Cultural adaptation of CBT as a human rights issue

Cultural Adaptation of CBT as a Human Rights Issue: A UK Study

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Abstract

Cognitive behaviour therapies have been used widely across the world and have been recommended as the first line of psychotherapeutic treatment for multiple mental health disorders. However, such blanket guidelines for use of Western-generated psychotherapies discount the socio-cultural determinants and aspects of mental health when recommended unadapted across ethnicities, eventually creating disparities in the *quality* of care available to different populations. Examining the cultural relevance of these therapies for ethnic minority groups has therefore become an important avenue of inquiry.

Recent decades have brought a revolution of cultural competency and adaptation research for such psychotherapies. Despite recent advances in cultural competency and adaptation research, the available body of literature in this domain remains limited and heterogenous. Furthermore, the lack of mandatory cultural competence training and the ineffectiveness of existing programmes increase the obvious discrepancy in the provision of mental healthcare services for certain minority groups, jeopardising equitable access and raising concerns about human rights protection.

Aims: This study aimed to explore UK-based CBT therapists' use of adaptations in their own practice, and understand what elements they tend to adapt, the impact and feasibility of their approaches, and the challenges faced by those who adapt and those who do not. The larger intention was to be able to gather information to recommend basic direction for policy and

research to create plans for the benefit of ethnic minority groups for whom access to quality, tailored healthcare is currently largely overlooked.

Method: The study involved developing a survey informed by existing literature and distributing it to UK-based CBT therapists.

Results: This study found that CBT therapists and their clients value cultural competency. It also found that therapists tend to believe that adapting CBT techniques and implementation and using culturally significant idioms and stories are impactful for their clients and practical to achieve as therapists. It further found that current barriers to adapting CBT for ethnic minority clients involves a lack of resources to study the efficacy of adaptations as well as a lack of well-established evidence-based adaptations in existing literature.

Conclusion: The authors recommend that policymakers and service managers prioritise the regulation of cultural competence in psychotherapy and afford resources and incentive to researchers and clinicians that would eventually help to improve the effectiveness of their approaches and enhance mental health outcomes for ethnic minority groups. Future research could build on this study using qualitative methods or creating more robust surveys, using random sampling, and drawing larger sample sizes.

In recent decades, psychotherapy seems to have become of significant importance to society at large and among policymakers in the UK (Holmes, 2002). Till date, one class of psychotherapy has emerged as the primary frontline treatment: Cognitive Behaviour Therapies (CBT). These therapies are efficient to administer, evidence-based, and do not require extensive expenditure or time as compared to other forms of therapy (Guadiano, 2008). However, despite their popularity among the clinical community, it is now well understood that CBT does not work as effectively for all communities alike; culture is an important determinant of its effectiveness (Rathod et al., 2018).

Significance of Cultural Considerations, Human Rights, and Resource Disparities

Firstly, a recent review of the public health budget for ethnic minority communities in the UK suggests that ethnic minority communities in the UK personally desire culturally appropriate mental health services (Ayoola & Butt, 2021). According to this review, the therapists' lack of cultural understanding affects not only ethnic minority engagement with services, but also a lack of trust in them. Here, ethnic minorities are defined as: "all ethnic groups except the white British group. It can include South Asians, East Asians, Black, Caribbean and other subgroups. Ethnic minorities include white minorities, such as Gypsy, Roma and Irish Traveller groups" (Racial Disparity Unit, 2021, Ethnic minorities section).

Secondly, research illustrates the value of cultural competence and adaptations in therapy as well as the pitfalls of a lack thereof. Several studies have shown that improved cultural competence and use of culturally adapted therapy can have more positive mental health outcomes for ethnic minorities (Sue et. al., 2009; Griner & Smith, 2006; Soto et al., 2019). Here, cultural competence is defined as providing culturally appropriate mental health services by attending to differences in language as well as cultural influences on values that shape the experience of mental ill-health and help-seeking behaviours (Bhui et al., 2007). Instances where the therapist imposes their own cultural beliefs onto the client are associated with poorer

outcomes, and lack of adaptation and sensitivity to cultural nuances can instead actively cause further distress for ethnic minority service users (Comas-Diaz, 2014; Naz et al., 2019; Perera et al., 2020; Crawford et al., 2016). This is no surprise considering that psychotherapies such as CBT hold assumptions that are rooted in western culture, rendering them value-laden, and use techniques that might work more effectively on ideologically-synced communities (Scorzelli & Scorzelli, 1994; Kirmayer, 2012).

