل ذکر بہتری 2 معتدل بہتری 3 معمولی/ہلکی بہتری 4 کوئی بہتری نہیں۔ 5 ناکافی معلومات

Specify whether with dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:
وضاحت کریں کہ آیا قطع تعلق کی علامات کے ساتھ : فرد کی علامات مابعد صدمہ تناؤ کے انتشار کی معیار پر پورا اترتی ہیں، اور اس کے علاوہ ، تناؤ کے جواب میں ، فرد کو درج ذیل میں سے کسی ایک کی مستقل یا بار بار علامات کا تجربہ ہوتا ہے:

Item 29 (1): Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
آئٹم **29** (1): عدِم شخصیت/اپنی شَخصیت کے ضیاع کا احساس: مسلسل یا بار بارالگ تھلگ محسوس کرنے کے تجربات، گویا کوئی شخص اپنے دماغی عمل یا جسم کا بیرونی مبصر ہے (مثال کے طور پر، ایسا محسوس کرنا جیسے کوئی خواب میں ہے؛ خود یا جسم کی غیر حقیقت کا احساس یا وقت کا آہستہ آہستہ چلنا).

In the [past month / worst month], have there been times when you felt as if you were separated from yourself, like you were watching yourself from the outside or observing your thoughts and feelings as if you were another person?	0 Absent 1 *Mild / subthreshold* 2 *Moderate / threshold* 3 *Severe / markedly elevated* 4 *Extreme / incapacitating* *Past Month* ________________ **Worst Month** _______________
[پچھلے مہینے / بدترین مہینے] میں، کیا ایسا وقت آیا ہے جب آپ کو ایسا محسوس ہوا جیسے آپ خود سے الگ ہو گئے ہوں، جیسے آپ اپنے آپ کو باہر سے دیکھ رہے ہوں یا اپنے خیالات اور احساسات کو ایسے دیکھ رہے ہوں جیسے آپ کوئی اور شخص ہو؟	0 موجود نہیں 1 ہلکا / درمیانی 2 معتدل / درمیانی حد 3 شدید / واضح طور پر زیادہ 4 انتہائی / نا کا رہ کر دینے والی پچھلا مہینہ _______ بدترین مہینہ_______
[If no:] (What about feeling as if you were in a dream, even though you were awake? Feeling as if something about you wasn't real? Feeling as if time was moving more slowly?)	
[اگر نہیں:] (ایسا محسوس کرنے کے بارے میں کیا خیال ہے جیسے آپ خواب کی حالت میں ہیں، حالانکہ آپ جاگ رہے ہیں؟ ایسا محسوس کرنا جیسے آپ کے بارے میں کوئی چیز حقیقی نہیں ہے؟ ایسا محسوس کرنا جیسے وقت زیادہ آہستہ سے آگے بڑھ رہا ہے؟)	
Tell me more about that.	
مجھے اس کے بارے میں مزید بتائیں۔	
How strong is this feeling? (Do you lose track of where you actually are or what's actually going on?)	
یہ احساس کتنا مضبوط ہے؟ (کیا آپ اس ہوش کو کھو دیتے ہیں کہ آپ اصل میں کہاں ہیں یا اصل میں کیا ہو رہا ہے؟)	
What do you do while this is happening? (Do other people notice your behavior? What do they say?)	

جب یہ ہو رہا ہوتا ہے تو آپ کیا کرتے ہیں؟ (کیا دوسرے لوگ آپ کے رویے کو دیکھتے/کا مشائدہ کرتے ہیں؟ وہ کیا کہتے ہیں؟)
How long does it last?
یہ کتنے عرصے کے لیے چلتا ہے؟ /کتنی دیر کے لیے ہوتا ہے.
Circle: Dissociation = *Minimal_ Clearly Present__ Pronounced__Extreme_*
د ائرہ لگائیں: علیحدگی= کم سے کم ____ واضح طور پر موجود _____ نُمایاں ____ انتہائی____
[If not clear:] (Was this due to the effects of alcohol or drugs? What about a medical condition like seizures?) [Rate 0=Absent if due to the effects of a substance or another medical condition]
[اگر واضح نہ ہو:] (کیا یہ شراب یا منشیات کے اثرات کی وجہ سے تھا؟ دوروں جیسی طبی حالت کے بارے میں کیا خیال ہے؟) [درجہ بندی 0 = غیر حاضر، اگر کسی نشہ یا کسی اور طبی حالت کے اثرات کی وجہ سے]
How often has this happened in the [past month / worst month]? Number of times ___________
یہ [پچھلے مہینے / بدترین مہینے] میں کتنی بار ہوا ہے؟ اوقات کی تعداد ________
Did this feeling start or get worse after (EVENT)?)? (Do you think they're related to (EVENT)? How so?) Circle: Trauma-relatedness = Definite Probable Unlikely
د ائرہ لگائیں: حادثے سے متعلق= واضح طور پر، ممکنہ طور پر، غالبًا ،ناممکن

Did this feeling start or get worse after (EVENT)? (Do you think they're related to (EVENT)? How so?) Circle: Trauma-relatedness = Definite Probable Unlikely
کیا یہ احساس (واقعہ) کے بعد شروع ہوا یا بدتر ہو گیا؟ (کیا آپ کو لگتا ہے کہ ان عقائد کا تعلق (واقعہ) سے ہے؟ ایسا کیسے؟) د ائرہ لگائیں: حادثے سے متعلق= واضح طور پر، ممکنہ طور پر، غالبًا ،ناممکن

<table>
<tr><td colspan="2">Item 30 (2): Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).</td></tr>
<tr><td colspan="2">آئٹم 30 (2):
حَقیقَت کے بَرخَلاف احساس/ غیرحقیقی خیالی احساس:ماحول/اردگرد کے غیرحقیقی ہونے کا مسلسل یا بار بارتجربہ (فرد کے ارد گرد کی دنیا کو غیر حقیقی، خواب جیسا، دور، یا مسخ شدہ محسوس کیا جاتا ہے)۔</td></tr>
<tr><td>In the [past month / worst month], have there been times when things going on around you seemed unreal or very strange and unfamiliar?</td><td>0 Absent
1 Mild / subthreshold
2 Moderate / threshold
3 Severe / markedly elevated
4 Extreme / incapacitating
Past Month _______________
Worst Month ______________</td></tr>
<tr><td>[پچھلے مہینے / بدترین مہینے] میں، کیا ایسا وقت آیا ہے جب آپ کے ارد گرد ہونے والی چیزیں غیر حقیقی یا بہت عجیب اور ناواقف لگیں تھیں؟</td><td>0 موجود نہیں
1 ہلکا / درمیانی
2 معتدل / درمیانی حد
3 شدید / واضح طور پر زیادہ
4 انتہائی / نا کا رہ کر دینے والی
پچھلا مہینہ _______
بدترین مہینہ_______</td></tr>
<tr><td colspan="2">[If no:] (Do things going on around you seem like a dream or like a scene from a movie? Do they seem distant or distorted?)</td></tr>
<tr><td colspan="2">[اگر نہیں:] کیا آپ کے ارد گرد جو چیزیں ہو رہی ہیں وہ ایک خواب کی طرح لگتی ہیں یا فلم کے کسی منظر کی طرح؟ کیا وہ دور نظر آتے ہیں یا مسخ شدہ؟</td></tr>
<tr><td colspan="2">Tell me more about that.</td></tr>
<tr><td colspan="2">مجھے اس کے بارے میں مزید بتائیں۔</td></tr>
<tr><td colspan="2">How strong is this feeling? (Do you lose track of where you actually are or what's actually going on?)</td></tr>
</table>

