



Original Paper

**Culturally Adapted Interventions in Mental Health:
Global Position Statement**

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Abstract: *The preponderance of western psychological concepts are often relied upon to conceptualise health-related phenomena. It is hardly surprising therefore that despite the availability of a number of interventions, studies have concluded that outcomes for minority cultural groups are not as good as for Caucasian people (western Europe and North America) in many high and middle income countries (HMIC). The evidence base of most psychosocial interventions is yet to be established in Low and Middle Income Countries (LMICs). There has been a propensity in some quarters to view low and middle income countries as passive beneficiaries of mental health knowledge, rather than as contributors or partners in knowledge production and development. A move towards a more equal bilateral relationship is called for, which should lead to better service provision. This Position Statement aims to highlight the current position and need for culturally adapted interventions. It is a global call for action to achieve a standardised mechanism to achieve parity of access and outcomes across all cultural groups regardless of country of residence.*

Keywords: *Cultural adaptation, interventions, mental illness, meta-analysis, minority ethnic, psychotherapies*

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BACKGROUND

Globalisation has created culturally enriched and diverse societies. From a social point of view, politics and the media have recognised the rapid social and cultural changes which accompany migration of people and the consequent flow of ideas within and between nations.

The concept of culture, and its influence upon individuals, is itself dynamic, and as individuals and societies change, so do the relevant aspects of their culture. Therefore, it would be fair to say that each individual has a unique culture that is part of a broader culture and is constantly changing as a result of various influences depending on tensions between the individual and their value systems at relational interfaces. Each individual is further influenced by their own experiences and an amalgamation of the culture of different subgroups that influences their tolerance, expression and explanation of psychological distress as well as their help-seeking behaviours and pathways to care (Fernando, 2014). Culture may be one factor that assists in determining the degree of resilience individuals' show in dealing with their problems. As a result, during the past several decades, there has been a steadily increasing recognition of the importance of cultural influences on life and health.

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There is a need to improve the cultural competence of health services, enabling provision of evidence-based personalised care, unbiased by views about an individual's majority or minority cultural status and influenced only by respect for their values and worldview. Cultural competence in services can be nurtured through ensuring an awareness of different cultures and through cultural adaptation of interventions that are evidence-based. In this way, services, individuals and their families can draw strength from their cultural background (Rathod et al., 2015).

Most interventions for mental and physical health disorders in high and middle income countries, as currently delivered, have been criticised as being developed in western Europe or North America and are not in tune with varied cultural beliefs (Mills, 2014; White, 2013; Tribe, 2014). This is one of the reasons why people are often reluctant to work with clinicians or service users who have different cultural backgrounds to their own. It is also hypothesised that clinicians may not have the confidence or the cultural competence to work with people from diverse cultures. The concept of cultural relevance has, thus, become significantly more critical and challenges mental health professionals to develop interventions that are more responsive to culturally diverse populations.

However, over 80% of people suffering from mental disorders are residing in low and middle-income countries (LMICS), with mental illness and substance abuse disorders presenting as an important cause of disease burden, accounting for 8.8% and 16.6% of the total burden of disease in low and middle-income countries respectively (world health organisation, 2004; 2008). Provision of psychotherapeutic interventions is limited in mainstream treatments in many LMICS. This can be attributed to a number of factors: different priorities, lack of resources, different explanatory health models, inadequate training, distance and transport issues and the religious and political landscape. An approach to delivering mental health treatments and training programmes in LMICS responsive to the local culture, incorporating a public health approach while embracing the diverse needs of the population has begun and presents opportunities for global Generalisability (Rathod et al. 2017).

With the increasing realisation of the need, cultural adaptation of many interventions for mental and physical health problems is occurring across the globe (Naeem et al, 2010; Rathod et al. 2013) but this has also highlighted the need for guidance and standardisation of the practice of adaptation through building on the evidence (Rathod et al, 2017).

WHAT IS CULTURAL ADAPTATION OF INTERVENTIONS?

Cultural adaptation in this paper is taken to be 'the systematic modification of an evidence-based treatment (EBT) or intervention (EBI) protocol to consider language, culture, and context in such a way that it is compatible with the individual's cultural patterns, meanings, and values' (Bernal, et al., 2009). Cultural adaptation of an EBI would need to incorporate cultural competence, intelligence and cultural sensitivity, as these would guide the adaptation process. Falicov (2009) described cultural adaptations to evidence-based interventions (EBIs) as procedures that maintain fidelity to the core elements of EBI while also adding certain cultural content to the intervention or its methods of engagement. We would also suggest that the success of such an adaptation should emulate, at least, the effectiveness of the original intervention (Rathod et al., 2015).