Despite the clear value of cultural considerations, classic CBT has been recommended as the first line of treatment for various mental health disorders via international clinical guidelines (David et al., 2018). While CBT has been tested rigorously using randomised control trials (RCTs), this methodology prioritises internal validity, making such studies less generalisable to populations that are not well-represented in them. In fact, not many studies have reported the ethnicity of their samples, and those that have mentioned using a majority of white European and American participants (Suinn, 2003; Villegas, 2009).

In the last few decades increased attention has been afforded to the importance of cultural competence in practice, and naturally with it, backlash against the need for culturally competent practice (Bassey & Melluish, 2013). A prominent criticism holds that cultural competence is not distinguishable from practitioner competence (Worthington & Dillon, 2011). The assumption is that the practitioner would seek knowledge about the client's needs and that any competent practitioner would then be able to deploy strategies that help the specific needs of the client. This leaves room to question whether cultural competence is a necessary addition to the discourse. The authors of the current study agree that practitioner competence and cultural competence are not distinguishable; practitioner competence itself should involve cultural competence as an integral component. One of the reasons many communities may exhibit varying levels of acceptance and outcomes towards certain western evidence-based interventions (EBIs) is the inherent diversity of perspectives between communities (Sue et al., 2009; Naeem et al., 2019). For instance, a notable contrast in perspectives can be observed

between different geographical regions such as the east and west. In fact, classic CBT has been accused of emphasising rationality and change thereby alienating cultural perspectives that value spirituality and acceptance (Iwamasa & Hays, 2019). For example, certain South and East Asian communities practise collectivism, where the conceptualisation of individual well-being involves the well-being of and harmony with the individual's community members (Joshanloo, 2014). Such cultures' conceptualisations of well-being tend to more readily accept negative affect as part of life as compared to more individualistic cultures that conceptualise well-being in terms of positive affect, autonomy, and control. Various Eastern philosophies also emphasise freedom from personal desires and focus more on contentment with their present situation (Joshanloo, 2014). Therefore, therapeutic techniques that emphasise self-growth at the cost of disturbing communal harmony can possibly put the individual in a worse mental state than before. Certain third wave cognitive behavioural therapies such as Acceptance and Commitment Therapy (ACT) do make use of ideas like mindfulness and acceptance that seem consistent with such Eastern philosophies and therefore theoretically could be beneficial when used with minimal adaptations in various cultures. A recent narrative review of ACT trials in Iran seemed to favour ACT for this population, but effect sizes were largely not reported (Akbari et al., 2022). Moreover, studies conducted in different countries imply that therapists would most likely have been of the same ethnicity as the client or at least have had good cultural understanding of the community considering their country of residence, and therefore may be naturally better-equipped with understanding and treating a client, possibly applying cultural adaptations informally. While therapeutic alliance could be a conflating factor here, the authors in this review discussed use of certain study designs that measured constructs more strongly emphasised in Iranian culture, making cultural adaptation a likely factor affecting effectiveness as well (Akbari et al., 2022). Further, according to Hall (2011) and colleagues, when applied in therapeutic settings in a Western country like the US, third-wave approaches may still reflect Western conceptions of mental health. Therefore,

despite use of philosophies that may theoretically have a level of ideological congruence with ethnic minority cultures, Western conceptualisations of such philosophies may not directly resonate with ethnic minority individuals, and implementation of such therapies may not necessarily be as effective for them. Thus, psychosocial nuances make it difficult for a single psychological intervention designed by and tested on a largely ethnically homogenous group of people to be effective (if unadapted) for those of different ethnicities (Sue et al., 2009; Naeem et al., 2019). Their differing perspectives, beliefs, values, and approaches to life and interactions can affect the aetiology and manifestations of mental health issues (leading to possible misdiagnosis if culture is not taken into account), the therapeutic goals that one might prefer to set (in line with their values and ideals), and responsiveness to techniques that might not be culturally sensitive (Kirmayer, 2012; Naeem et al., 2019; Rathod et al., 2020). Because the client's cultural identity is intertwined with the therapeutic process, a practitioner would not have the knowledge upon which to base strategy if they were not culturally competent enough to acknowledge the client's ethnicity and understand their own biases. If these considerations are not made during formulation of the therapeutic intervention, the formulation itself could be unfounded and the 'treatment' in such cases has the potential to cause further distress as discussed in the literature above, and adversely affect the quality of life of ethnic minority individuals. This is a serious concern for basic human rights of minority populations.

Here, it must be acknowledged that every member even within a certain group will have multiple overlapping identities creating various unique subjective experiences affecting thought and behavioural patterns. For instance, diversity of perspectives will exist even *within* communities, such as between urban and rural populations within a community residing in the same geography. However, cultural identity is an important factor that is known to affect psychosocial systems, thus warranting the need for culturally informed psychotherapeutic practice (Kirmayer, 2012; Arundell et al., 2021).