یہ احساس کتنا مضبوط ہے؟ (کیا آپ اس ہوش کو کھو دیتے ہیں کہ آپ اصل میں کہاں ہیں یا اصل میں کیا ہو رہا ہے؟)
What do you do while this is happening? (Do other people notice your behavior? What do they say?)
جب یہ ہو رہا ہوتا ہے تو آپ کیا کرتے ہیں؟ (کیا دوسرے لوگ آپ کے رویے کو دیکھتے/کا مشائدہ کرتے ہیں؟ وہ کیا کہتے ہیں؟)
How long does it last?
یہ کتنے عرصے کے لیے چلتا ہے؟ /کتنی دیر کے لیے ہوتا ہے.
Circle: Dissociation = *Minimal_ Clearly Present__ Pronounced__Extreme_*
د ائرہ لگائیں: علیحدگی= کم سے کم ____ واضح طور پر موجود ____ نُمایاں ____ انتہائی____
[If not clear:] (Was this due to the effects of alcohol or drugs? What about a medical condition like seizures?) [Rate 0=Absent if due to the effects of a substance or another medical condition]
[اگر واضح نہ ہو:] (کیا یہ شراب یا منشیات کے اثرات کی وجہ سے تھا؟ دوروں جیسی طبی حالت کے بارے میں کیا خیال ہے؟) [درجہ بندی 0 = غیر حاضر، اگر کسی نشہ یا کسی اور طبی حالت کے اثرات کی وجہ سے]
How often has this happened in the [past month / worst month]? Number of times ___________
یہ [پچھلے مہینے / بدترین مہینے] میں کتنی بار ہوا ہے؟ اوقات کی تعداد ________
Did this feeling start or get worse after (EVENT)?)? (Do you think they're related to (EVENT)? How so?) Circle: Trauma-relatedness = Definite Probable Unlikely
د ائرہ لگائیں: حادثے سے متعلق= واضح طور پر، ممکنہ طور پر، غالبًا ،ناممکن

APPENDIX B2

Hamilton Depression Rating Scale

ہیملٹن پَیْمانَۂ دَرجہ بَندی برائے ذہنی دباؤ

Commentary

The Hamilton Depression Rating Scale is the most widely used clinician-administered depression assessment scale. The original version of the scale contains 17 items pertaining to the assessment of symptoms of depression experienced over the past week.

تبصرہ

ہیملٹن کا پَیْمانَۂ دَرجہ بَندی برائے ذہنی دباؤ سب سے زیادہ استعمال ہونے والا معالج کے زیر انتظام ذہنی دباؤ کی تشخیص کا پیمانہ ہے. اس پیمانے کے اصل صورت میں 17 مد شامل ہیں جو گزشتہ ہفتے کے دوران ذہنی دباؤ کی علامات کی تشخیص سے متعلق ہیں۔

PLEASE COMPLETE THE SCALE BASED ON A STRUCTURED INTERVIEW

براہ کرم ایک منظم مُذاکرہ کے ذریعے پیمانہ کو مکمل کریں

Instructions: for each item select the one "cue" which best characterizes the patient. Be sure to record the answers in the appropriate spaces (positions 0 through 4).

ہدایات: ہر مد کے لیے ایک "اشارہ" کا انتخاب کریں، جو مریض کی علامات کو بہترین انداز میں بیان کرے. مناسب جگہوں (0 سے 4) یا (0 سے 2) میں جوابات کو قلم بند کرنا یقینی بنائیں۔

Anwar Khan
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1. DEPRESSED MOOD ***(sadness, hopeless, helpless, worthless)***
0- Absent.
1- These feeling states indicated only on questioning.
2- These feeling states spontaneously reported verbally.
3- Communicate feeling stated non-verbally, i.e., through facial expression, posture, voice and tendency to weep.
4- Patient reports virtual only these feeling states in his/her spontaneous verbal and non-verbal communication.

1-**افسردہ مزاج** (اداسی، ناامید، لاچار، بے وقعت)
0- موجود نہیں ہے -
1- یہ احساس کی کیفیتیں صرف سوال کرنے پر ظاہر ہوتے ہیں۔
2- یہ احساس خود بخود زبانی طور پر بیان ہوتا ہے.
3- بغیر کہے محسوسات بیان کیے، یعنی چہرے کے تاثرات، جسم کی حالت، آواز اور رونے کے رجحان کے ذریعے۔
4- مریض بے ساختہ اپنی علامات زبانی اور جسمانی حالت کے ذریعے بیان کرتا ہے.

2. FEELINGS OF GUILT
0- Absent.
1- Self-reproach, feels he/she has let people down.
2- Ideas of guilt or rumination over past errors or sinful deeds.
3- Present illness is a punishment. Delusions of guilt.
4 - Hears accusatory or denunciatory voices and/or experiencing threatening visual hallucinations.

.2 احساس جرم.
0- موجود نہیں ہے۔
1- خود کو ملامت کرنا/خود کو کوسنا، محسوس کرنا کہ لوگوں کو مایوس کیا ہے۔
2- ماضی کی غلطیوں یا گناہوں پر احساس جرم یا سوچ بچار.
3- موجودہ بیماری عذاب ہے۔ جرم کا وہم۔
4 - مذمتی اورالزام آمیز آوازیں سننا یا خطرناک بصری فریب کا تجربہ کرنا.

3. SUICIDE
0- Absent.
1- Feels life is not worth living.
2- Wishes he/she were dead or any thoughts of possible death to self.
3- Ideas or gestures of suicide.
4- Attempts at suicide (any serious attempt rate 4).

3. خودکشی-
0- موجود نہیں ہے-
1- محسوس ہونا کہ زندگی جینے کے قابل نہیں ہے-
2- مرنے کی خواہش یا اپنی ممکنہ موت کے بارے میں خیال-
3- خودکشی کے خیالات یا حرکات/کوششیش -
4- خودکشی کی کوششیں (کوئی بھی سنگین کوشش کی درجہ بندی 4 پر کریں).

4. INSOMNIA: EARLY IN THE NIGHT
0-No difficulty falling asleep.
1-Complains of occasional difficulty falling asleep, i.e., more than 1⁄2 hour.
2-Complains of nightly difficulty falling asleep.

4. بے خوابی/نیند کا نہ آنا: رات کے اوائل میں
0-سوجانے میں کوئی دشواری نہیں ہے-
1-سوجانے میں کبھی کبھار دشواری کی شکایت، یعنی آدھے گھنٹے سے زیادہ-
2-رات کو سونے/نیند میں دشواری کی شکایت-

5. INSOMNIA: MIDDLE OF THE NIGHT
0-No difficulty.
1-Patient complains of being restless and disturbed during the night.
2- Waking during the night – any getting out of bed rates 2 (except for purposes of voiding).

