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Culturally Adapted Trauma-Focused Cognitive Behavior Therapy (CatCBT) for Media Exposure Induced Secondary Traumatic Stress (MEISTS) – A Pilot Study

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Abstract

The current research aimed to assess effectiveness of culturally adapted trauma-focused cognitive behavior therapy (CatCBT) in reducing media exposure induced secondary traumatic stress (MEISTS) in university students through two modalities, face-to-face and self-help interventions. It was hypothesized that face-to-face and self-help modalities of CatCBT would reduce MEISTS in comparison to waitlist control group. For this purpose, a pilot study was designed having a sample of *N=30* participants, selected through purposive convenient sampling from two public sector universities of Karachi. The participants were then divided through random assignment into three groups: two intervention groups and one waitlist control group, each group having 10 participants. Pre and post assessments were done using the Secondary Traumatic Stress Media-Induced Questionnaire (STSM-IQ; Comstock & Platania, 2017), and Cognitive Distortions Questionnaire (CD-Quest; De Oliveira et al., 2015). Post intervention assessment indicated a significant reduction in MEISTS and cognitive distortions through both, face-to-face and self-help modality. Based on the post treatment assessment, it can be concluded that CatCBT can be an effective approach to deal with MEISTS in univesity students and especially the significant role of self-help modality in this regard can prove to be a step towards reducing the economic burden of mental health issues in low- and middle-income countries like Pakistan.

Key words: CBT, Trauma, Secondary Trauma, Pakistan, Cultural adaptation

Introduction

Secondary traumatic stress (STS) is a multi-faceted construct with 3 conceptually inter-related but distinct sub factors of intrusion, avoidance, and arousal (Bride et al., 2004). STS was originally conceptualized in the context of professions providing psychological help to trauma clients (Figley, 1983). It was then expanded to all helping professionals and even futher later, STS was re-conceptualized by Comstock and Platania (2017) as being extended to be exhibited in laypersons as a result of exposure to traumatic content through media. Literature has established the presence of media exposure induced secondary trauma through multiple researches (Khalily et al., 2017) and it is recognized that the manifestation of PTSD and STS are relatively similar, with different etiologies (Greinacher et al., 2019).

Studies have consistantly indicated that Pakistani population has been facing the effects of traumatic events, however these studies are limited in number and may not accuratly represent the current scenerio. Niaz et. al., (2006) found 37% of the earthquake survivors to have PTSD and 23% to have co-morbid depression. Mubeen et al., (2013) found 59% PTSD and 54.4% depression in flood victims of Sindh, Pakistan. Regarding the impact of indirect exposure to trauma, Yazdani and Shafi (2014) found 54% adolescents to be experiencing moderate symptoms of vicarious trauma in those indirectly exposed to traumatic events happening to others.

CBT is known to be one of the most researched therapies and it fulfils the gold standard criteria for a ‘well-established’ and empirically supported therapy (Beck & Fleming, 2021). As per WHO, trauma-focused CBT is the most successful treatment for trauma along with Eye Movement Desensitization and Reprocessing (EMDR; Ponniah & Hollon, 2009). Multiple researches and systematic reviews have found individual and group trauma-focused CBT

following natural disasters and various kinds of trauma to be effective (Hamblen et al., 2010), however, studies relevant to Pakistani culture are very limited.

There is dearth of research done on the adapted version of CBT in Pakistan, especially for trauma. With that, media induced secondary traumatic stress being an arguably new area of interest for Pakistan makes it one of its kind research. In terms of different modalities, a wide variety of available self-help literature is based on CBT and considerable literature have suggested in favor of CBT based self-help (O'Mahen et. al., 2014). However, this domain also lacks depth in terms of research base in Pakistan. Self-help factor of this therapy is very important as in a developing country there is a wide gap between demand and supply of therapeutic services. If self-help therapy in the domain of trauma symptoms proves to be effective, this can bridge the gap and lessen the burden of trauma treatment. Keeping the research gap into consideration, the current study was designed to assess the extent to which Ca-TFCBT may prove to be suucessful in reducing media exposure secondary traumatic stress in people through face-to-face and self-help modalities.

