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ORIGINAL RESEARCH

The acceptability of cognitive behaviour therapy in Indonesian community health care

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Abstract

Cognitive behaviour therapy (CBT) is considered to be the most empirically supported treatment in the Western world. However, many authors emphasize the need for cultural adaptations of CBT for patients in a non-Western context. Before considering such adaptations, it is important to investigate the reasons and the degree to which this type of treatment should be adapted. One important factor is the acceptability of CBT by local health care consumers in non-Western countries, for which there is only very limited empirical evidence. This explorative study aimed to investigate the acceptability of CBT's principles and specific interventions in Indonesia. Lectures and video clips were developed, demonstrating various mainstream CBT principles and procedures. These were presented to 32 out-patients and mental health volunteers from various Indonesian community health centres (*Puskesmas*), who were asked to rate to what extent they considered the presented materials to be acceptable in accordance with their personal, family, cultural and religious values. Acceptance in all four value domains was rated as very high for the general features of CBT, as well as for the content of the video clips. There were no significant differences in acceptability between the value domains. The presented study suggests that mainstream CBT applications, which are slightly culturally adapted in terms of language, therapist–patient interaction and presentation, might resonate well with consumers in community health centres in Indonesia.

Key learning aims

(1) Adapting CBT to non-Western patients should be based on empirical evidence.
(2) The potential need for adaptation of CBT might depend on the acceptability of unadapted CBT.
(3) Acceptability is assumed to be related to patients' values.

Keywords: acceptability; cognitive behaviour therapy; community mental health centres; cultural adaptation; Indonesia

Introduction

Cognitive behaviour therapy (CBT) encompasses a great variety of psychological interventions for a broad range of psychopathologies that have accumulated considerable evidence for its effectiveness. Until now, however, most treatment outcome studies have been carried out involving predominantly patients from ethnic and cultural majorities in Western countries, with cultural minorities being generally under-represented (Rathod *et al.*, 2015), and CBT studies in non-Western countries being far outnumbered. Despite the stipulated relevance of cultural factors in psychopathology and its treatment, there is an ongoing debate whether

mainstream Western CBT can be generalized to patients living in non-Western cultures (Cardemil, 2010; Draguns, 2013). It seems fair to assume that treatments should be culturally adapted if these appear to be significantly less acceptable (e.g. conflicting with a person's values and customs), less accessible (e.g. limited pathways to mental health care, failure to engage in treatment) and less efficacious (e.g. too little improvement, more drop-outs) with individuals in specific cultural groups (Cardemil, 2010) than would be expected based on results in other cultural contexts.

Cultural adaptation of psychological treatments has been described as: 'the systematic modification of an evidence-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values' (Bernal *et al.*, 2009; p. 362). As Rathod *et al.* (2015; p. 28) state: 'CBT has the potential, with adaptation, to achieve multiple objectives within multicultural health care – it allows for the incorporation of tradition and languages and uses personal, cultural, and collective resources to increase self-awareness in healing. CBT can also serve to modify health-related behaviours, improve self-management, and instil hope and resilience'.

Recent meta-analyses showed that culturally adapted cognitive behavioural treatments are somewhat more effective than their non-adapted counterparts (e.g. Griner & Smith, 2006; Hall *et al.*, 2016; Van Loon *et al.*, 2013). In a review of 12 meta-analyses covering a wide range of mental disorders, Rathod *et al.* (2018) concluded that cultural adaptations show a moderate to large effect size in comparison with care as usual. A major limitation is that the bulk of the cultural adaptations in these studies pertains to patients living in Western countries with cultural backgrounds that differ from the dominant culture (notably minorities, immigrants or refugees). Studies addressing the application and adaption of CBT to patients living in non-Western parts of the world are only recently emerging. One example is the study by Arjadi *et al.* (2018b), who found beneficial effects of internet-based behavioural activation for depression in Indonesia. Three randomized controlled trials in Pakistan found culturally adapted CBT for depressed patients to be more effective than treatment as usual (Naeem *et al.*, 2009, 2010, 2015). A meta-analysis from China (Ng and Wong, 2018) including 53 studies found stronger treatment effects in the 23 studies using adapted CBT compared with the 30 studies using un-adapted CBT. Despite the apparent greater effectiveness of culturally adapted treatments, direct comparisons between culturally adapted and un-adapted treatments are lacking, and it remains relatively unclear what adaptations have been made in most studies (Rathod *et al.*, 2018).