5. بے خوابی: رات کے درمیانی حصہ میں نیند نہ آنا.
0-نیند آنے میں کوئی مشکل نہیں.
1-مریض رات کے وقت بے چین اور پریشان رہنے کی شکایت کرتا ہے-
2- رات کے وقت جاگ جانا - بار ہا بستر سے باہر نکلنے کی درجہ بندی 2 پر کریں). (سوائے رَفَعِ حاجَت کے)-

6. INSOMNIA: EARLY HOURS OF THE MORNING
0-No difficulty.
1- Waking in early hours of the morning but goes back to sleep.
2- Unable to fall asleep again if he/she gets out of bed.

6. بے خوابی: صبح کے ابتدائی اوقات میں نیند نہ آنا.
0-نیند آنے میں کوئی مشکل نہیں.
1- صبح کے اوائل میں جاگنا لیکن دوبارہ سو جانا۔
2- بستر سے اٹھنے کی صورت میں دوبارہ نیند نہ آنا.

7. WORK AND ACTIVITIES
0-No difficulty.
1-Thoughts and feelings of incapacity, fatigue or weakness related to activities, work or hobbies.
2- Loss of interest in activity, hobbies or work – either directly reported by the patient or indirect in listlessness, indecision and vacillation (feels he/she has to push self to work or activities).
3-Decrease in actual time spent in activities or decrease in productivity. Rate 3 if the patient does not spend at least three hours a day in activities (job or hobbies) excluding routine chores.
4- Stopped working because of present illness. Rate 4 if patient engages in no activities except routine chores, or if patient fails to perform routine chores unassisted.

7. کام اور دیگر سرگرمیاں.
0-کام اور دیگر سرگرمیوں میں کوئی مشکل نہیں۔
1- سرگرمیوں، کام یا مشاغل سے متعلق معذوری، تھکاوٹ یا کمزوری کے خیالات اوراحساسات۔
2- سرگرمی، مشاغل یا کام میں دلچسپی کا فقدان۔ یا تو مریض کی طرف سے براہ راست یا بلاواسطہ بے حسی، بے فیصلہ کن پن اور تذبذب کی اطلاع دی جاتی ہے (ایسا محسوس ہوتا ہے کہ اسے خود کو کام یا سرگرمیوں کی طرف دھکیلنا پڑے گا)۔
3- سرگرمیوں میں گزارے گئے حقیقی وقت میں کمی یا پیداواری صلاحیت میں کمی۔ درجہ بندی 3 پر کریں اگر مریض روزانہ کم از کم تین گھنٹے سرگرمیوں (نوکری یا مشاغل) میں نہ گُزارے. معمول کے کاموں کو چھوڑ کر گزارتا ہے۔معمول کے کاموں کو چھوڑ کر۔
4- موجودہ بیماری کی وجہ سے کام کرنا چھوڑ دیا۔ درجہ بندی 4 پر کریں اگر مریض معمول کے کاموں کے علاوہ کسی سرگرمی میں مشغول نہیں ہوتا ہے، یا اگر مریض بغیر مدد کے معمول کے کام انجام دینے میں قاصر رہتا ہے۔

8. RETARDATION (slowness of thought and speech, impaired ability to concentrate, decreased motor activity)
0-Normal speech and thought.
1-Slight retardation during the interview.
2-Obvious retardation during the interview.
3-Interview difficult.
4-Complete stupor.

8. پسماندگی/سُست رَوی (سوچ اور گفتگو کرنے میں سستی، توجہ مرکوز کرنے کی صلاحیت میں کمی، حرکات و سکنات میں کمی).
0- معمول کےمطابق گفتگو اور سوچ۔
1-مذاکرے کے دوران ہلکی سی سُست رَوی۔
2-مذاکرے کے دوران واضح پسماندگی/ سُست رَوی۔
3- مذاکرہ کرنا مشکل ہو۔
4-مکمل بے حسی/مکمل سکتے کی حالت۔

9. AGITATION
0- None.
1- Fidgetiness.
2- Playing with hands, hair, etc.
3- Moving about, can't sit still.
4- Hand wringing, nail biting, hair-pulling, biting of lips.

9. بے چینی/ اضطراب.
0- موجود نہیں۔
1- بے چینی/ بے قراری
2- ہاتھوں، بالوں وغیرہ سے کھیلنا۔
3- گھومنا پھرنا/چلنا پھرنا، ٹِک کر نہ بیٹھ سکنا.
4- ہاتھ کا مروڑنا، ناخن کاٹنا، بال کھینچنا، ہونٹ کاٹنا۔

10. ANXIETY PSYCHIC.
0- No difficulty.
1- Subjective tension and irritability.
2- Worrying about minor matters.
3- Apprehensive attitude apparent in face or speech.
4- Fears expressed without questioning.

10. نفسیاتی بے چینی
0- کوئی مشکل نہیں۔
1- موضوعی تناؤ اور چڑ چڑا پن۔
2- معمولی باتوں کی فکر کرنا۔
3- خوفناک رویہ چہرے یا گفتگو سے ظاہرہونا.
4- بغیر پوچھے خوف کا اظہار۔

11. ANXIETY SOMATIC (physiological concomitants of anxiety) such as: gastro-intestinal, dry mouth, wind, indigestion, diarrhea, cramps, belching cardio-vascular-palpitations, headaches, respiratory hyperventilation, sighing urinary frequency, sweating.

0- Absent.
1- Mild.
2- Moderate.
3- Severe.
4- Incapacitating.

11. جسمانی بے چینی/پرشانی (جسم کے ساتھ مشترک ا ضطراب/ا ضطراب کی جسمانی علامات) جیسے کہ: معدی اِمعائی، منہ کی خشکی، پیٹ میں گیس، بد ہضمی، اسہال، پیٹ میں درد او مروڑ، ڈکارنا، دل کی دھڑکن تیز ہونا، سر میں درد سانس کا تیز ہونا، پیشاب کا بار بار آنا، پسینہ آنا.
0- موجود نہیں ہے۔
1- ہلکی نوعیت کا.
2- معتدل نوعیت کا.۔
3- شدید نوعیت کا.
4- نااہل/ ناکارہ بنا نے کی حد تک.

12. SOMATIC SYMPTOMS GASTRO-INTESTINAL.

0- None.
1- Loss of appetite but eating without staff encouragement. Heavy feelings in abdomen.
2- Difficulty eating without staff urging. Requests or requires laxatives or medication for bowels or medication for gastro-intestinal symptoms.

12. جسمانی علامات معدہ او آنت -
0- کوئی نہیں۔
1- بھوک کا نہ لگنا لیکن کسی کی حوصلہ افزائی کے بغیر کھانا کھا لینا ۔ پیٹ میں بھاری پن یا بدہضمی کے احساسات۔
2- کسی کی درخواست/تاکید کے بغیرکھانا کھانے میں دشواری۔ جلاب آور دوا کی ضرورت ہونا، یا معدے او آنت کی علامات کے لیے دوا کی ضرورت ہونا.

13.GENERAL SOMATIC SYMPTOMS
0-None.
1-Heaviness in limbs, back or head. Back aches, headaches, muscle aches. Loss of energy and fatigability.
2-Any clear-cut symptom rates 2.