Objective of the Study

To assess the effectiveness of face-to-face and self-help modality of Ca-TFCBT in reducing symptoms of MEISTS in university students

Hypotheses of the Study

H1: There will be reduction in the level of MEISTS in university students after using the face-to-face and self-help modality modalities of Ca-TFCBT.

H2 - There will be difference in the level of MEISTS between the intevention groups and the waitlist control group.

Method

Design of the Study

A pre-post quantitative research design was used in the present research. Pre-intervention assessment was done, followed by a 9 session intervention plan, after which post-intervention assessment was done.

Sample

Sample of *N=30* participants, ages ranging from 18 to 24 years, selected through purposive convenient sampling from two public sector universities of Karachi was divided through random assignment into three groups: face-to-face modality, *n=10* (*M*=19.10,*SD*=1.10), self-help modality, *n=10* (*M*=18.80,*SD*=.42), and waitlist control group, *n=10* (*M*=20.80,*SD*=1.61).

As an inclusion criteria, participants were needed to understand English and Urdu languages, they were to be free from any diagnosed mental illness, or organic brain damage, and were to have moderate to high scores on secondary traumatic stress media-induced questionnaire (STSM-IQ). It was also ensured that participants who had faced any direct trauma within 1 week of data collected were not be included in the study. This was to ensure that secondary traumatic stress being exhibited is really due to media, and not due to any current personal circumstances.

Assessment Protocols

Demographic information form

The demographic information form was used to gain information relevant to the resaerch and inclusion criteria.

Secondary Traumatic Stress Media-Induced Questionnaire (STSM-IQ)

Secondary Traumatic Stress Media-Induced Questionnaire (STSM-IQ) is a modified version of Secondary Traumatic Stress Scale. Developed by Comstock and Platania (2017) the purpose of the STSM-IQ is to determine if secondary traumatic stress occurs in the layperson after exposure to repeated real life traumas through television and social media. It has 16 items and three sub-scales of avoidance, arousal, and re- experience/intrusion. Comstock and Platania (2017) calculated its Cronbach Alpha to be .90.

Cognitive Distortion Questionnaire (CD-QUEST)

Cognitive Distortions Questionnaire (de Oliveira et. al., 2015) is a self-report scale that is used to evaluate the frequency and intensity of 15-types of cognitive distortions. It has three different scores: frequency, intensity, and total (composite) score. Total of frequency and intensity ranges from 0 to 45; the grand total is the sum of the total score of each item, ranging from 0 to 75. Cognitive Distortions Questionnaire showed adequate internal consistency, Cronbach alpha=0.85, in its original version.

Procedure

First of all, approval from the Ethical Review Committee and permissions from the authors of questionnaires and the 9-session manualized culturally adapted trauma-focused cognitive behavior intervention plan was sought. After that, potential participants were approached and were briefed about the research. Participants who showed interest in the research were then brifed about informed consent and were presented with the pre-intervention measures, including the demographic information form, STSSM-IQ, and CD-Quest. Those meeting the inclusion criteria were then divided into three groups: face-to-face modality, self-help modality, and waitlist control group through random assignment. The face-to-face modality group was started with the 9 session manualized Ca-TFCBT plan while the self-help

modality group was given a pre-intervention training to help them understand the usage of self-help material. The treatment plan was identical for both groups and was based on the manual called "Basid ki Kahani" developed by Pakistan Association of Cognitive Therapists (Naeem et al., 2016) for treating trauma. For both the groups, there were total 9 sessions; in the face-to-face modality, participants had to meet the researcher twice a week, over the course of 5 weeks, for each session lasting for 30 minutes, while the self-help modality group had the leverage to utilize the intervention material at their own pace however they were also required to complete material from 2 sessions each week. This group was also required to meet with the researcher after 4 sessions as a follow-up to ensure compliance to the intervention.

