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Original Paper

An evidence-based framework for cultural adaptation of Cognitive Behaviour Therapy: Process, methodology and foci of adaptation

Farooq Naeem, Peter Phiri, Amina Nasar, Ashley Gerada, Tariq Munshi, Muhammad Ayub, Shanaya Rathod

Abstract. *Currently there is no evidence-based framework for culturally adapting CBT for clients from the Non-Western cultural background. We adapted CBT for black and ethnic minority communities in the UK and local population in Pakistan. This paper describes the framework that evolved from this work, with a focus on the process of adaptation, details of methods used and the areas that need to be focused in order to culturally adapt CBT in a given culture. As far as we are aware this is the first adaptation framework that is evidence based and has been tested through field testing. A series of mixed method studies were conducted in Pakistan and the UK. Adaptation process starts with (a) background information gathering (b) in-depth interviews and focus groups with the stake holders; i.e., patients, carers, community leaders and health professionals (c) development of guidelines (d) cultural adaptation of therapy material, and (e) field testing adapted therapy. Through an iterative process we developed semi structured interviews that can be used now in low resource settings. The cultural adaptation of CBT should focus on three fundamental areas; (1) awareness of relevant cultural issues and preparation for therapy, (2) assessment and engagement, and; (3) adjustments in therapy. The adapted CBT was found to be effective in RCTs. Recently; the above methodology was used to culturally adapt CBT in China, Middle East and Morocco.*

Keywords: Cognitive Behavioral Therapy (CBT), culturally adapting CBT, framework, Non-Western cultures.

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BACKGROUND AND INTRODUCTION

Cognitive Behaviour Therapy and Culture.

Cognitive Behavioral Therapy (CBT) has a strong evidence base and is recommended by the National Institute of Health and Care Excellence (NICE) in the UK and by the American Psychiatric Association (APA) in the US, for a variety of emotional and mental health problems. However, it has been suggested that CBT is underpinned by the Western cultural values (Scorzelli & Reinke-Scorzelli, 1994, Hays & Iwamasa, 2006), and that for it to be effective among patients from Non-Western cultures, it should be

Farooq Naeem: Queens University, Kingston, Ontario, Canada; Addiction and Mental Health Services - Kingston, Frontenac, Lennox and Addington, Kingston, Ontario, Canada. Peter Phiri: Southern Health NHS Foundation Trust, Hampshire, England; Services Institute of Medical Sciences, Lahore, Pakistan. Amina Nasar: Services Institute of Medical Sciences, Lahore, Pakistan. Ashley Gerada: Addiction and Mental Health Services-Kingston Frontenac Lennox. Tariq Munshi: Queens University, Kingston, Ontario, Canada; Addiction and Mental Health Services-Kingston Frontenac Lennox. Muhammad Ayub: Queens University, Kingston, Ontario, Canada. Shanaya Rathod: Southern Health NHS Foundation Trust, Hampshire, England; Southampton University, Southampton, England.
Correspondence to: Professor Farooq Naeem, Queens University, Ontario, Kingston, Canada. Address: 385 Princess Street, Kingston, Ontario, Canada.

mailto: farooqnaeem@yahoo.com

culturally adapted (Rathod & Kingdon, 2009). At the roots of these suggestions, it has been said that Western are different from Eastern cultures in a number of the so-called core values such as Individualism-Communalism, Cognitivism-Emotionalism, Free will-Determinism and Materialism-Spiritualism (Laungani, 2004).

Therapists working with ethnic minority clients in the US have developed guidelines for adaptation of psychotherapies in different settings (Bernal, Bonilla, & Bellido, 1995; Hwang, 2006; Hwang, Wood, Lin, & Cheung, 2006; Tseng, 2004). Most of these guidelines describe therapists' experiences of working with Chinese or Latino clients, and address broad clinical and therapeutic issues. Furthermore, the existing guidelines did not directly result from research addressing cultural issues. In general, the literature on guidance of this kind for cognitive therapists is limited (Hays & Iwamasa, 2006).