13. عمومی جسمانی علامات
0-موجود نہیں ہے۔
1-اعضاء، کمر یا سر میں بھاری پن، کمر میں درد، سر درد، پٹھوں میں درد، توانائی کی کمی اور تھکاوٹ ۔
2-کسی بھی واضح علامات کی درجہ بندی 2 پر کریں۔

14. GENITAL SYMPTOMS (symptoms such as loss of libido, menstrual disturbances)
0-Absent.
1-Mild.
2-Severe.

14. توالدو تناسل کی علامات/جنسی علامات (علامات جیسےکہ جنسی خواہش کی کمی، ماہواری میں خلل/مسائل)
0-موجود نہیں ہے۔
1- معتدل نوعیت کا.
2- شدید نوعیت کا.

15.HYPOCHONDRIASIS
0-Not present.
1-Self-absorption (bodily).
2-Preoccupation with health.
3-Frequent complaints, requests for help, etc.
4-Hypochondriacal delusions.

15. **صحت کے بارے میں خبط/وہم.**
0-موجود نہیں ہے۔
1-آپنے آپ میں مگن ہونا (جسمانی)۔
2-صحت کےبارے میں سوچنا/استغراق۔
3-بار بار شکایات کرنا، دوسروں سے مدد کی درخواستیں کرنا، وغیرہ۔
4-یہ وہم ہونا کہ مجھے بیماری لاحق ہے.

16.LOSS OF WEIGHT (RATE EITHER a OR b)

a) According to the patient	b) According to weekly measurements
0-No weight loss.	0-Less than 1 lb weight loss in week.
1- Probable weight loss associated with present illness.	1-Greater than 1Ib weight loss in week.
2- Definite (according to patient) weight loss.	2-Greater than 2Ib weight loss in week.
3- Not assessed	3- Not assessed

16. وزن میں کمی (اے یا بی پر درجہ بندی کریں)-

اے) مریض کے مطابق	بی) ہفتہ وار پیمائش کے مطابق
0- وزن میں کمی نہیں ہوئی۔	0- ہفتے میں 1 پونڈ سے کم وزن میں کمی۔
1- موجودہ بیماری سے وابستہ ممکنہ وزن میں کمی ہوئی ہے۔	1- ہفتے میں 1 پونڈ سے زیادہ وزن میں کمی۔
2- قطعی وزن میں کمی ہوئی ہے(مریض کے مطابق)۔	2- ہفتے میں 2 پونڈ سے زیادہ وزن میں کمی۔
3- اندازہ نہیں کیا گیا۔/پیمائیش نہیں کی گی۔	3- - اندازہ نہیں کیا گیا۔/پیمائیش نہیں کی گی۔

17.INSIGHT

0-Acknowledges being depressed and ill.
1-Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
2-Denies being ill at all.

17. بصیرت/ خود آگاہی۔

0- اُداس اور بیمار ہونے کا اعتراف۔
1-بیماری کو تسلیم کرتا ہے لیکن اس کی وجوہات بیان کرتا ہے جیسا کہ خراب خوراک، آب و ہوا، زیادہ کام، وائرس، آرام کی ضرورت ،وغیرہ۔
2- بالکل بیمار ہونے سے انکار۔

APPENDIX B3

State-Trait Anxiety Inventory for Adults

Please provide the following information

براہ کرم مندرجہ ذیل معلومات فراہم کریں۔

نام _______________ عم _______________ صنف _______________
ر

Nam _______________ Ag _______________ Gende _______________
e e r

DIRECTIONS

A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to the right of the statement to indicate how you feel *right* now, that is, *at this moment*. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

ہدایات

متعدد بیانات، جنہیں لوگوں نے اپنے آپ کو بیان کرنے کے لیے استعمال کیا ہے، وہ ذیل میں دیے گئے ہیں۔ ہر بیان کو پڑھیں اور پھر بیان کے دائیں جانب مناسب نمبر پر دائرہ لگائیں یہ بتانے کے لیے کہ آپ اس وقت، یعنی اس وقت کیسا محسوس کر رہے ہیں۔ کوئی صحیح یا غلط جواب نہیں ہیں۔ کسی ایک بیان پر زیادہ وقت نہ لگائیں بلکہ وہ جواب دیں جو آپ کے موجودہ احساسات کو بہترین انداز میں بیان کرتا ہو۔

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Not At All=1 Somewhat=2 Moderately So=3 Very Much So=4

1= بالکل نہیں 2=کسی حد تک 3= مناسب حد تک 4= بہت زیادہ

4	3	2	1	
				1. I feel calm.
				١- میں پرسکون محسوس کرتا ہوں۔
				2. I feel secure.
				٢-میں خود کو محفوظ محسوس کرتا ہوں۔
				3. I am tense.
				٣-میں تناؤ کا شکار ہوں۔
				4. I feel strained.
				۴-میں دباؤ محسوس کرتا ہوں-
				5. I feel at ease.
				۵-میں آرام او سکون محسوس کرتا ہوں۔
				6. I feel upset.
				٦- میں پریشان/بےقرار محسوس کرتا ہوں۔
				7. I am presently worrying over possible misfortunes.
				٧-میں فی الحال ممکنہ بدقسمتی سے پریشان ہوں۔
				8. I feel satisfied.
				٨-میں خود کو مطمئن محسوس کرتا ہوں۔
				9. I feel frightened.
				٩- میں خوفزدہ محسوس کرتا ہوں۔
				10. I feel comfortable.
				١٠- میں خود کو آرام دہ محسوس کرتا ہوں۔
				11. I feel self-confident.
				١١- میں خود اعتمادی محسوس کرتا ہوں۔
				12. I feel nervous.
				١٢- مجھے گھبراہٹ محسوس ہوتی ہے۔
				13. I am jittery.
				١٣- میں پریشان ہوں
				14. I feel indecisive.
				١٤- میں غیر فیصلہ کن کیفیت کا شکار ہوں-
				15. I am relaxed.
				١٥- میں پر سکون ہوں۔
				16. I feel content.

				۱۶- میں اطمینان محسوس کرتا ہوں۔
				17. I am worried.
				۱۷-میں پریشان ہوں۔
				18. I feel confused.
				۱۸- مجھے الجھن محسوس ہوتی ہے۔
				19. I feel steady.
				۱۹- میں خود کو مستحکم محسوس کرتا ہوں۔
				20. I feel pleasant
				۲۰- مجھے خوشگوار محسوس ہوتا ہے۔
				21. I feel nervous and restless.
				۲۱- مجھے گھبراہٹ اور بےچینی محسوس ہوتی ہے۔
				22. I feel satisfied with myself.
				۲۲- میں اپنے آپ سے مطمئن محسوس کرتا ہوں۔
				23. I wish I could be as happy as others seem to be.
				۲۳- کاش میں اتنا ہی خوش رہ سکتا جیسا کہ دوسرے نظر آتے ہیں۔
				24. I feel like a failure.
				۳٤. مجھے ایک ناکامی محسوس کرتا ہوں۔
				25. I feel rested.
				۲۵- میں آرام محسوس کرتا ہوں۔
				26. I am "calm, cool, and collected".
				۲۶- میں پرسکون ہوں ، مرتب ہوں ، اور خود کفیل ہوں-
				27. I feel that difficulties are piling up so that I cannot overcome them.
				۲۷- مجھے لگتا ہے کہ مشکلات اتنی بڑھ رہی ہیں کہ میں ان پر قابو نہیں پا سکتا۔
				28. I worry too much over something that really doesn't matter
				۲۸- میں کسی ایسی چیز پر بہت زیادہ فکر مند ہوں جس سے واقعی کوئی فرق نہیں پڑتا۔
				29. I am happy.
				۲۹- میں خوش ہوں۔
				30. I have disturbing thoughts.
				۳۰- میرے ذہن میں پریشان کن خیالات ہیں۔