Table 1

Details of the 9 Sessions Culturally Adapted Trauma-Focused Cognitive Behavior Thearpy Intervention Plan

Session Plan

Session	Aims and Objectives	Description of Activities
1 Psychoeducation Behavioural strategy	• Psychoeducation about trauma • Improving sleep and relaxation	This session revolved around psychoeducating clients about trauma, its prevalence, causes, and trauma reactions and symptoms. The session also catered to activiating parasympathatic response of relaxation in participants, thus reducing arousal and imporoving sleep through breathing retraining, thus reducing intrusive symptoms of trauma.
2 Behavioural strategy	• Tackling avoidance	The second session utilized Successive Approximation technique; clients were asked to first list down all triggers, areas, and activities that they avoid due to them being anxiety provoking. They were then required to rate them from producing lowest to highest intensity of anxiety. They

		were then to start with the least anxiety provoking task and perform that task by breaking it into micro steps and performing it till it stoped being anxiety provoking. Following the same pattern, they were required to tackle all tasks listed by them.
3 Behavioural strategy	• Establishing relationship between emotions and behaviours • Explaining how stress leads to reduction in activities which further cause negative alteration in mood and cognition.	This session included activity planning through ladder technique, and activity scheduling. In these techniques, importance of activities in daily life was explained and how various activities can be broken down to their basic components so that they can be incorporated easily was also elaborated. It also explained how a participant may plan to gradually increase the number of activities from basic to more complex ones. In the activity scheduling technique, focus was on ensuring that participants learnt to have balanced activities in the four domains: creative, personal, social and spiritual and entertainment. This part also dealt with making the participants develop an activity scheduling dairy where they would list down daily activities in the form of a time table so that they are able to realistically perform activities required for improved psychological health.
4 Behavioural strategy	• Improving participants' problem solving skills	In this session, problem solving skill was taught to the participants. As a first step, problems were specified. Once that was done, possible solutions were identified and the best solution was chosen. It was also explained how breaking the solution into maximum possible small steps makes it further easier for even the most stressed out participant to be successful in resolving any issue.
5 Cognitive strategy	• Understanding vicious cycle • Understanding and	In this session, 3 activities were utilized. First activiticy was making vicious cycle. In this activity, it was taught to the

	identifying cognitive distortions	participants about how a trigger can start a vicious cycle of negative thoughts leading to disturbed emotions, physical issues and dysfunctional behaviours. After the explanation, participants were required to think of any trigger and make the vicious cycle. Second activity was making thought diary. After understanding and making the vicious cycle, making thought diary was done to reinforce participants' concept of triggers, emotions, thoughts, and physical symptoms along with helping them identify these components in their daily life. The last activity was identifying cognitive distortions. This activity was focused on helping them understand the errors in their thinking that might be affecting them adversely.
6 Cognitive strategy	• Thought challenging	In this session, thought challenging was done. In this activity, participants were required to go one step beyond just identifying their thoughts in various situations and were needed to find evidences for and against them. In the thought diary, learnt to be made in the fifth week, participants were required to add up two more columns that would deal with the "for and against" evidences.
7 Cognitive strategy	• Developing alternate positive thoughts	Once participants were able to find evidences for and against their thoughts in the last session, they were then required to learn how to create an alternate thought that is more realistic and positive.
8 Behavioural strategy	• Improving interpersonal relationships	This session focused on understanding errors of behaviors, along with assertiveness training, and conflict resolution. In these activities, participants were taught to identify errors of their behaviours that

		have a negative impact on their interpersonal relations. Assertiveness training focused on developing participants' assertiveness skills for improving their relations. First, assertiveness was explained to the participants and then tips for improving it were communicated. In conflict resolution, possible reasons for conflicts were explained and their resolutions were elaborated.
9 Behavioural and cognitive strategies	• Relapse prevention	This session included suggestions for relapse prevention such as doing one thing at a time, being mindful of one's limitations and communicating them to others too, knowing your strengths and weaknesses, seeking guidance, improving sleeping schedule, eating healthy, exercising, doing enjoyable activities, being social and staying positive.

Results

The result was compiled and analyzed using pre-post analysis.