All in all, the lack of cultural considerations in Western psychotherapies paired with the research that shows the value of such considerations for the sizable population of ethnic minorities in the UK elevates the concern to a human rights issue. Current considerations focus on racial and ethnic disparities in access to and institutional racism in existing mental health services (Commission on Race and Ethnic Disparities, 2021). While these are important discussions, simply achieving good access to therapy may not lead to better mental health outcomes for a group if the *quality* of that care is inadequate at best and actively harmful at worst.

Current Status of Cultural Considerations in Psychotherapy

Beyond focusing solely on cultural competence, researchers are trying to adapt existing interventions to serve the needs of ethnic minorities as a step towards integrating cultural competence and EBIs (Whaley & Davis, 2007). Here, cultural adaptation of interventions is defined as "the systemic modification of an evidence-based treatment or intervention protocol to consider language, beliefs, and culture in context in such a way that is compatible with the clients cultural patterns, meanings, and values" (Perera et al., p. 3-6, 2020; Bernal et al, 2009).

Castro and colleagues argue that there exists a continuum on which adaptations exist, where one end consists of EBIs in their pure unadulterated forms, while the other end contains adaptations of EBIs so grounded in a specific culture that the fidelity of the core elements of the original EBI is lost (2010). Even within this continuum, distinctions can further be made between culturally-sensitive interventions (e.g. CS-CBT) and culturally-adapted interventions (e.g. CA-CBT) (Beck, 2016). This distinction can be likened to that drawn by Resnicow and colleagues between surface structure and deep structure levels of cultural sensitivities in a therapeutic intervention (1999). CS-CBT, similar to surface structure modifications, focuses on more superficial altercations such as acknowledging and discussing cultural perspectives of the client, pairing therapists and clients of matching ethnicities, using native language, etc. Such

considerations do seem valuable considering certain barriers that ethnic minority individuals claim to experience with mental health services in the UK, including language barriers, lack of understanding of racial disparities that contribute to patient distress, and fear of being discriminated against by service professionals (NHS Race and Health Observatory, 2022). CA-CBT on the other hand applies 'deep structure' modifications such as incorporating the client's cultural values and beliefs into the intervention, using specific cultural metaphors, etc., and tends to be adapted to cater to the needs of a specific ethnic group. Some literature argues that it is not practical nor feasible for a therapist to become an expert on every culture (Whaley & Davis, 2007). However, while CA-CBT requires more effort, time, and resources to develop and test, it has the potential to improve both, the client's acceptance of the intervention as well as their outcomes post-intervention (Hwang, 2011). Therefore, while using superficial elements of cultural sensitivity is a start, ethnic minorities may benefit most if the ultimate goal for research and practice is to develop and apply more specific adaptations; the evidence in favour of such adaptations certainly warrants further work to be done in the field and for appropriate resources and quality training to be widely available for therapists to use.

In recent years, various researchers have attempted to create frameworks for adapting therapy to benefit ethnic minority individuals (Hwang, 2016). Naeem conducted a review of various culturally adapted CBT studies for The Cognitive Behaviour Therapist (2019). However, a recent review of cultural adaptations of various interventions for black and ethnic minority (BAME) groups revealed something that is also apparent in Naeem's review: that researchers are testing various types (content-related, therapist-related, organisation-related, etc.) and combinations of adaptations, which has increased the heterogeneity between studies and made it difficult to determine which types of adaptations are actually most beneficial (Arundell et al., 2021). According to this review, approximately 80% used more than one type of adaptation. The most common adaptations involved explicit use of cultural references such

as use of culturally-relevant scenarios, terms, or metaphors, and language translation by the therapist (use of an interpreter or a bilingual therapist).

It is evident that adaptation testing is at a nascent stage despite the conversation around cultural sensitivity in therapeutic interventions having been aflame for decades. As of 2021, the British Association for Behavioral and Cognitive Psychotherapies (BABCP) does not have "cultural competence" in its Standards of Conduct, Performance, and Ethics (BABCP, 2021). The BABCP and the IAPT service did publish a BAME Service User Positive Practice Guide that includes therapies that are culturally adapted for specific populations based on research (BABCP, 2019). However, there is no research around the impact created by these guides. Attempts have been made to create cultural competency training programs for therapists, but they lack proper regulation and show limited efficacy due to variations in the adaptations (Clegg et al., 2016). As a result, therapists report feeling under confident about meeting a client's needs based on their cultural identities (Naz et al., 2019).