Cultural adaption has often been assumed to be from high income to low and middle income countries but it is important to note that there are increasingly a range of counter-flows from LMIC to HIC (White et al, 2014). Health pluralism where more than one model of healing are used is being increasingly considered and evaluated (Halliburton, 2004, 2009; Tribe, 2007; Incayamar et al, 2009).

EVIDENCE OF BENEFITS OF CULTURAL ADAPTATION

In high and middle income countries, work on psychological interventions in a range of conditions has concluded that the outcome of the interventions as currently delivered for minority cultural groups is not as good as for the majority populations (Bhugra, 1997; Rathod et al., 2005) Often individuals from minority cultural groups do not engage with clinicians and interventions due to different attributions to illness symptoms that lead to alternative help-seeking behaviours into care. Even when

they begin seeking interventions, they may not complete them for the same reasons. Lack of cultural relevance can lead to a lack of trust in the systems of care.

Few evaluations of the effectiveness of interventions have included adequate numbers of non-Western cultural groups (Alvidrez et al., 1996), and few studies report on adaptations of proven interventions for use by culturally distinct populations (Loon., van Schaik., Dekker., Beekman (2013). For example, Hispanics and Asians are highly under-represented in research samples (Hussain-Gambles et al., 2004; Miranda et al., 2005; Wells et al., 2001), as requirements of literacy in the language of current residence systematically exclude individuals who are not fluent in this. Even when language is not an issue, clinical trials on psychological interventions generally enrol few minority clients, and analysis of trial results is usually not done separately based on ethnic group (Carroll et al., 2009).

There are therefore few studies of the effectiveness of evidence-based interventions in minority groups. The current criteria for judging good research designs may or may not be feasible for research on non-dominant cultural groups, and there are no paradigms for developing measures or for interpreting existing measures to incorporate ethnicity and racialized experiences (Helms, 2015). Therefore, the generalisation of findings to many ethnic and cultural groups may not be valid or even appropriate. Under-representation of minority groups in research samples is a significant concern that prompted the National Institutes of Health (NIH- a part of the U.S. Department of Health and Human Services) to issue a policy in 1994 (updated in 2001 (NIH, 2001)) mandating that ethnic minorities be included in all NIH-funded research. Despite this, there have only been a few randomised trials that have been able to demonstrate the efficacy of psychological interventions in minority groups (Grant et al., 2012; Ingman et al. 2016).

A recent review of meta-analyses of culturally adapted interventions in mental health showed a moderate to large effect for culturally adapted interventions. However, the authors argue that the only conclusions are that adapting interventions for culture is better than usual care due to limited studies including active controls and very few with non-adapted treatment arms in the meta- analysis. Moreover, the authors warrant caution in interpreting these results as most of these meta-analytic reviews lacked methodological rigour and were plagued with other problems, such as inadequate poor consideration of theoretical underpinning and cultural issues (Rathod et al, 2017).

The current evidence base may also be skewed by the fact that research published in high impact academic journals in HIC (high income countries) comes from countries where there are resources, facilities, impetus and a priority to report research. Patel and Sumathipala, (2001) noted that 94% of papers published in 6 leading academic psychiatry journals came from people based in HIC. So only 6% of papers came from parts of the world where approximately 90% of the population live. Therefore there is limited evidence of the effectiveness of these interventions in these countries, It seems important that this should change to ensure equity of service provision and a mutual sharing of information (Tribe, 2017). It is important to consider how different countries may use different types of interventions and adapt them based on resources and including spiritual interventions (for example; Raguram et al, (2002); Castillo, (2003).

Despite the potential for a cultural mismatch to render treatments ineffective, clinicians and researchers are disseminating psychological interventions globally, across widely diverse cultures (Casas, 1988; Chen et al., 2007; Naeem et al., 2010). Sometimes, local adaptations are made based on local cultural knowledge and some have been successful (Carter et al., 2003; Hinton et al., 2004; Kubany et al., 2003; Patel et al., 2007; Rahman et al., 2008; Rojas et al., 2007). Culture has, on occasions been seen as an additional factor or an 'add-on' rather than as a central or dominant organising factor for many people seeking help for their psychological distress. (Mills, 2014; Summerfield, 2008; 2012; Fernando, 2014, 2017).