Table 2

Frequency and Percentages of Demographic Variables

Variables	Intervention Group 1		Intervention Group 2		Waitlist Control Group	
	F	*%*	*f*	*%*	*f*	*%*
Gender						
Male	1	10	1	10	7	70
Female	9	90	9	90	3	30
Socioeconomic Status						
Upper class	1	10	-	-	-	-
Upper middle class	3	30	4	40	3	30
Middle class	6	60	6	60	5	50
Lower middle class	-	-	-	-	2	20
Lower class	-	-	-	-	-	-
Marital Status						

Single	10	100	9	90	7	70
Engaged/In relationship	-	-	1	10	3	30
Married	-	-	-	-	-	-
Seperated	-	-	-	-	-	-
Divorced	-	-	-	-	-	-
Widow/Widower	-	-	-	-	-	-
Other	-	-	-	-	-	-
Family Type						
Nuclear	7	70	7	70	3	30
Joint	3	30	3	30	7	70
Other	-	-	-	-	-	-
Occupation						
Full time student	7	70	7	70	5	50
Full time employed	-	-	-	-	-	-
Full time student, part time employed	3	30	3	30	3	30
Part time student, part time employed	-	-	-	-	2	20
Currently Enrolled in Program						
Undergraduate (Bachelors)	10	100	10	100	10	100
Postgraduate (Masters)	-	-	-	-	-	-
Postgraduate (PhD)	-	-	-	-	-	-

Note. Table 2 indicates the demograpic variables of the study participants.

Table 3

Descriptive Statistics and Univariate Normality of Study Variables of Pre and Post-Intervention Phase (N=30)

Variables	Items	α	*M*	*SD*	SK	K	Range	
							Actual	Potential
Pre-Intervention								
MEISTS	16	.83	53.83	9.91	.07	-1.09	38-72	16-80
Intrusion	4	.72	12.10	3.22	.12	-.23	5-18	4-20
Avoidance	6	.58	21.86	3.81	-.11	-.96	15-28	6-30
Arousal	6	.65	19.86	4.50	.15	-.87	13-2	6-30
FCD	15	.79	27.10	6.97	.51	-.13	17-44	0-45
ICD	15	.82	27.06	7.37	-.24	-1.20	16-41	0-45
Post-Intervention								
MEISTS	16	.89	42.00	10.81	.26	-.31	22-65	16-80

Intrusion	4	.68	9.83	3.01	.80	-.07	6-17	4-20
Avoidance	6	.66	16.76	4.18	-.21	-.53	8-25	6-30
Arousal	6	.79	15.40	4.46	. 33	-.35	8-25	6-30
FCD	15	.89	19.80	8.80	-.00	-1.02	6-36	0-45
ICD	15	.92	19.80	9.89	.17	-.93	4-39	0-45

Note. MEISTS=Media Exposure Induced Secondary Traumatic Stress, FCD=Frequency of Cognitive Distortions, ICD= Intensity of Cognitive Distortions, M=Mean, SD=Standard Deviation, SK=Skewness, K=Kurtosis

Table 3 indicates that the Cronbach alpha reliabilities are in acceptable range (George & Malley, 2003) and the data is also normally distributed (Hair et al., 2017).

Table 4

Paired Sample T-Test Results Comparing Pre-Intervention and Post-Intervention Scores for Intervention Group 1 (N=10)

Variables		*M*	*SD*	*t(df)*	*p*	*95%CI*		*Cohen's d*
						LL	*UL*	
MEISTS	Pre-Test	53.90	12.25	5.79(9)	.000	12.55	28.64	1.95
	Post-Test	33.30	8.47					
Intrusion	Pre-Test	12.20	4.02	3.45(9)	.007	1.51	7.28	1.41
	Post-Test	7.80	1.75					
Avoidance	Pre-Test	21.60	4.06	5.76(9)	.000	4.80	10.99	1.91
	Post-Test	13.70	4.19					
Arousal	Pre-Test	20.10	5.80	5.26(9)	.001	4.73	11.86	1.73
	Post-Test	11.80	3.45					
FCD	Pre-Test	28.10	8.46	6.63(9)	.000	9.29	18.91	1.73
	Post-Test	14.00	7.78					
ICD	Pre-Test	27.60	6.63	4.74(9)	.001	6.69	18.90	1.61
	Post-Test	14.80	9.08					

Note. MEISTS=Media Exposure Induced Secondary Traumatic Stress, FCD=Frequency of Cognitive Distortions, ICD= Intensity of Cognitive Distortions, M=Mean, SD=Standard Deviation

Table 4 shows that as per the t-values, there is a significant difference in the levels of MEISTS and its sub-components of intrusion, avoidance, and arousal, as well as levels of frequency and intensity of cognitive distortions; all the scores were lower in the post intervention assessment.