AN EVIDENCE-BASED FRAMEWORK FOR CULTURALLY ADAPTING CBT

Currently, no adaptation framework of the kind described above has been developed using a robust methodology or tested through Randomised Controlled Trials (RCTs). This has been the objective of oue previous work on the development of culturally adapted CBT for psychosis in Black and Minority Ethnic (BME) communities in the UK (vgr., Black British, African-Caribbean, Black African and Pakistani and Bangladeshi), and for depression and psychosis in Pakistan. Currently, this framework is being used in Morocco, the Middle East region and China.

A series of qualitative studies substantiated by the ethnographic approach were conducted. Culturally sensitive CBT thus developed was tested in small feasibility studies, and found to be effective. In the initial phases of our Pakistani project, clinical psychologists (n=5) were interviewed about their experiences of providing therapy, in particular CBT, to depressed patents (Naeem, Gobbi, Ayub, Kingdon et al., 2010). Depressed patients themselves (n=9) were also interviewed, focusing on presenting symptoms, referral procedures, attribution styles, the acceptability of talking therapies, and obstacles in their delivery (Naeem et al., 2010, 2014, 2015). Focus groups were also conducted with University students (n=34) to find out the extent to which CBT was consistent with their personal, religious, family, social and cultural values (Farooq Naeem, Gobbi, Ayub, & Kingdon, 2009). The study group further utilised their help in the selection of culturally equivalent terminology used in CBT. Information gathered from these preparatory qualitative studies, as well as the first author's (FN) own field observations and experience were collated to develop a framework that guided the CBT adaptation process (F. Naeem, Ayub, Gobbi, & Kingdon, 2009). Preliminary evaluation of the adapted CBT found it to be effective in local settings (Farooq Naeem, Waheed, Gobbi, Ayub, & Kingdon, 2011). This methodology was replicated to adapt CBT for psychosis (semi-structured interviews with 33 patients, 30 caretakers and 29 mental health professionals) in Pakistan (Naeem et al., 2014).

In the UK project, a similar methodology was undertaken with specific ethnic groups (namely, Black British, African-Caribbean, Black African and Pakistani and Bangladesh) in two sites (Hampshire and West London). In-depth, face to face, semi-structured interviews and focus group interviews were conducted with psychotic patients (n=15), lay members from the respective communities (n=52), CBT therapists (n=22), and experienced health professionals working with service users from these groups (n=25) (Rathod, Kingdon, Phiri, & Gobbi, 2010). Findings from this study have resulted in a manual of adapted CBT (Rathod et al. 2015). In a randomised trial to test the acceptability and feasibility of culturally adapted CBT for post treatment psychosis, the intervention group showed statistically significant reductions in overall symptomatology on CPRS scores (p=0.047) with some gains maintained at six months follow-up (Rathod, Phiri, Harris, Underwood, Thagadur, Padmanabi & Kingdon, 2013).

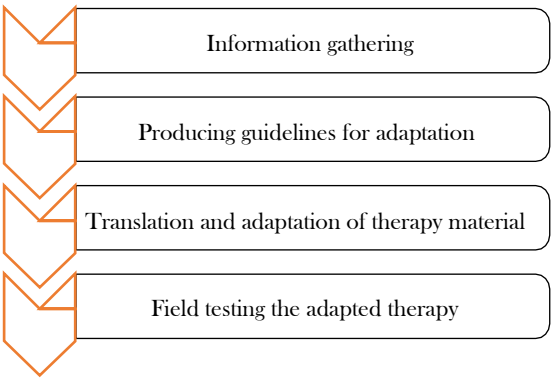
The guidelines developed from the above-mentioned works were also used to deliver and test adapted therapies through a number of trials in a variety of settings (for example, primary and secondary care) for various problems (i.e., depression, psychosis and selfharm) (Habib, Dawood, Kingdon, & Naeem, 2014; Husain et al., 2013, 2014; Naeem et al., 2011, 2014, 2015, 2016). These trials confirmed the effectiveness of culturally adapted CBT.