Although in general the need for cultural adaptations seems evident at face value, the pertinent question is *which* adaptations might be needed, and *how* this should take place. The process of cultural adaptions may be conceptualized on a continuum, from 'importing' Western CBT at one extreme, to 'total adaptation' (basically developing novel treatments in a particular cultural context) at the other extreme. Regarding the latter, detailed proposals have been advanced by, for example, Hinton and Jalal (2014), Hinton and Patel (2017) and Naeem *et al.* (2009) on the many factors that should be taken into account for such an adaptation. Bernal *et al.* (1995) proposed a widely cited adaptation framework consisting of eight adaptation factors, namely language, persons, metaphors, content, concepts, goals, methods and context. It is assumed that incorporating the culturally specific explanatory theory of mental problems, and the local symptom conceptualization by patients and caregivers will lead to a culturally acceptable treatment approach. In addition to these content-related factors, format-related elements are, for example, the use of supportive (written) materials, the duration of treatment, family involvement, deployment of local therapists, and collaboration between mental health care professionals and traditional health care providers.

On the other hand, rather than developing a treatment in non-Western countries from scratch, it might be more efficient to depart from treatments that have already proven to be effective in a Western context, and subsequently establish what adaptations need to be implemented in order to

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enhance their acceptability, accessibility and effectiveness (Bernal *et al*., 2009; Cardemil, 2010; Spilka and Dobson, 2015).The underlying argument is that this so-called 'benchmarking' strategy is more practical, more cost-effective, and does justice to the already existing empirical evidence for such treatments in Western countries.

However, before actually implementing treatments in clinical practice in non-Western countries, it is relevant to investigate *a priori* its acceptability for the recipients of care (Cardemil, 2010). This focus on the demand side of mental health care might inform us about the potential need for cultural adaptations. Because acceptability has many aspects, in the present study we narrow this down to a person's values. Values are defined as 'principles or standards of behaviour; one's judgement of what is important in life' (Oxford English Dictionary). Schwartz (2012) described values as trans-situational goals, varying in importance, that serve as guiding principles in the life of a person or group.

Remarkably, research on treatment acceptability is rather scarce outside the Western world. Three publications are of particular relevance to the present study. Scorzelli and Reinke-Scorzelli (1994) carried out an explorative study among 62 university students in India. After a workshop on cognitive treatment, 82% of the participants indicated (by answering 'yes' or 'no') that this approach conflicted with their values, more specifically with their religious (mostly Hindu; 40%), or cultural and family (47%) values. A similar study in Thailand by the same authors (Scorzelli and Reinke-Scorzelli, 2001) involved managers and directors of mental health institutions. After a workshop on rehabilitation counselling, 93% of the participants found the treatment to be consistent with their family, cultural and religious (mostly Buddhism) beliefs. These authors provided some speculative interpretations of these widely divergent findings between their two studies. In a study on acceptability of the cognitive model among 32 male and female university students in Pakistan (Naeem *et al*., 2009) a workshop on psychotherapy, CBT and different concepts around CBT was held. The participants used visual analogue scales to rate the compatibility of four value domains: personal, family, social and cultural, and religious values. The results showed a general trend of moderate to high agreement among students, indicating that the CBT concepts did not conflict with their values.

Studies into acceptability in more general terms are also scarce. In rural Pakistan, the feasibility and acceptability of a CBT-based WHO group program called Problem Management Plus (PM+; World Health Organization, 2016) was found to be acceptable by patients, families and lay-helpers (Khan *et al*., 2019). In an online survey in Indonesia, it was found that about three-quarters of the 904 Indonesian respondents (who varied between not depressed and moderately depressed) considered an internet-based treatment (i.e. behavioural activation) for depression an acceptable option (Arjadi *et al*., 2018a). Although these first results seem to be in favour of CBT being acceptable in South and South-East Asia, this issue is in dire need of more research.