Table 5

Paired Sample T-Test Results Comparing Pre-Intervention and Post-Intervention Scores for Intervention Group 2 (N=10)

Variables		*M*	*SD*	*t(df)*	*P*	*95%CI*		*Cohen's d*
						LL	*UL*	
MEISTS	Pre-Test	53.00	10.82	4.36(9)	.002	6.40	20.19	1.64
	Post-Test	39.70	3.80					
Intrusion	Pre-Test	11.40	3.47	2.75(9)	.022	0.46	4.73	0.99
	Post-Test	8.80	1.31					
Avoidance	Pre-Test	21.80	4.73	3.54(9)	.006	1.95	8.84	1.67
	Post-Test	16.40	2.91					
Arousal	Pre-Test	19.80	4.15	3.87(9)	.004	2.20	8.39	1.37
	Post-Test	14.50	1.64					
FCD	Pre-Test	28.00	7.88	3.93(9)	.003	3.83	14.16	1.21
	Post-Test	19.00	6.89					
ICD	Pre-Test	28.70	7.71	5.36(9)	.000	6.36	15.63	1.37
	Post-Test	17.70	8.24					

Note. MEISTS=Media Exposure Induced Secondary Traumatic Stress, FCD=Frequency of Cognitive Distortions, ICD= Intensity of Cognitive Distortions, M=Mean, SD=Standard Deviation

Table 5 shows that as per the t-values, there is a significant difference in the levels of MEISTS and its sub-components of intrusion, avoidance, and arousal, as well as levels of frequency and intensity of cognitive distortions; all the scores were lower in the post intervention assessment.

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Table 6

One-way ANOVA Results Comparing Post-Intervention Scores for Intervention Group 1, Intervention Group 2, and Waitlist Control Group (N=30)

Variables	Intervention Group 1 (n=10)		Intervention Group 2 (n=10)		Waitlist Control Group (n=10)								95% CI	
	M	SD	M	SD	M	SD	F	P	η^2	i-j	Mean (i-j)	SE	LL	UL
MEISTS	33.30	8.47	39.70	3.80	53.00	8.12	19.90	.000	.77	IG1<WCG	-19.70	3.18	-27.59	-11.80
										IG2<WCG	-13.30	3.18	-21.19	-5.40
Intrusion	7.80	1.75	8.80	1.31	12.90	2.88	16.69	.000	.74	IG1<WCG	-5.10	.93	-7.41	-2.78
										IG2<WCG	-4.10	.93	-6.41	-1.78
Avoidance	13.70	4.19	16.40	2.91	20.20	2.57	9.79	.000	.76	IG1<WCG	-6.50	1.47	-10.15	-2.84
										IG2<WCG	-3.80	1.47	-7.45	-.14
Arousal	11.80	3.45	14.50	1.64	19.90	3.44	19.21	.001	.64	IG1<WCG	-8.10	1.33	-11.39	-4.80
										IG2<WCG	-5.40	1.33	-8.69	-2.10
FCD	14.00	7.78	19.00	6.89	26.40	7.41	7.15	.003	.58	IG1<WCG	-12.40	3.29	-20.57	-4.22
ICD	14.80	9.08	17.70	8.24	26.90	8.72	5.28	.012	.53	IG1<WCG	-12.10	3.88	-21.73	-2.46

Note. MEISTS=Media Exposure Induced Secondary Traumatic Stress, FCD=Frequency of Cognitive Distortions, ICD= Intensity of Cognitive Distortions, M=Mean, SD=Standard Deviation, p=Significance, η^2=Eta Square, i-j=Mean Difference, IG1=Intervention Group 1, WCG=Waitlist Control Group, IG2=Intervention Group 2, SE=Standard Error, LL=Lower Limit, UL=Upper Limit

Table 6 indicates that one-way Analysis of Variance (ANOVA) was carried out to assess the differences in the post-intervention scores of intervention groups and the waitlist control group. The p values indicated that there is a significant difference between the intervention and control groups.