PROCESS OF ADAPTATION

The process of adaptation of CBT starts with gathering information from the different stakeholders, using a qualitative methodology. This information is then analysed to develop guidelines that can be used to deliver a culturally adapted CBT. The therapy material is then translated and included in a manual and field tested again to allow further adjustments and refinements.
In short, the steps of this process comprise the following sequence:

Stage 1: Review of previous literature and discussions with field experts, ultimately aimed at gathering information, through the use of qualitative methods, from patients and caretakers/lay persons, therapists/mental health practitioners and service managers concerning their experiences and views about a particular problem.
Stage 2: Guidance and specific norms to adapt the CBT manual
Stage 3: Translation and adaptation of therapy material into a manual
Stage 4: Field testing the adapted CBT manual and further refinement of the guidelines

Figure 1 Process of adaptation



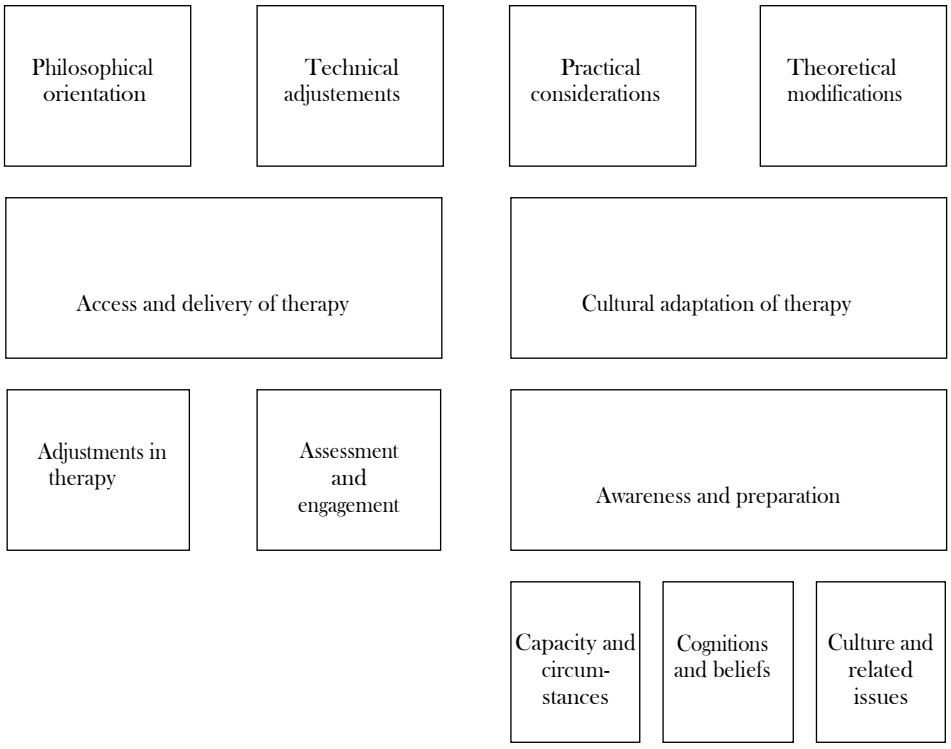
METHODOLOGY: HOW TO ADAPT CBT

Both qualitative and quantitative methods are used in this phase. During the qualitative stage, semi-structured interviews are used to gather information that can be used for the development of more or less precise guidelines for adaptation. The following areas are typically explored in interviews and focus groups (1) philosophical and cultural orientation of the patient, including his/her beliefs about a given illness, its causes and the treatment, especially non-medical treatments including the patient's experience of any non-pharmacological help received; (2) an understanding of caretakers' views about the problem, its causes and treatment, as well as their beliefs about help-seeking and any non-pharmacological treatment; (3) the experience of health professionals, including therapists, who help patients carrying the given problem, and identify barriers they have to overcome in helping these patients. Questions were asked to further identify techniques the helpers believed were in need of modifications, as well as those which they found useful; (4) further information gathered from expert therapists, spiritual and religious leaders and community elders. (The semi-structured interviews evolved from open-ended questions and focus groups in our initial work can be requested from the first author). The data thus obtained is analysed using a thematic content analysis and question analysis. A name-the-title technique (Naeem et al., 2009) is used to find equivalent terminology, rather than using literal translations. A feasibility study is conducted to determine whether the adapted therapy is acceptable. Finally, a larger RCT is conducted to determine the therapy's effectiveness.

FOCI OF CBT'S CULTURAL ADAPTATION

Our experience suggests that in the process of modifying a given therapy to adapt it to a different culture, it is not only adaptation per se that is essential, but also factors such as access to therapy, its delivery and, most importantly, its availability. Only a brief outline is provided here, as details have been published elsewhere (e.g. Rathod et al. 2015). Cultural adaptation of CBT should focus on the following levels:
(i) Philosophical orientation
(ii) Practical considerations of societal and health system-related factors
(iii) Technical adjustments of methods and skills and
(iv) Theoretical or conceptual changes.