Background of the present study

The present study aims to contribute to the development of a CBT approach that is applicable in the context of community health centres (*Pusat kesehatan masyarakat*, or *Puskesmas* for short) in Indonesia. Although in a *Puskesmas* various disciplines such as general practitioner, midwife, dentists and nurses are employed, mental health has traditionally been an under-served area. Moreover, with over 9000 *Puskesmas* across Indonesia, only a handful of these employ psychologists, thereby underscoring the need for capacity building. For that reason, the Faculty of Psychology of the Universitas Gadjah Mada in Yogyakarta, Indonesia took the initiative in 2004 to deploy psychologists in *Puskesmas* (Retnowati, 2011), starting in Yogyakarta, and gradually spreading across the country. It has been found that psychologists in primary health care in Indonesia consider capacity building, in particular the need to acquire skills in delivering evidence-based treatments, as very important (Setiyawati *et al*., 2014).

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The present study addresses the acceptability of the principles and practice of CBT for Indonesian mental health patients and those involved in community health centres. Thereby, we specifically focused on common mental disorders (anxiety and depression), as their prevalence is estimated to be as high as 9.8% across Indonesia (Badan Penelitian dan Pengembangan Kesehatan, 2019). To explore treatment acceptability in a more experiential way rather than providing a textual description, we developed video materials that served to demonstrate the actual content and interactions during treatment sessions. The current research question pertains to the extent to which mainstream CBT procedures with minor cultural adaptations agree with the Indonesian participants' personal, family, cultural and religious values. These four value domains were derived from the above-mentioned studies by Naeem *et al.* (2009) and Scorzelli and Reinke-Scorzelli (1994, 2001), and can be considered to range from proximal (i.e. personal) values to more distal (i.e. religious) values.

Method

Participants

Because of their close link to Indonesian community (mental) health care, patients as well as mental health volunteers were recruited to participate in this study. Patients receiving a psychological treatment at one of the *Puskesmas* (community health centres) in Yogyakarta were invited for participation by their own psychologists. The 10 patients who consented to participate were assumed to be representative of *Puskesmas* patients suffering from common mental disorders.

In addition to patients, 22 volunteers (also referred to as *Kader*) were invited to participate, as they play an important role in the Indonesian health care system. These volunteers are usually women with no specific training in health care, who find it important to contribute to the welfare of their local community. Part of their task is to take care of their neighbours in their community, to accompany them to the health care centre, and to assist patients to comply with a prescribed health care regimen.

The total sample consisted of 32 participants who gave their written informed consent. Mean age was 44.9 years ($SD = 12.3$; range 22–64 years), with 30 women and two men. Ten participants were unmarried, 21 were married, and one was widowed. Their educational level was senior high school ($n = 15$), junior high school ($n = 12$) or lower education ($n = 5$). Ethical approval for this study was obtained from the Faculty of Psychology, Universitas Gadjah Mada, Yogyakarta, Indonesia.

Materials

Development of video clips

We developed nine brief role-played video clips (5–8 minutes each), each demonstrating a particular CBT procedure concerning the assessment and interventions of anxiety and depressive problems of a fictional patient (see below).

The videos were developed using the following steps: first, an outline of each of the clips was written by the authors. In each clip a brief explanation of a procedure was given by the role-played therapist, followed by a specific demonstration of that particular procedure. This was done in such a way that these would follow mainstream CBT conventions. Initially, the case pertained to a male patient suffering from panic-related symptoms. He had catastrophic cognitions concerned with somatic anxiety symptoms such as dizziness and fear of collapsing, which lead to avoidance of situations such as going out by himself, leading to feelings of depression. Next, the second (female: 'therapist') and first author (male: 'patient') video recorded the role plays of nine topics (see details below) in English.

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After the videos were watched by the third author and her team of Indonesian psychologists, we decided to make a few modifications in the case description (but not in the actual interventions) to make this more characteristic of mental out-patients usually seen in *Puskesmas*. Our discussion led to a shift of emphasis in the case presentation from mostly intrapersonal anxiety to predominantly interpersonal anxiety. Therefore, the patient role was rewritten as the wife of a community leader (instead of a male) who exhibited the fear of public speaking and interacting in community meetings (instead of self-focused panic attacks). Her catastrophic thoughts and worries referred to the negative opinion of other people (instead of a somatic catastrophe), and to the somatic anxiety symptoms, most notably dizziness. These symptoms led to avoidance of social situations, and taking precautions to prevent dizziness, resulting in serious restrictions in daily life, and feelings of depression.