				31. I lack self-confidence.
				۳۱- مجھ میں خود اعتمادی کی کمی ہے۔
				32. I feel secure.
				۳۳-میں محفوظ محسوس کرتا ہوں۔
				33. I make decisions easily.
				۳٤- میں آسانی سے فیصلے کرتا ہوں۔
				34. I feel inadequate.
				۳٤. میں ناکافی محسوس کرتا ہوں۔
				35. I am content.
				۳۵. میں مطمئن ہوں-
				36. Some unimportant thought runs through my mind and bothers me.
				۳٦. کچھ غیر اہم خیال میرےذھن میں گھومتے ہیں اور مجھے پریشان کرتے ہیں۔
				37. I take disappointments so keenly that I can’t put them out of my mind.
				۳۷. میں مایوسیوں کو اتنی شدت سے دل پہ لیتا ہوں کہ میں انہیں اپنے ذہن سے نہیں نکال سکتا۔
				38. I am a steady person.
				۳۸. میں ایک مستحکم اومضبوط شخص ہوں۔
				39. I get in a state of tension or turmoil as I think over my recent concerns and interests
				۳۹. جب میں اپنے حالیہ خدشات اور مفادات کے بارے میں سوچتا ہوں تو میں تناؤ یا افراتفری کی حالت میں ہو جاتا ہوں۔
				40. I feel pleasant
				٤٠. مجھے خوشگوار محسوس ہوتا ہے۔

APPENDIX C

CULTURALLY ADAPTED TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY FOR PAKISTANI POPULATION

1. INTRODUCTION

The initial Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) protocol consists of ten steps. For further information, refer to Cohen, Mannarino, Kliethermes, & Murray (2012) and Kangas, Milross, & Bryant (2014). This section outlines the proposed modifications to the current TF-CBT protocol.

2. ADAPTATIONS IN STEPS OF TF-CBT

The following adaptation have been made in different steps of TF-CBT:

2.1 Assessment

Assessment stands as one of the pivotal steps in the therapeutic process. A thorough assessment empowers the therapist to grasp the intricacies and manifestations of the patient's symptoms. With a precise understanding of the symptomology, the therapist can then tailor the treatment course effectively. Assessment should be conducted through the following methods:

2.1.1 Use Translated and Culturally Adapted Diagnostic Tools

Self-reported assessment scales can be misleading because patients may not fully comprehend the terminologies used in the statements. Therefore, therapists are encouraged to utilize diagnostic tools that incorporate both qualitative and quantitative components, administered with therapist assistance. An example of

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such a diagnostic tool for PTSD is the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5). However, since the original version of CAPS-5 is in English, it should undergo proper translation into Urdu. In the current study, CAPS-5 was translated into Urdu and effectively utilized for assessing PTSD symptoms among the designated patients.

2.1.2 Explore Knowledge, Attitude and Beliefs about Mental Illnesses

Understanding a patient's knowledge, attitude, and beliefs regarding mental illnesses is crucial. In Pakistani society, there is often a lack of awareness about mental illnesses, leading to the development of negative attitudes and beliefs. Many individuals attribute mental illnesses to supernatural forces such as ghosts or the evil eye (Khan & Anwar, 2018; Shah, Khalily, Ahmad, & Hallahan, 2019). Assessing a patient's knowledge, attitude, and beliefs about mental illnesses is essential for identifying cases where treatment resistance may be rooted in myths and stereotypes.

2.1.3 Examine Knowledge, Attitude and Beliefs about Treatment

In Pakistan, there is a scarcity of mental health treatment facilities, leading people to seek assistance from faith healers and Hakeems (providers of herbal medicine). Additionally, there is a strong belief in the religious and spiritual abilities of local Peers and religious scholars. Assessing a patient's knowledge, attitude, and beliefs about mental illnesses and treatment can aid therapists in understanding the patient's expectations and level of compliance with the proposed treatment.

2.1.4 Find Family Involvement Level

In Pakistan, a collectivist society with joint family systems prevails, allowing family members to significantly influence one another in daily affairs. It's imperative for therapists to gauge the level of family involvement and engagement in the treatment process. Recognizing negative family involvement or reluctance toward treatment enables therapists to take appropriate preventive measures.

2.2 Engagement

Following a thorough assessment, the therapist can determine the modalities of engagement. Effective patient engagement is crucial as it fosters the development of a robust therapeutic alliance between the patient and therapist.

2.2.1 Style of Treatment

In Pakistan, therapists are often regarded as spiritual healers, and there is considerable respect for doctors and health professionals. Patients typically anticipate a collaborative approach to treatment from therapists, preferring a more paternalistic style. It's common for patients to bring gifts and souvenirs for therapists as a gesture of appreciation. Consequently, therapists should strive to adopt a collaborative style of therapy to align with patients' expectations and cultural norms.

2.2.2 Show Openness

In Pakistan, patients tend to exhibit less openness towards therapists, largely due to prevailing stereotypes and dysfunctional beliefs surrounding mental health. Consequently, they may communicate less and attempt to conceal their symptoms during therapy sessions. Thus, therapists must adopt an approach that emphasizes

openness and warmth, particularly by attuning to the non-verbal cues provided by patients. Additionally, it's common for individuals in Pakistan to utilize locally crafted idioms and expressions. Hence, therapists should be well-versed in these colloquialisms, as they may serve as vehicles for patients to articulate their emotions or symptoms.

2.2.3 Use of Religious Quotes and Folk Stories

In Pakistan, there is a strong affinity for culture and religion among the populace. It's common for people to participate in various religious and cultural gatherings, where local faith healers, peers, and religious scholars often reference quotes from the Quran (the Holy Book) and draw upon characters from folk stories. Interestingly, patients often anticipate similar practices from therapists during their treatment. There's a prevailing belief that therapists with a more religious appearance, such as sporting a beard, possess greater competence in addressing mental health issues. Hence, therapists are encouraged to incorporate religious quotes and anecdotes from folk stories into their treatment approach, aligning with patient expectations and cultural norms.

2.2.4 Make Structural Changes in Psychotherapy

If necessary, therapists have the flexibility to make structural adjustments to psychotherapy, such as altering the duration or frequency of sessions. This flexibility is crucial as patients in Pakistan often adhere to a preference for quicker solutions. Additionally, there's a common belief among patients that psychotherapists, akin to medical doctors, have the authority to prescribe medication, which is perceived as a means to rapidly alleviate symptoms. Therefore, therapists may need to address these expectations and considerations

when designing treatment plans, ensuring alignment with patient beliefs while adhering to ethical and professional standards.