Figure 2 The foci of adaptation

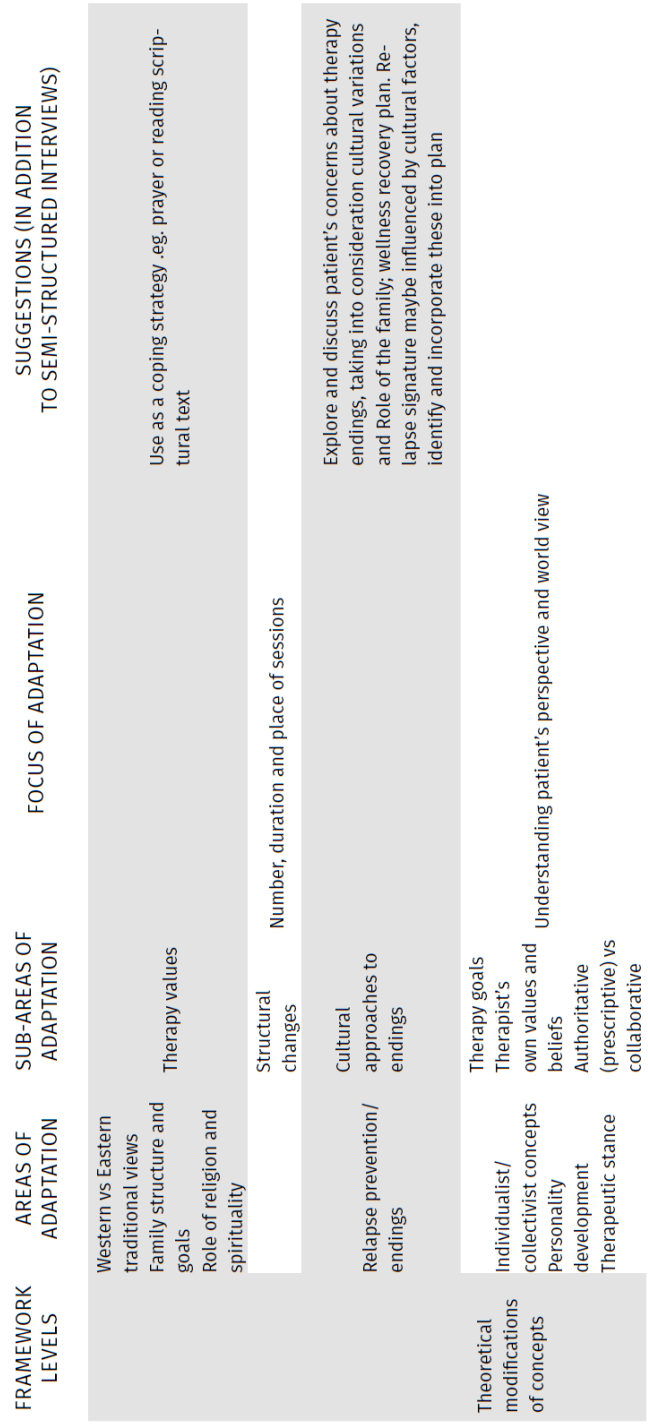


To effectively adapt CBT in a given culture, the following areas of cultural competence (The Triple-A Principle) must be covered; (1) Awareness of relevant cultural issues and preparation for therapy; (2) Assessment and engagement (3) Adjustments in therapy techniques ("technical adjustments"). Awareness of relevant cultural issues, in turn, involves (a) Issues related to culture and religion, (b) Consideration of the capacity and additional circumstances or characteristics of the health system, and (c) Philosophical orientation including knowledge and beliefs related to health, illness and its management. There are wider political issues that some may consider go beyond the scope of cultural adaption; for example, whether therapists from a Caucasian background accept the need for adaptation of a certain therapy orientation, and what are their beliefs towards a particular cultural group, potential receiver of the treatment.

Table1. An evidence-based framework for adaptation of CBT: The foci of adaptation

FRAMEWORK LEVELS	AREAS OF ADAPTATION	SUB-AREAS OF ADAPTATION	FOCUS OF ADAPTATION	SUGGESTIONS (IN ADDITION TO SEMI-STRUCTURED INTERVIEWS)
Philosophical orientation	Awareness and prep	Cognitions and beliefs	Beliefs and attributions about illness, health and health providers (Knowledge, beliefs and expectations about healing and the healers, common presenting complaints, beliefs about illness and its causes, its treatment, treatment providers, therapy, involvement of non-medical healers) Help-seeking behaviours and pathways into care	Explanatory model of illness Interview. Discussion with expert therapists Terminology acceptable to patient
		Migration stress	Oscillation between host culture, culture of origin and societal culture	Has individual integrated with culture host culture Has individual assimilated to new culture or is there lack of involvement in culture of origin and host culture (this contributes to separation and marginalisation)
	Awareness and prep/ assessment and engagement	Culture and related factors	Culture and spirituality (Understanding culture and religion, cause and effect relationships, interpretation and treatment of common emotional health symptoms by religious persons or elders, effect of stigma, family involvement, strengths and difficulties in a given culture in dealing with mental disorders, like spiritual coping skills, local healing practices) Language (consider bi-multi-lingual factors), idioms of distress, images, stories	Faith healers, religious or community elders involvement Good rationale for CBT, explain how 'talking can help, especially to those with an external locus of control Name the title technique, advice from community members and elders