Studies undertaken in low and middle income countries with different ethnic groups are increasing and these will contribute to our understanding and knowledge internationally. A recent study in Nigeria, one of the WHO longitudinal study sites, demonstrated better long term outcomes for patients with a severe and enduring mental illness, with "unexplained cultural factors" being cited as possible positive reasons for this (Jablensky et al, 1992; Cohen et al, 2009). . There have been trials

conducted in LMIC demonstrating the efficacy of culturally adapted interventions. These include culturally adapting therapy (Naeem et al., 2010) as well as adapting to local resources (Rahman et al., 2008). Although these and similar trials have been successful in showing the efficacy of culturally adapted interventions, they have not been formulated in terms of policy on a local, national or regional basis. Since these have not been utilized on a bigger scale, the effectiveness in generalizable terms remains questionable. This, therefore, means that apart from some scientific applause, the interventions have not been able to show the real impact, that they have the potential for.

CULTURALLY ADAPTED E-MENTAL HEALTH INTERVENTIONS

Recently e-mental health interventions have been proposed as viable solutions to address the mental health treatment gap in both high income (HICs) and in LMICs (Harper-Shehadeh et al., 2016; Arjadi et al., 2015). Online and e-interventions have been shown to help individuals interact and socialize with other people and ultimately overcome feelings of loneliness (Miller et al., 2015). Patients have also expressed interest in further receiving health related information from their doctors and allied healthcare workers through email and text messages (Miller et al., 2015). This form of service delivery has several advantages over the face-to-face treatments. It is relatively easy to tailor the content of the interventions linguistically and culturally according to various ethnic groups in an online setting (Eylem et al., 2015; Sanchez et al., 2017). Care does have to be taken to ensure interventions remain easy to find and use, and understandable with respect to language (Gorzynski et al., 2013).

Reviews of patient centred information on physical activity for people living with schizophrenia has found that online information and interventions are often not user friendly and easy to understand, with reading language requirements far above recommended grade 6-8 levels. Additionally, information is not tailored for age, gender, or culture, to help ensure behaviour change is realistic for this population group (Gorzynski et al, 2018). Despite the increasing potential of e-interventions (Miller et al., 2015), steps need to be taken to ensure online interventions are reaching target populations in an accessible, and culturally appropriate manner.

E-mental health interventions are particularly appealing for people of different cultural groups who are concerned about stigma and shame associated with help-seeking from their formal and informal networks (Eylem et al., 2016). From the service-providers perspective, e-mental health interventions promise to tackle the issue of cultural mismatch between the service provider and the service user, distance or transport issues which are restricting the provision of psychological therapies (Eylem et al., 2015; Sanchez et al., 2017).

The effectiveness and efficacy of culturally adapted e-mental health interventions have been mostly tested in HICs (Harper-Shehadeh et al., 2016; Unlu Ince et al., 2014; Tulbure et al., 2015) However, recently more RCTs have been conducted in middle income (LMICs) (Ip et al., 2016; Wang et al., 2013) and in LMICs (Arjadi et al., 2015). A recent RCT in a school sample of 257 Chinese adolescents in China showed that culturally adapted e-mental health intervention resulted in reductions of depressive symptoms at the 12 month follow up in comparison to the control group with a medium effect size ($d=0.36$) (Ip et al., 2016). Furthermore, culturally adapted e-mental health has promising implications in reducing depressive symptoms among migrant populations with constricted reach-ability in HICs (e.g. Unlu Ince et al., 2014). For instance, Unlu and colleagues tested the effectiveness of culturally adapted e-mental health, problem-solving intervention in a sample of 96 Turkish migrants with depressive symptoms in the Netherlands. The results showed significant improvement in depression symptoms in intervention group in comparison to the control group ($d=0.72$) (Unlu Ince et al., 2014).

Overall, current evidence suggests that e-mental health interventions can address the treatment gap and increase the impact of the culturally adapted psychological interventions in HICs, MICs as well as in LMICs. However, participant engagement remains the main challenge (Clarke et al., 2015). In line with the systematic reviews on the cultural adaptation of face-to-face psychological therapies, recent meta-analysis suggests that the extent of cultural adaptation has an effect on intervention efficacy in e-mental health literature (Harper-Shehadeh et al., 2016). Thus, more personalized or tailor made

strategies during the recruitment process are crucial in increasing the impact of culturally adapted e-mental health interventions (Sanchez et al., 2017).

ADAPTATION OF INTERVENTIONS

Adapting interventions for personalised care in developed countries or in LMICs carries inherent challenges and difficulties. It is easy to assume a global understanding of the culture or subculture. A number of biases such as stereotyping, causing incorrect adaptations when the intervention should allow latitude and flexibility for an assessment of every individual's personal values can be present. Cultural adaptation also proposes to modify evidence-based interventions, and the dilemma exists as to when fidelity to the core intervention is lost when adaptation compromises the effectiveness of an intervention (Rathod et al. 2015).