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Discussion

The current pilot study aimed to assess the effectiveness of CatCBT in reducing MEISTS through face-to-face and self-help modality.

Pre-post results showed a significant decrease in the level of MEISTS and the frequency and intensity of cognitive distortions in university students after utlizing face-to-face as well as self-help modalities of CatCBT. It indicates that both modalities are effective in this regard, however face-to-face version had higher values of Cohen's d, compared to self-help version, indicating that though both modalities are effective, the individual therapy is higher in its effectiveness.

Results of current research corroborate with existing literature; CBT has been found to be an effective treatment for a number of psychological issues (Flynn & Warren , 2014) including trauma (Lu et al., 2009). Culturally adapted trauma informed Cognitive Behavioural Therapy was also successful in reducing PTSD symptoms in Pakistani women exposed to domestic violance through the self-help based modality (Latif et al., 2021). However, this is the first time that this culturally adapted manualized approach to trauma treatment has been evaluated in the context of secondary trauma and as a face-to-face treatment modality.

The results of all such studies warrant a question about what exactly is the specific component that brings about positive change in trauma victims or survivors. A probable answer to this question is the utilization of techniques that are in line with the symptoms of trauma.

Starting off with the first session, psychoeducation and inducing relaxation leading to improved sleep through breathing retraining was done. Psychoeducation is part of majority of evidence based therapies for trauma and PTSD (Foa et al., 2009). In the current study, participants reported that they felt good about knowing why they were affected by the content viewed on media and that others share similar symptoms as them; this made them feel more normal in their

experiences.

Sleep disturbances have been found to occur in posttraumatic stress disorder (PTSD; Lewis et al., 2020). It was reported by majority of the participants of the present research that breathing retraining proved to one of the most beneficial techniques for them and really helped them with improved sleep quality.

The second session utilized successive approximation as the main intervention. It was aimed at reducing the avoidance behaviours. In trauma related issues, numbing and avoidance are very common; Numbing is an automatic reaction to uncontrollable physiological arousal, while avoidance is more controlled by individuals and is an active way of dealing with trauma related intrusions (Feuer et al., 2005). The participants of the present research reported to have greatly benefitted from this technique as after learning it, they were able to overcome the avoidance towards multiple tasks.

The third session was also related to the issue of avoidance. It catered to avoidance by activity scheduling technique. Through the utilization of this technique, participants were able to bring about a poitive change in their daily life and break free from the avoidance. Most participants reported to incorporate activities of social nature in their daily schedule; this is in line with the collectivistic culture of participants. It is also important to note that prior literature also suggests that social factors are often instrumental in recovery from trauma symptoms (Charuvastra & Cloitre, 2008). As activity scheduling is brief and focuses on achieving simple goals, it made it very practical in the trauma care context as well. The effectiveness of activity scheduling has been proven through multiple prior researchs as well (Darnell et al., 2017).

The fourth session used cognitive intervention; problem solving. Trauma tends to negatively affect cognitions and renders participants unabile to solve basic issues (Sutherland & Bryant, 2008). Hence, adaptive problem solving serves to be an important intervention for trauma clients; prior

literatue supports this claim that adaptive problem solving is imperative for psychological adjustment during and after stressful events (Bell & D'Zurilla, 2009). Empirical studies have reported that individuals who have experienced any kind of trauma tend to utilize more maladaptive problem solving and they are also associated with higher PTSD symptom severity (Dirkzwager et al., 2003). Literature suggests that developing problem solving skills in individuals exposed to any type of trauma empowers them through building crisis management skills and mitigating trauma effects. Further studies have indicated that enhancing problem solving skills mobilize the personal resources to adjust with the problems after disaster (Ferdos & Seyed-Hossein, 2007).