Practical considerations of societal and health system related factors	Assessment and engagement	Capacity and circumstances	Societal factors (Gender, education, socio-economic status, reading and writing skills) Immigration factors/policies; health system, local provider reputation, patient experience and satisfaction, levels of the stigma of mental illness and inequalities eg. Racism; funding arrangements.	Consider patient's narratives, cultural identity; acculturation level (acculturation stress especially where 2nd generation is involved)

FRAMEWORK LEVELS	AREAS OF ADAPTATION	SUB-AREAS OF ADAPTATION	FOCUS OF ADAPTATION	SUGGESTIONS (IN ADDITION TO SEMI-STRUCTURED INTERVIEWS)
Technical adjustments of methods and skills		Cognitions and beliefs	Cognitive errors and dysfunctional beliefs	Use of dysfunctional attitude scale
			Barriers to therapy, engagement in therapy and homework etc.	
	Access and delivery/ awareness and preparation	Capacity and circumstances	System related issues (Number of therapists, training needs, financial resources, referral system) Barriers to accessing therapy, referrer's perceptions	Providing sessions in the community
	Assessment and engagement/adjustment in therapy	Therapeutic alliance	Patient-Therapist relationship Therapeutic Self-disclosure Trust Collaborative empiricism versus Paternalism	How are the elderly or persons in authority treated in community First impressions count and be mindful that your speech can reflect attitude and beliefs you hold about other culture groups
	Adjustments in therapy		Local idioms of distress, metaphors/ stories etc.	Validation of feelings/problem solving
		Specific techniques	Assertiveness, problem-solving, behavioural techniques, Socratic dialogue Guided discovery Normalisation	Socialising patient to cognitive model Use culturally appropriate metaphors Draw from cultural premise
		Use of electronic devices	Mobile phones, smartphone apps, for self-monitoring Develop appropriate audio or visual materiel where illiteracy is an issue	
	Formulations	Cultural formulation	Formulations should take into account, individual's cultural background and patient perspective, including their community Include cultural strengths	