2.2.5 Be-careful about Language Barrier

Patients may encounter difficulty comprehending complex terminologies, and certain words or terms associated with their mental illness may evoke sensitivity. Consequently, it is imperative for therapists to employ culturally appropriate and locally understandable language. For example, Irfan, (2016) has advocated for the utilization of various locally comprehensible terminologies during treatment, as delineated in Table **1**.

Table 01 Examples of Locally Understandable Terminologies

English and Original Versions	Local Versions
Cognitive Behavioral Therapy	**صدمے پر مرکوز شعوری کرداری معالجہ کا ضابطہ کار** (Therapy to correct thoughts/cognitions and behavior)
Cognitive Errors	شعوری/سوچ کی خرابیاں (Errors of thoughts/thinking)
Negative Thinking	غلط/منفی سوچ (Wrong/negative thinking)
Fight or Flight	جنگ/مقابلہ کرنا یا پرواز/بھاگ جانا کا ردعمل (The fight or flee response)
Passive	جامد/ غیر متحرک (Cold devil)
Black and white thinking	سب یا کچھ نہیں سوچنا/محدود سوچ (Limited thinking/ all or nothing thinking)
Aggressive	جارحانہ/لڑنے والا (Ready to fight)

2.3 Psychoeducation

Psychoeducation entails educating patients about the nature and origins of mental health issues, as well as informing them about available treatment options. Through psychoeducation, patients can enhance their understanding and awareness of mental illnesses and corresponding treatments. Therapists must exercise caution and consideration regarding several factors when providing psychoeducation:

2.3.1 Culture and Religion

In Pakistan, where culture and religion hold significant sway, therapists must refrain from discussing topics that contradict local cultural and religious norms. For instance, therapists should avoid referencing foods like pork, which are prohibited in Islam, and refrain from suggesting actions that are culturally inappropriate, such as asking female patients to uncover their faces. However, therapists can effectively utilize religious quotes and folk stories during treatment, as these elements have profound motivational effects on the overall therapeutic process. For example, verses from the Quran and Sahih al-Bukhari can be employed to educate and inspire patients regarding their treatment journey:

a) Prophet Muhammad stated, "There is no disease that Allah has created, except that He also has created its treatment." (Sahih al-Bukhari, Volume 7, Book 71, Number 582).
b) Allah states in the Quran, "And if Allah touches you with harm, none can remove it but He, and if He touches you with good, then He is Able to do all things" (Surah Al-AnAam, 6:17).
c) Allah also says in the Quran, "And when I am ill, it is He (Allah) who heals me" (Surah Ash-Shu'ara' 26:80).

2.3.2 Language

In Pakistan, while many educated individuals may comprehend English, the general populace often feels more at ease communicating in Urdu or local languages. Therefore, therapists should endeavor to deliver psychoeducation in the local language. Moreover, they should strive to translate complex terminologies into the local language to facilitate better understanding among patients. Below are examples of some psychiatry terminologies translated into the local language, as depicted in Table **2**.

Table 2 Examples of Locally Comprehensible Terminologies

English and Original Terms	**Translated into Local Languages**	
	Pushto	**Urdu**
Depression	خپګان (Sadness)	ذہنی دباؤ (Mentally Depressed)
Bereavement	ماتم کول (To do mourning)	سوگ/ماتم کرنا (To mourn)
Intrusive Distressing Memories	مداخله کوونکی غمجن یادونه (Intruding sad memories)	خیال انداز/دخل انداز پریشان کن یادیں (Obsessive/intrusive disturbing memories)
Insomnia	بې خوبی (Sleeplessness)	بے خوابی (Cannot Sleep)
Derealization	حقیقت سره په ټکر کې خیال (Thinking that is in contradiction to reality)	حقیقت کے برعکس خیال (Thinking as opposed to reality)
Depersonalization	د شخصیت نشتوالی/ د خپل ځان پورې اړه نلري (Lack of personality/ Personality does not belong to itself)	عدِم شخصیت (Not to belong to oneself)

2.3.3 Involvement of Family and Peers

In Pakistan, patients often seek information, advice, and guidance from a diverse array of sources, including family members, peers, and individuals within their social circles. Consequently, it is essential for therapists to incorporate the patient's family and social network into the process of psychoeducation. This involvement is crucial because patients tend to heed and accept information, advice, and guidance received from these trusted sources. By engaging with the patient's family and social circle, therapists can effectively influence and mitigate dysfunctional behaviors, thereby fostering positive therapeutic outcomes.

2.3.4 Locally Available Literature

The therapist ought to retain several copies of locally published books, magazines, and other such literature, providing them to patients. This enables them to read and gain awareness regarding mental health conditions and treatment options. Locally accessible literature is typically published in native languages such as Urdu or Pashto, thus ensuring ease of comprehension for patients.

2.4 Affective Expression and Modulation

This step aims to facilitate patients in expressing their emotions and subsequently modulating negative emotions. Enhancements can be implemented to localize the process of Affective Expression and Modulation.

2.4.1 Using Local Vocabulary and Translated Scales

Patients should be assisted by guiding them to articulate their overall emotions and, more specifically, their emotional distress using locally familiar words and concepts. If the therapist intends to employ the Subjective Units of Distress Scale, it is advisable to utilize its translated and locally adaptable version. Please refer to

the Table 02 for a selection of locally employed words for expressing emotional states.

2.4.2 Identify Factors Affecting Expression or Modulation

Despite Pakistanis generally being sociable and extroverted, there exists a notable reticence in openly expressing personal or private feelings, particularly among females. In Pakistani culture, females and young individuals are often discouraged from openly discussing personal matters in the presence of elders. Additionally, there is a prevailing notion that expressing pain or distress is indicative of weakness, leading many to conceal their emotions. Therefore, therapists must exercise caution regarding these cultural factors that may inhibit patients from expressing their emotions freely.

2.5 Cognitive Coping

This step is designed to facilitate patients in acquiring various coping mechanisms and styles. Therapists can integrate the following cultural adaptations:

2.5.1 Use of Religion and Spirituality

As previously noted, individuals in Pakistan place significant importance on their religious and spiritual beliefs. Hence, therapists can recommend religious and spiritual coping techniques. The following coping techniques have been proposed by Achour, Bensaid, & Nor (2016):

a) Trust in Allah (God)- In the Holy Quran (Chapter 6:102 and 11:123) Allah says that all Muslims should place their unconditional trust on Allah in every matter, as Allah is the ultimate source of guidance and conform.

b) Performance of Prayer- All Muslims offer five times prayers every day. And Prayer (salat) can be the most helpful strategy to cope with stress.

c) Remembrance of Allah (God) (Zhikr)- For Muslims, remembrance of Allah (all forms of remembrance of Allah like for example, supplications and recitation of the Holy Quran) can really help in coping with life stress, anxiety, and other worries.