The World Health Organisation has recognised the issue and work has begun in this area. http://www.who.int/substance_abuse/research_tools/translation/en/. Rathod and colleagues (2018) have described an evidence-based methodology to adapting interventions using a model of coproduction and use of evidence.

Table 1 Evidence based methodology for adaptation of interventions (Naeem et al, 2016)

Stage 1: Review of previous literature and discussions with field experts, followed by information gathering using qualitative methods from patients, carers, lay persons, therapists, mental health practitioners and service managers concerning their experiences and views.
Stage 2: Producing guidance on adapting the intervention manual based on information.
Stage 3: Translation and adaptation of intervention material/manual.
Stage 4: Field testing the adapted intervention manual through a RCT and further refinement of guideline.

This model is currently being used to adapt interventions in a number of countries including China, Morocco and in countries in the Middle East (Li et al, 2017).

WHAT 'CAREIF' PROPOSES

There is an urgent need to review the availability of culturally adapted interventions and available adaptation frameworks. Standardised guidelines including lists or catalogues of resources and some measures of effectiveness and acceptability for different adapted interventions are required. This would require not only a series of round table conferences of experts (including experts with lived experience), but also needs empowered communities and patient leaders in a social change movement.

International Level

We have to recognise that the world is rapidly becoming truly global and that the challenges and opportunities of the intermingling of different ethnicities, nationalities and cultures have to be addressed thoughtfully and proactively. International organisations can shape the landscape by influencing global policies in health and social care through promoting the need for culturally competent services that deliver culturally adapted interventions and lead to good outcomes and experiences of every individual. It is vital that issues of power and financial disparities are considered and confronted in any consultation and that these do not influence decision-making which should be based on evidence. International organisations are often located in HMIC and socialised into particular models of health care, which they may assume can be generalised around the world, when this may not be the case.

Government and National Level

We believe that governments and political leaders play a crucial role in influencing and celebrating cultural diversity by addressing stereotypes and valuing cultures. A consistent message of the strength in diversity can mitigate the tendency to dehumanise specific cultural groups and promote a healthy respect for all cultures. Where necessary, there should be policies to ensure that appropriate services and interventions are made available.

Better information systems would help, for example, national drug approving agencies could set expectations that new drugs should have data on risk-benefit ratios for cultural minorities so that prescription decisions could be more data-driven.

Local Service Level

Systems of health care should know the cultural breakdown of the population they serve and develop culturally informed services that are inviting to minority cultures in their setting.

There should be monitoring systems in place to identify, address and mitigate cultural disparities in the provision of care. This should include means to ensure that staff are adequately trained in culturally competent interventions and reduce the likelihood of the differences in outcomes across cultures. Monitoring of outcomes is essential to understand other factors that may be contributing to these differences and make attempts to impact on them.

Cultural literacy and sensitivity of mental health providers

Cultural competency should be required for all providers of mental and physical health care across the world. The elements of cultural competency should at least include an understanding of explanatory health beliefs, psychopathology, idioms of distress and help-seeking behaviour for individuals of different cultures but for the populations which they serve. Clinicians who provide interventions should be competent in delivering culturally adapted interventions, curious about different cultural understanding and open to understanding their patients understanding of their psychological distress.

We recognize that all cultures are dynamic, and adapt to their changing circumstances and hence clinicians should keep their knowledge and understanding current through different means.

Concerted research effort to obtain data on cultural minorities

There should be an effort to include individuals from minority cultures in various clinical trials. Research should encourage a separate subgroup analysis of multiple interventions based on cultural subgroups. Specific funding should be available to develop an evidence base of effective interventions across cultural groups.

A more personalized approach and participatory research techniques need to be incorporated in recruitment plan and researchers should make sure they spend enough time to network with their target population (e.g. through regular community visits) before they start their research.

Empowerment of communities

There should be recognition of the need for cultural competence for various cultural groups around the world and a comprehensive set of interventions that are needed to address access, outcomes and stigma. In addition to community outreach and education, individuals from particular cultural groups who have dealt with mental illness (individuals with lived experiences) should be used as ambassadors to spread the education and positive message of culturally adapted interventions. A variety of measures are needed including enlisting the help of religious, political and cultural leaders of that group to have a just society.

CONFLICT OF INTEREST:

None of the authors have received funding to prepare this manuscript. The authors are however experts in this field and have received research grants, lectured on the topic and published widely in this area.

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