Finally, all nine videos were re-recorded displaying an Indonesian context. For that purpose, role plays in Bahasa Indonesia (the national language) were carried out by two local Indonesian female psychologists, notably the third author (in the role of 'therapist') and a junior member of the Centre for Public Mental Health (as the 'patient'). Herewith, at least three of the eight factors mentioned by Bernal *et al.* (1995) were addressed, namely language (i.e. using local and culturally appropriate language), person (i.e. a cultural match between patient and therapist), and context (i.e. an anxiety problem that involved relations with other people).

Video clips

In nine separate clips the following topics were covered:

Clip 1: Explaining the CBT rationale. After a brief introduction of the purpose and structure of the session, the therapist explained the relation between cognitions, emotions and behaviours, using the classic burglar example described by Beck *et al.* (1979).

Clip 2: Problem exploration. The therapist asked questions that helped to get a clear sight on specific problematic situations (i.e. anxiety in social situations), the beliefs held, and the related avoidance and safety behaviours.

Clip 3: Exploring core beliefs. Using the downward arrow technique, this clip demonstrated in an interactive manner how to help the patient to move from a specific situational belief to a core belief.

Clip 4: Explaining the two-column technique. This clip showed how to elicit evidence for and against a problematic belief ('I will go crazy') using a Socratic dialogue. After having completed the two columns the patient was again asked how strong her belief is.

Clip 5: Explaining the pie chart technique. This technique explored alternative explanations of the patient's belief that people might think she is 'crazy' when she would faint and lie on the floor.

Clip 6: Situational exposure. After explaining the principle of exposure *in vivo*, therapist and patient worked together to construct a fear hierarchy, and to formulate a specific homework assignment related to giving a brief speech during a community gathering.

Clip 7: Interoceptive exposure. Connecting with the patient's somatic fears, the therapist first explored the patient's belief that she might fall on the ground when feeling dizzy and not holding on to a table. Subsequently, dizziness was induced by turning her around in a swivel chair, then standing up whilst refraining from holding on to something. This was followed by a discussing of her beliefs about the dangerousness of dizziness.

Clip 8: Response prevention. Explaining its principle, and relating this to situations familiar to the patient, an example was given how to formulate a homework assignment.

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Clip 9: Behavioural activation. The therapist explained the relation between lack of reinforcement and depressed mood. The principle of behavioural activation was introduced, emphasizing the distinction between mastery and pleasure. Next, they collaboratively designed a homework assignment.

Questionnaire

Participants filled out a questionnaire booklet containing questions that pertained to the degree on which each of the aspects (presented in detail in Tables 1 and 2) agreed with the participants' personal values, family values, cultural values and religious values (largely similar to Naeem *et al.*, 2009). Answers were given on a Likert scale from 1 ('not at all converging with values') to 10 ('totally converging with values'). For each topic, open questions were added to elicit spontaneous comments.

Procedure

After accepting the invitation, participants were welcomed as a group at the Faculty of Psychology where they attended four sets of 30-minute lectures by the third author (D.S.) and subsequently watched the nine video clips. The lectures focused on the nature and principles of psychological treatments in general and CBT in particular, the cognitive model of psychopathology, and the practice of CBT. After each lecture, participants were asked to fill in part of the questionnaire booklet. Next, participants were shown the nine video clips, and after each video clip, answered questions about the relation between the clips' content and their personal, cultural, family and religious values.

Analytic plan

Repeated measures analyses were carried out to test for differences between the mean scores of the four value domains for each of the items separately.

Results

Quantitative results

The principles and practice of CBT that were discussed during the lectures received high mean scores, indicating a high level of agreement with the four value domains (see Table 1). Repeated measures analyses revealed no statistical differences between these domains on any of the items. Visual inspection of the absolute mean scores suggested that the items most in agreement (with means scores higher than 9) with all value domains were: 'Individual responsibility for personal behaviour', 'Patient–psychologist collaboration', 'CBT as a multi-session treatment, 'The role of homework in CBT' and 'Identifying core-beliefs'. The least agreed items with mean scores somewhat below 8, were 'The emphasis on individualism in CBT', and the 'Equal position of patient and psychologist'.

In line with the above findings, Table 2 shows that the content of each of the nine video clips was rated as considerably in agreement across all four value domains. Repeated measures analyses revealed no statistical differences between value domains for each of the nine clips. In addition, participants found the CBT procedures easy to understand, and considered each of these to be helpful for solving their problems.