2.5.2 Use of Local Proverbs, Traditional Quotes and Folk Stories

In addition to religious and spiritual coping techniques, therapists can utilize local proverbs, traditional quotes, and folk stories as sources of reframing to motivate patients to shift from negative to positive thinking. Therapists can particularly cite examples of heroes or other well-known characters from stories to facilitate cognitive restructuring and inspire patients towards a better life.

2.6 Trauma Narrative

In this step, the therapist assists the patient in recognizing inaccurate trauma-related cognitions by encouraging them to confront their traumatic experiences. Furthermore, therapists help patients identify more accurate ways of thinking. Therapists can integrate the following cultural adaptations:

a) Incorporate locally available stories or vignettes to aid in identifying inaccurate trauma-related cognitions.

b) Address cultural barriers that may impede patients from acknowledging inaccurate trauma-related cognitions, such as conservative cultural beliefs surrounding sex or virginity, particularly concerning female patients.

2.7 Homework

The therapist should assign tasks to the patient that can be completed at home. Providing homework assignments will help keep patients engaged and maintain their connection with therapy. Given the lower level of mental health literacy among patients in Pakistan, they may not fully grasp the significance of homework, potentially resulting in noncompliance with assigned tasks. To address this, therapists should offer regular reminders and involve the patient's family. For individuals with strong religious inclinations, adherence to homework schedules can be facilitated by aligning them with prayer times or through regular calls.

2.8 Safety Enhancing

The therapist must develop a safety plan for the patient and impart safety skills for navigating potentially risky situations that may arise in the future. It's crucial for therapists to be particularly attentive to any cultural values or beliefs that could impede the effectiveness of safety planning, such as social norms that condone violence.

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CULTURALLY ADAPTED EYE MOVEMENT DESENSITIZATION AND REPROCESSING THERAPY FOR PAKISTANI POPULATION

INTRODUCTION

The foundational Eye Movement Desensitization and Reprocessing protocol consists of eight phases. For further elaboration, refer to the works authored by Shapiro (2001) and Leeds (2016) which delve into the protocols and procedures of therapy.

ADAPTATIONS IN STEPS OF EMDR FOR PTSD

Various adaptations have been implemented at different stages of Eye Movement Desensitization and Reprocessing for Post-Traumatic Stress Disorder.

History Taking, Case Conceptualization and Treatment Planning

During this phase, the therapist gathers comprehensive information regarding the symptoms reported by the patient. Additionally, they acquire details about the traumatic events the patient has experienced or witnessed.

Use Translated and Culturally Adapted Diagnostic Tools

Self-reported assessment scales may pose a risk of misunderstanding, as patients might struggle with the terminology within the statements. Hence, therapists are encouraged to utilize diagnostic tools that encompass both qualitative and quantitative sections, preferably administered with therapist assistance. An example of such a diagnostic tool for PTSD is the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5). However, given that the original version of CAPS-5 is in English, it is essential to ensure accurate translation into Urdu. In the present study, CAPS-5 was translated into Urdu and effectively employed for assessing PTSD symptoms among the selected patients.

Explore Knowledge, Attitude and Beliefs about Mental Illnesses

Understanding a patient's Knowledge, Attitude, and Beliefs regarding mental illnesses is crucial. In Pakistani society, there is often a lack of awareness about mental health, leading to the formation of negative attitudes and beliefs. Many individuals attribute mental illnesses to supernatural forces such as ghosts or the evil eye (Khan & Anwar, 2018; Shah, Khalily, Ahmad, & Hallahan, 2019). Assessing Knowledge, Attitude, and Beliefs can aid in identifying cases resistant to treatment due to myths and stereotypes.

Examine Knowledge, Attitude and Beliefs about Treatment

In Pakistan, the availability of mental health treatment facilities is comparatively limited. Consequently, individuals often seek assistance from faith healers and Hakeems (providers of herbal medicine). Additionally, there is a strong belief in the religious and spiritual abilities of local Peers and religious scholars. Evaluating a patient's Knowledge, Attitude, and Beliefs regarding mental illnesses and treatment can assist therapists in understanding the patient's expectations and level of compliance with treatment.

Explore Cultural and Religious Factors Affecting Treatment Plan

Several cultural and religious factors can significantly influence the overall treatment plan. It's essential for therapists to gather information about these factors and tailor the treatment plan accordingly. Here are some key considerations:

a) *Personal relationship with therapist:* Patients in Pakistan prefer a collaborative approach when interacting with therapists. It is common for patients to express appreciation through gifts, and they expect therapists to accommodate their schedules.

b) Family involvement: Given the prevalence of joint family systems in Pakistan, there is a strong interdependency among family members. Therapists should ensure proper involvement of family members in the treatment process.

c) *Social and religious activities:* Many individuals in Pakistan enjoy participating in various social and religious activities. Therapists should consider these preferences when scheduling treatment sessions. For instance, patients may wish to attend cultural events or weekly religious congregations, which may impact the treatment schedule.

d) *Culturally or religiously sensitive matters:* Pakistani culture and religion are deeply valued, and individuals are sensitive to practices that align with their beliefs. Therapists should avoid including activities in the treatment plan that conflict with local culture or religion. For example, scheduling treatment sessions during prayer (salat) times should be avoided.

By incorporating these considerations into the treatment plan, therapists can ensure cultural competence and enhance treatment outcomes for patients in Pakistan.

Preparation

EMDR is an extensively interactive therapeutic approach. In the Preparation phase, the therapist is tasked with providing psychoeducation to the patient. Subsequently, informed consent should be obtained, and a therapeutic alliance established between the therapist and the patient. The therapist is responsible for instructing the patient on various aspects of EMDR, such as the utilization of bilateral eye movements, the timing of Bilateral Stimulation, changes in movements, and the implementation of a Stop Signal, among other techniques. Throughout the

preparation stage, therapists need to exercise caution regarding the following factors:

Culture and Religion

In Pakistan, individuals maintain deep connections with their cultural and religious heritage. Therapists must refrain from discussing topics that contradict local cultural and religious norms. For instance, referencing foods like pork, which is prohibited in Islam, should be avoided. Similarly, actions that are culturally inappropriate, such as requesting female patients to reveal their faces or engage in physical contact, must be avoided.

Furthermore, therapists should employ culturally appropriate metaphors when explaining the EMDR model or process. Conversely, therapists can incorporate religious quotes and draw upon folk stories during treatment, as these elements often yield significant motivational effects on the overall treatment process. Therapists may also discuss healing rituals and other symbols pertinent to the patient's culture or religion. For instance, verses from the Quran and Sahih al-Bukhari can be utilized during treatment to educate and inspire patients regarding their therapeutic journey.

a) The Prophet said, "*There is no disease that Allah has created, except that He also has created its treatment."* (Sahih al-Bukhari, Volume 7, Book 71, Number 582).

b) Allah says in Quran, "*And if Allah touches you with harm, none can remove it but He, and if He touches you with good, then He is Able to do all things*" (Surah Al-AnAam, 6:17).

c) Allah says in Quran, "*And when I am ill, it is He (Allah) who heals me*" (Surah Ash-Shu'ara' 26:80).

Language

Although many educated individuals in Pakistan possess proficiency in the English language, the majority tend to feel more at ease communicating in Urdu or their local dialects. Therefore, therapists are encouraged to utilize the local language when explaining the concepts and theories of EMDR. They should endeavor to convey complex terminology by providing translations into the local language. Table **1** illustrates examples of certain psychiatry terms translated into the local dialect.