The next three sessions also uitlized cognitive technique called as cognitive restructuring. In this technique, individuals are trained to analyse and assess their thoughts for accuracy and functionalilty. The basic premise of CBT is that it is the people's interpretations of situations rather than the situations themselves that influence their reaction. The cognitive model of trauma argues the same (Ehlers & Clark, 2000). It asserts that exposure to trauma has the capacity to distort cognitions and it can lead victims to develop negative appraisals of the trauma which can result in a sense of current external or internal threat. The effect of cognitive distortions on mainatainince of trauma symptoms and other psychiatric illnesses have been established multiple times (Fang & Chung, 2019). Keeping in mind the extent to which cognitions play a key role in creating and maintaining the trauma symptoms, cognitive restructuring gain especial significance as a key technique of CBT.

Benefits of cognitive restructuring for reducing trauma symptoms are also well established in patients with PTSD (Mueser et al., 2015). Participants of the current study reported some initial difficulty in learning cognitive restructuring, however once learned, they claimed it to be one of the most effective and potentially far reaching techniques, after breathing training, which would benefit them in long run.

The eighth session aimed to improve communication skills and interpersonal relations. Literature suggests that traumatic events have the potential to impact interpersonal relationships and attachment behaviors. Traumatic experience can take root in the memory system of the individual, creating a progressive inclined in avoidance of interpersonal triggers. Traumatic experience can also negatively affect on self-awareness, intimacy, and communication, leading to imbalance in healthy interpersonal relationships. This maladaptive interpersonal affect may also increase the risk of revictimization in individuals exposed to trauma (McFarlane & Bookless, 2001).

Keeping in view the significance of interpersonal distortions in trauma victims, a number of trauma informed treatment models focus on working on enhancing effective communication and improving interpersonal relations (Markowitz et al., 2009). The participants of current research reported to have greatly benefitted from the training of interpersonal skills, especially that of understanding different types of communications and learning to be assertive rather than aggressive in times of conflicts. The resultant change in the interpersonal consequences of the learned altered way of communication helped them root for the new way of being interpersonally and helped them stick to the taught methods.

The last session was about relapse prevention which essentially summerized the learnings of previous eight sessions.

The reported benefits and challenges of the techniques were communicated by both intervention groups uniformly however the self-help modality group provided added insights. The participants who completed the therapy program reported it to be beneficial for them as it allowed them to take therapy at their own pace especially without the fear of anyone knowing that they were taking therapy. It has been found that despite the consistent improvement in psychotherapeutic practices and the efforts to make it easier for people to avail these services, people still tend to

underutilize psychotherapy due to various reasons. Stigma is the most common problem that stops people from seeking help (Owen et al., 2013). Mobility is also a major contributing factor of therapy underutilization especially in developing countries like Pakistan. Adding to that, financial constraints further aggravate the scenario.

In all such cases, self-help has proven to be the answer. Particularly, in places with limited resources allocated to mental health, self-help techniques can prove to be a highly effective method in providing the required help to masses (Baguley et. al., 2010).

Conclusion

The findings of current research indicate that culturally adapted trauma informed cognitive behavioural therapy is successful in reducing trauma symptoms in university students. The findings further sugge that as a first step towards betterment of mental health of masses, self-help may be a viable option in fighting against the barriers that stop people from seeking the much needed professional help. Especially in a developing country like Pakistan, with limited resources and man power, and with low awareness of needs and their fulfillment in the context of mental health, self-help is an option that if further explored and developed well can bring about a positive change.

Limitations and Recommendations for Future Research

A possible limitation of the current study is the lack of follow up; though post analysis of data showed a significant decline in media exposure induced secondary traumatic stress, a follow up is required to ensure that this improvement is not due to any other factor and is in actuality overall long term betterment in the mental state.

Along with this, future studies should focus on using other self-help approachs, such as audio versions of interventions rather than only bibliotherapy based self-help so that the research base of this domain can be expanded. Computer based self-help can also be explored for the populations who

have easy access to computers and internet.

Lastly, the present study lacks a detailed qualitative analysis of the data. Most participants declared that their thoughts had changed from being bleak to more positive; a more detailed analysis of such data could have enriched the present study more. In future researches, a system for ensuring qualitative analysis may be incorporated to gain further understanding of how this therapy is bringing about a change.

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