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Table 1. Mean scores of agreement with CBT principles and practice

Topic	Personal values Mean (*SD*)	Cultural values Mean (*SD*)	Family values Mean (*SD*)	Religious values Mean (*SD*)
Principles of CBT				
1. CBT as a treatment for mental disorders	8.7 (1.6)	8.1 (1.7)	8.4 (1.8)	8.8 (1.4)
2. The cognitive model of psychopathology	8.5 (1.6)	8.3 (1.5)	8.5 (2.0)	8.5 (2.0)
3. The relation between events, thoughts, emotions, behaviours	8.3 (1.9)	8.3 (1.8)	8.3 (2.1)	8.6 (2.1)
4. Individual responsibility for personal behaviour	9.5 (0.9)	9.3 (1.1)	9.3 (1.3)	9.5 (0.8)
5. The emphasis on individualism in CBT	7.5 (3.0)	6.7 (3.0)	7.2 (3.0)	7.2 (3.0)
6. Patient–therapist collaboration	9.5 (0.9)	9.3 (1.0)	9.4 (0.9)	9.5 (0.8)
7. Equal relation between patient and therapist	7.3 (2.7)	7.3 (2.6)	7.2 (2.8)	7.2 (2.8)
Practice of CBT				
1. CBT as a multi-session treatment	10.0 (0.0)	9.7 (1.6)	10.0 (0.0)	10.0 (0.0)
2. The role of homework in CBT	9.6 (1.8)	9.6 (1.8)	9.3 (1.8)	9.1 (2.0)
3. The nature and use of the Socratic dialogue	8.5 (2.2)	8.3 (2.2)	8.5 (2.2)	8.7 (2.0)
4. Identifying dysfunctional thoughts	8.7 (1.8)	8.3 (1.8)	8.3 (1.8)	8.6 (1.7)
5. Changing dysfunctional thoughts	8.8 (1.4)	8.3 (1.5)	8.5 (1.5)	8.4 (1.7)
6. Identifying core beliefs	9.5 (1.9)	9.5 (1.9)	9.5 (1.9)	9.5 (1.9)

1, no agreement at all with values; 10, total agreement with values.

Table 2. Mean scores of agreement with the CBT procedures shown in the nine video clips

Topic of video clip	Easy to understand[a] Mean (*SD*)	Help problem solving[a] Mean (*SD*)	Personal values[b] Mean (*SD*)	Cultural values[b] Mean (*SD*)	Family values[b] Mean (*SD*)	Religious values[b] Mean (*SD*)
1. Explanation of CBT rationale	8.8 (1.5)	8.9 (1.6)	8.9 (1.3)	8.7 (1.4)	8.8 (1.4)	8.9 (1.3)
2. Problem exploration	8.3 (2.2)	8.3 (1.8)	7.7 (2.4)	7.1 (2.5)	7.6 (2.4)	7.7 (2.4)
3. Identifying core beliefs	8.3 (2.0)	8.0 (2.4)	8.1 (2.1)	7.9 (2.1)	8.1 (1.9)	8.2 (1.9)
4. Flexible thinking: evidence for and against	8.7 (1.7)	8.8 (1.6)	8.4 (1.7)	8.2 (1.7)	8.3 (1.9)	8.4 (1.9)
5. Flexible thinking: pie chart	8.8 (1.4)	8.5 (1.5)	8.5 (1.5)	8.3 (1.7)	8.2 (2.0)	8.4 (1.7)
6. Situational exposure	8.8 (1.5)	8.3 (2.2)	8.6 (1.6)	8.6 (1.4)	8.5 (1.6)	8.7 (1.5)
7. Interoceptive exposure	9.1 (1.2)	8.8 (1.8)	8.8 (1.6)	8.7 (1.6)	8.8 (1.4)	8.8 (1.4)
8. Response prevention	9.1 (1.3)	9.1 (1.2)	8.9 (1.3)	8.7 (1.4)	8.8 (1.4)	8.9 (1.3)
9. Behavioural activation	9.0 (1.4)	9.1 (1.3)	8.9 (1.3)	8.7 (1.4)	8.9 (1.3)	9.0 (1.4)

[a]Scores: 1, not at all; 10, totally.
[b]Scores: 1, no agreement at all with values; 10, total agreement with values.