Table 1 Examples of Locally Comprehensible Terminologies

English and Original Terms	**Translated into Local Languages**	
	Pushto	**Urdu**
Trauma	دړدیدلې پرهار ژوبله (Traumatic injury) (Damage or harm)	صدمہ یا چوٹ (Trauma or Injury)
Eye Movements	د سترګو حرکت (Movements of Eye)	آنکھوں کی حرکت (Movements of Eye)
Rapid Eye Movement	د سترګو ګړندی حرکت د سترګو چټک حرکت (Fast movements of an eye) (Rapid eye movements)	آنکھ کی تیز حرکت (Fast movements of an eye)
Intrusive Distressing Memories	مداخله کوونکی غمجن یادونه (Intruding sad memories)	خیال انداز/دخل انداز پریشان کن یادیں (Obsessive/intrusive disturbing memories)
Insomnia	بې خوبئ (Sleeplessness)	بے خوابی (Cannot Sleep)
Desensitization	بې حسه کول (To Desensitize)	غیر حساسیت (De-sensitivity)
Reprocessing	بیرته حواس ته راوړو (Bring back to senses)	دوبارہ زیر حس لانا (Bring it back to sensing)

Locally Available Literature

Therapists are advised to maintain a supply of locally published books, magazines, and similar literature to distribute to patients. This enables patients to access information about mental health illnesses and treatment options. Since the locally available literature is published in native languages such as Urdu or Pashto, patients can readily comprehend the material.

Adapting EMDR Related Terminologies

During the preparation stage, therapists should adapt EMDR-related terminology to simpler, culturally appropriate terms for better understanding. Examples of such adaptations include:

a) Changing "safe place" to "happy or good place" since in Pakistan, safety is often associated with freedom from war and social violence due to ongoing terrorism and poverty.
b) When asking patients to imagine a "safe" place, therapists should provide culturally and religiously relevant examples, such as "family" or "heaven," considering the sensitivity of cultural and religious values in Pakistan.
c) In "Container Exercises," replacing "container" with terms like "basket," "pot," or "jar" as the term "container" commonly refers to large trucks for transporting goods in Pakistan. Additionally, using metaphors from Urdu literature such as "dil" (heart) can enhance understanding.

Simplifying "positive and negative cognitions" to "good or bad cognitions" and using simpler language when discussing cognition. For instance, instead of asking about "negative cognitions," therapists can inquire about "bad experiences" related

to an event. Providing lists of positive and negative cognitions in local languages like Urdu or Pashto can facilitate patients in expressing their emotions effectively.

Assessment

During the assessment phase, therapists should carefully consider the following elements:

a) When prompting patients to select an image, therapists must avoid suggesting culturally or religiously inappropriate examples, particularly when working with female patients in Pakistani culture. It's essential to maintain sensitivity and avoid any actions that could be perceived as unethical.

b) Similarly, when guiding patients through the process of "naming emotions," therapists should steer clear of culturally or religiously inappropriate words or emotions. Additionally, some emotions in Pakistani culture may be challenging for patients to verbalize, so therapists should be patient and understanding.

If therapists plan to administer the Subjective Units of Distress Scale, it's crucial to use a translated and locally adapted version. This ensures that the scale accurately captures the patient's distress levels in a culturally relevant manner.

Desensitization

During desensitization, therapists should pay attention to the following elements:

a) It's important to avoid excessive use of eye movements during desensitization, particularly considering that certain eye movements may be perceived as culturally inappropriate in Pakistani culture. This is especially

crucial when working with female patients, as cultural sensitivities should be respected.

b) Therapists should refrain from touching patients, especially female patients, as touching or tapping females, even on the hand, is culturally prohibited and considered inappropriate in Pakistani culture.

Utilizing the patient's religious or spiritual beliefs can be effective for cognitive interweaves during desensitization. Incorporating these beliefs can enhance the therapeutic process and make it more relevant and meaningful for the patient.

Installation

During the installation phase, therapists should consider the following factors:

a) Patients, particularly if they are illiterate, may find Bilateral Stimulation movements strange or even perceive them as magical or hypnotic. In Pakistan, both educated and uneducated individuals may have beliefs in magic or hypnotic powers. Consequently, patients may interpret Bilateral Stimulation techniques such as eye movements or tapping as akin to techniques used by magicians. It's important for therapists to address any misconceptions about Bilateral Stimulation by explaining the process in a simple and clear manner. Additionally, therapists should clarify that while magic may be a cultural belief, it is prohibited in Islam, and assure patients that Bilateral Stimulation is a therapeutic technique grounded in evidence-based practice.

Another factor to consider during the installation phase is the cultural relevance of the positive emotions being integrated. Therapists should ensure that the positive emotions being installed align with the patient's cultural background and values. Additionally, it's important to tailor the language and examples used during the

installation process to resonate with the patient's cultural context. This can enhance the effectiveness of the installation and improve the patient's engagement with the therapy process.

Closure

This marks the final phase during which therapists determine whether to proceed with closure or end therapy with the patients. Closure resembles the preparatory stage. Therapists are tasked with offering appropriate empathy, providing psychoeducation, and normalizing the patient's experience through statements. They should emphasize positive aspects by inquiring about the most significant positive change experienced by the patient. It is imperative to adhere to standard closure strategies, including the application of the container technique. However, therapists must bear in mind any adjustments made to such techniques earlier (refer to Section 2.24 for Adapting EMDR Related Terminologies). Additionally, therapists should remind patients of previously discussed techniques for managing emotions and self-care.

By incorporating these elements, therapists can ensure a comprehensive and supportive closure process for their patients:

a) **Closure Assessment:** Prior to deciding on closure, therapists should conduct a thorough assessment of the patient's progress and readiness for transition.
b) **Collaborative Decision-Making:** The decision regarding closure should be made collaboratively between the therapist and the patient, taking into account the patient's goals and needs.

c) **Review of Treatment Goals:** It's beneficial to review the treatment goals established earlier in therapy to evaluate whether they have been achieved or require further work.

d) **Discussion of Future Support:** Before concluding therapy, therapists should discuss with the patient the availability of ongoing support options, such as follow-up sessions or referrals to other professionals if necessary.

Final Session Rituals: Consider incorporating rituals or activities in the final session to provide closure and mark the end of the therapeutic journey, such as summarizing progress, expressing gratitude, or setting future intentions.

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Anwar Khan, a young academic and researcher, is your ultimate guide to mastering research methods in clinical psychology and mental health sciences. With over a more than decade of experience in academia and a prestigious Post Doctorate in Organizational Behavior and Psychometrics, Anwar has significantly contributed to the field, authoring over thirty articles in peered reviewed research journals. His diverse teaching portfolio spans Organizational Behavior, and Mental Health, enriching his insights with practical wisdom. As a dedicated mentor to sixteen MPhil and two PhD scholars, Anwar is deeply committed to cultivating the next generation of researchers. This book is a rich compilation of his extensive knowledge and experience, designed to empower scholars and practitioners in conducting impactful research in the mental health sciences.

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