FRAMEWORK LEVELS	AREAS OF ADAPTATION	SUB-AREAS OF ADAPTATION	FOCUS OF ADAPTATION	SUGGESTIONS (IN ADDITION TO SEMI-STRUCTURED INTERVIEWS)
	Western vs Eastern traditional views Family structure and goals Role of religion and spirituality	Therapy values		Use as a coping strategy .eg. prayer or reading scriptural text
		Structural changes	Number, duration and place of sessions	
	Relapse prevention/ endings	Cultural approaches to endings		Explore and discuss patient's concerns about therapy endings, taking into consideration cultural variations and Role of the family; wellness recovery plan. Relapse signature maybe influenced by cultural factors, identify and incorporate these into plan
Theoretical modifications of concepts	Individualist/ collectivist concepts Personality development Therapeutic stance	Therapy goals Therapist's own values and beliefs Authoritative (prescriptive) vs collaborative	Understanding patient's perspective and world view	

Culture, religion and spirituality remain as important components of peoples' lives, and therefore require full attention and exploration in this context. These factors influence belief systems, especially those related to health, well-being, illness and help-seeking in times of distress. Culture and religion influence the cause-effect relationship. For example, the cause of a mishap might be described as "evil eye" or even "God's will". People are also likely to use religious coping strategies, when dealing with distress (Bhugra,

Bhui and Rosemarie, 1999). On the other hand, culture, religion and spirituality may give rise to myths and stigmas associated with mental illness. Clients from many Non-Western cultures use a bio-psycho-socio-cultural-spiritual model of disease –thus, not limited to just the psychological nature of mental health problems. It may be crucial for therapists to acknowledge that their clients will attend therapy as well as use their traditional help-seeking pathways. Actually, involving faith healers, religious leaders or community elders might help.

There is also a need to consider the language used in therapy. Language needs to be adapted and, in that sense, literal translations do not work. We have used the name-the-title technique in our work. Similarly, the involvement of family members or caretakers needs to be studied. It offers both, possibilities and problems. Professionals and others involved in adaptation tasks should assess family participation and consider both the pros and cons, common stressors, guilt and stigma of mental illness in the household.

Interviews with the stakeholders are also likely to offer insights into common barriers related to personal issues, for example, gender, socio-economic or other problems. A major part of "traditional" CBT, involves reading or writing the informational material for various homework assignments. This needs to be sensitively assessed so that alternative methods can be used, e.g., audio tapes and audio diaries, beads, counters or symbols for diary-writing.

A detailed discussion should focus on system needs. These are really important in terms of access to and delivery of therapy. For example, existing health and immigration policies, the number of therapists, training programs and training needs. Service structure and needs, system organization including referral modalities might have significant implications in terms of access to therapy. Similarly, clients' knowledge of and their beliefs about the health system, treatment providers, available treatments and their likely outcomes, are important factors in service utilization and engagement. Questions must be asked in particular about psychotherapy. The pathways to care and help-seeking behaviours have to do with factors related to social and health systems, cultural and religious beliefs.