Qualitative findings

In addition to the quantitative data, participants were invited to write any kind of comment for each of the topics discussed. Many of these comments appeared to be rather general in nature, repeating what had been said during the lectures or in the video clips, rather than being actual comments on their content.

Regarding the *CBT principles* some comments emphasized the relevance of interpersonal aspects, notably the need for other people in one's life, and the importance of collaboration during treatment.

Comments on the *CBT procedures* referred to CBT as a multisession therapy ('Regular consultations are needed to shape new behaviours'), and the importance of homework assignments ('Doing homework can be a parameter of how strong the patient wants to heal'). Regarding the Socratic dialogue most comments were generally supportive, such as: 'Without

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any questions the psychologist will not know the patient's problems'. The intervention of challenging dysfunctional beliefs and core beliefs was met with comments like: 'It is necessary to prove that the thought is not always true', and 'Because that belief is the root of the problem to be solved'.

Two of the four value domains were explicitly mentioned by a few participants. Regarding family values, some comments were made on the relevance of family support, as well as on one's responsibility towards the family. Quite remarkably, religious values were hardly addressed, although referring to the cognitive model a few participants remarked for instance: 'The religious and faith approach helps as well'.

Video clips

Comments on the video clips supported the usefulness of the two cognitive techniques for their use of diagrams. Interestingly, the behavioural interventions involving exposure and activation led to most supporting comments.

The overall conclusion from the qualitative data points to a general sense of support for CBT practices and interventions.

Discussion

This study investigated the extent to which mental health care out-patients and health care volunteers in Indonesia consider the principles and practice of CBT to agree with their personal, family, cultural and religious values. In particular, introductory lectures and nine video clips demonstrating the therapist–patient interactions with specific CBT procedures for emotional disorders were evaluated. Overall, the results show that the participants rated all CBT-related topics as highly agreeing with the four value domains, with no differences between these domains. In line with the high endorsement scores on the quantitative questionnaire, qualitative comments revealed that most aspects of CBT were considered to be understandable and helpful. We interpret these findings as a general support for the acceptability of CBT interventions for anxiety disorders in Indonesian community health care, similar to the findings of Arjadi *et al.* (2018a) and Naeem *et al.* (2012). More specifically, our findings are mostly in line with those of Naeem *et al.* (2009) and Scorzelli and Reinke-Scorzelli (2001), who also found moderate to high agreement of their participants' values with CBT. This is somewhat in contrast to the widely assumed need for elaborate fine-tuning related to cultural values (see e.g. Hinton and Jalal 2014). It also raises the question whether it would be necessary to entirely adapt CBT to the Indonesian context. It might be that just a limited amount of tweaking (i.e. adapting language, local examples, therapist–patient cultural match) will be sufficient, thereby retaining the general CBT approach, and benefitting from the empirical database that already exists in the Western world (see Cardemil, 2010).

Our qualitive data suggest the relevance of family support and involvement. This may point to the fact that interdependence is a prominent Indonesian value, rather than the emphasis on independence in Western conceptualizations of psychological well-being. In addition, although only a few participants mentioned their Islamic faith as an important factor in promoting mental health, religion and belief systems play an important role in Indonesian daily life, with around 85% of the population being Muslim.

Strengths

This is the first study to apply a mixed-method approach to elicit comments from Indonesian mental health care volunteers and out-patients on their views about the theoretical and practical aspects of CBT. Our sample has therefore relatively high ecological relevance, in

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contrast to previous studies, which involved students and mental health care managers (Naeem *et al.*, 2009; Scorzelli and Reinke-Scorzelli, 1994, 2001). The limited cultural adaptation of CBT in the lectures and video clips consisted of the use of the local language, the presence of two local actors, and a problem to which the participants could easily relate. Furthermore, instead of presenting participants with only workshops (e.g. Naeem *et al.*, 2009; Scorzelli and Reinke-Scorzelli, 1994, 2001), we also used additional brief video demonstrations of CBT procedures for emotional disorders. This method presented the participants with very concrete and identifiable insight into the procedures and the ways they were delivered.

Limitations

Being a preliminary exploration, this study has some limitations. The sample consisted of a relatively small number of selected participants, being a mix of out-patients and mental health volunteers. In particular, these volunteers may already hold a favourable attitude towards a psychological approach in general. However, due to the small sample size it was not possible to statistically test differences between these two subgroups. Moreover, our sample cannot be considered representative of the very large and culturally diverse population of Indonesia.