Dysfunctional beliefs and cognitive errors may vary from culture to culture (Padesky & Greenberger, 1995). There is at least some research evidence to suggest that this might be the case (Sahin & Sahin, 1992; Tam et al., 2007). Beliefs related to dependence on others, need to please people around, need to submit to demands of loved ones, and sacrificing one's needs for the sake of family are relatively common in different population. These will assist therapists in achieving what might be culturally appropriate rather than strictly pursuing the aims of therapy linked to the Western world's culture.

Structured assessment tools can be used to assess patients beyond the routinely used ones. We have highlighted the importance of beliefs about illness and its treatment, and this can be evaluated with the help of the Short Explanatory Model Interview (SEMI) (Lloyd et al., 1998). This interview explores the client's cultural background, nature of the presenting problem, help-seeking behaviour, interaction with physician/healer, and beliefs related to mental illness. The Asian Cultural Identity Schedule (Bhugra, Bhui, Rosemarie, 1999) is, for example, an instrument used to assess cultural identity and adjustment of patients in the host culture, assisting the therapist in the adjustment of therapy to the client's level of acculturation. This scale describes key concepts of cultural identity such as religion, attitudes toward the family, leisure activities, rites of passages, food and language. However, this is a lengthy instrument, ao therapists should familiarise themselves with the instrument, and use some of the questions that they consider relevant to their work. Other commonly used assessment instruments can be used such as the Dysfunctional Attitude Scale (DAS) (Weissman & Beck, 1978) useful to evaluate dysfunctional beliefs, and, in case of doubt, usable with family members or other in the community to see whether some of the supposedly dysfunctional beliefs are acceptable within this community.

Engagement and therapeutic alliance has been described as a difficulty when providing therapy to different cultural groups (Rathod et al, 2005). Competence then involves not only clinical competence but also an understanding of the patient's culture and religion. In addition to exploring barriers in delivering therapy, barriers in engagement should be studied. Information regarding patient-therapist relationship can be easily gathered and can help improve engagement. Involvement of caretakers and relatives usually proves vital in this regard and should be explored.

In our experience, only minor adjustments in CBT are required. However, some notable similarities exist across non-Western cultures. Clients from SAM find it difficult to recognise thoughts & emotions. Clients

found meditation and mindfulness exercise particularly helpful to help them acknowledge their thoughts and emotions. The focus of therapists is normally physical symptoms and behaviours at the start. Clients find behavioural techniques (Behavioural activation, experiments, etc.) and problem solving, particularly easy to use. Socratic dialogue and downward arrow techniques are particularly difficult to use in this group. Clients feel uncomfortable if the Socratic dialogue is used without sufficient preparation; the experienced healers from this cultural background use stories and images to convey their message, and understanding idioms of distress might help. Finally, structural changes might be required in the provision of therapy, and this should be explored depending on the organisation of the system and distance from the treatment facility. These include time, duration, number and gaps between therapy sessions. These authors have described the detailed findings from their studies elsewhere (Naeem, Phiri, et al., 2015).

PRACTICAL APPLICATIONS OF THE FRAMEWORK: FURTHER BARRIERS AND PITFALLS

Additional factors might need careful consideration. For example, it will be presumptuous to believe that everyone from a given culture is the same or has identical characteristics. There must be flexibility in applying the culturally adapted therapy. Similarly, migrants from a certain background while sharing some commonalities with the culture of origin, might have wide variations. Racial tensions, experiences related to migration and political and social systems in the host culture should be taken into consideration. There might be wide variations between the first and second generation clients. An assessment of acculturation might help. It might also be helpful to start with cultural adaptation of a focused problem and using a manualized form of therapy.

CONCLUSION

This paper highlights the process, methods and foci of cultural adaptation of CBT. As far as we are aware this is the first evidence-based framework for adapting CBT for clients from the Non-Western Cultures. Adaptation of CBT can be accomplished through a series of steps that involve the various stakeholders. The process of adaptation should focus on both theoretical and philosophical considerations as well as on practical issues in improving access to therapy, and in adjusting therapy techniques for the need of local population.

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