Furthermore, the emphasis during the lectures on just CBT and its techniques might have led to an unintended positive framing of this particular type of psychotherapy. On the other hand, it also suggests the potential benefit of a clear explanation of treatment components to increase their acceptability. Considering the measurements, acceptability was measured with a purpose-made questionnaire, in which the value domains were not explicitly described but only indicated in broad terms, similar to the approach by Naeem *et al.* (2009), and Scorzelli and Reinke-Scorzelli (1994, 2001). This might have obscured a more detailed assessment of the way in which the participants relate CBT to specific values. Finally, as an alternative explanation for the very high endorsement scores, response tendencies, such as acquiescence and socially desirable responding might have been influential. It has been found that these response tendencies are generally more prominent in participants with a non-Western background (Johnson *et al.*, 2011).

Recommendations for future research

In order to further explore the acceptability of empirically supported treatments in non-Western contexts, various steps can be taken. Firstly, to address this study's limitations of its small sample size and lack of representativity, larger and more diverse samples need to be studied. In particular, a huge country like Indonesia is characterized by a vast cultural and socio-economic diversity, which is assumed to impact for instance mental health literacy, vulnerability to mental health problems, and access to mental health care. Because the present study has been carried out in an urban region on the Indonesian island of Java, replication in rural areas and on remote islands is therefore recommended. As an aside, it should be mentioned that lack of representativity can be considered a more general issue in treatment outcome research, in which diversity does not get the attention that it deserves. Secondly, the operationalization of 'values' requires more attention. In our own, as well as in previous studies, values have been presented in a broad and undefined manner. Instead of investigating value domains, it might be more insightful to investigate specific values, as has been for example been proposed by Schwartz (2012). In his theory, he conceptualizes 10 (and in his later work, 19) basic values that serve as internalized standards or norms, leading to goals, and to specific actions and behaviours. Examples of values according to this theory are hedonism, security, conformity, tradition, benevolence and universalism. There is empirical evidence for cross-cultural stability and hierarchical ordering of these values (Schwartz, 2012). Thirdly, as this study relies on self-report data of acceptability in rather broad terms, an important next step would be to focus

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on the actual patient behaviour when receiving treatment. It would be important to investigate the obstacles in care delivery, and the way in which these are (amongst others) related to differences between patient values and psychologist values. In parts of Indonesia, for example, it is not appreciated to disclose personal discomfort or 'bad' thoughts, as it would violate the principle of harmony in Javanese culture. This might clash with the therapist's use of a typical CBT thought record, in which patients are asked to write down their negative thoughts.

Finally, in addition to a theoretical perspective, a more in-depth ethnographic approach would involve focus group discussions with a wide variety of local health care consumers, health care professionals, traditional healers, as well as religious leaders. Such a qualitative approach may shed more light on values that are important for patients and other stakeholders, and on ways in which these can be incorporated in treatment approaches. As an example, discussing the Islamic modification of CBT, Hodge and Nadir (2008) argue that, whereas the structure of the CBT approach may be retained, its secular and individualistic concepts can be tuned to the spiritual and more collectivistic Islamic belief system, whilst at the same time retaining its effectiveness.

Research into the acceptability of psychological treatments in general and CBT in particular would potentially contribute to promoting mental health care in non-Western countries, and for patients with a non-Western background. Values are considered to be important factors of acceptability, as these constitute the things that patients find important in their life, and that guide their goals and behaviours. The challenge is to integrate knowledge and awareness about values in the research and practice of CBT. In the end, optimizing patient acceptability (including patient values), compliance and treatment outcome are among the key variables in promoting mental health care in non-Western countries such as Indonesia.

Key practice points

(1) Mainstream CBT interventions seem to be acceptable in a non-Western context.
(2) Patient values are assumed to play a role in treatment acceptability.
(3) Therapists should be aware of patient acceptance of treatments.

Further reading

Rathod, S., Gega, L., Degnan, A., Pikard, J., Khan, T., Husain, N., ... & Naeem, F. (2018). The current status of culturally adapted mental health interventions: a practice-focused review of meta-analyses. *Neuropsychiatric Disease and Treatment*, *14*, 165–177.

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