The value of culturally adapted EBIs is acknowledged in the literature, but there is limited research on how it translates to clinical practice in the UK. Therefore, the study aimed to understand how CBT therapists in the UK are modifying their practices for ethnic minority clients and their challenges. This is an exploratory study and aims to inform professionals, researchers, service managers, and policymakers on prioritising certain issues to help clinicians eventually improve the quality of services for ethnic minority clients by considering the effects of cultural identity on ____.

Method

To investigate these questions, our team used secondary research to design a self-report survey consisting of 14 multiple-choice items and distributed it to UK-based CBT therapists. The sample consisted of 34 participants.

Results

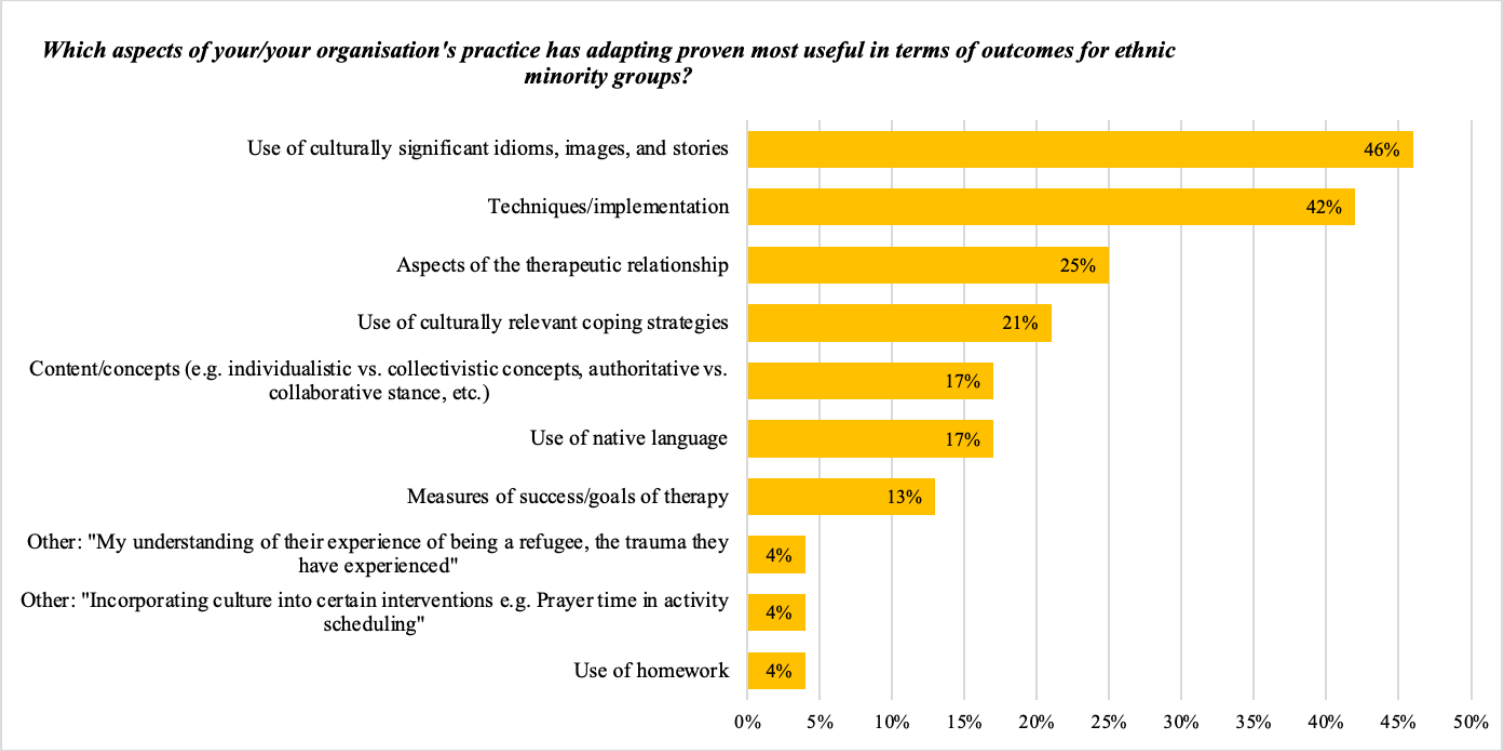
Approximately 85% of our sample had ethnic minority clients. Of the therapists who said there have been times when their clients switched therapists to someone of matched ethnicity, 76% said that their clients wanted someone who understood their culture, 14% said that their reason did not pertain to cultural competency, and about 10% said that they did not state a reason.

The most common reasons stated by the therapists for not adapting therapy were 'Lack of resources to try and study the efficacy of new techniques for different cultures' and 'Lack of existing evidence-based adaptations', while other reasons stated were 'Lack of education/training in handling cultural diversity', 'Institutional racism', and 'I/we do not feel like there is a pressing need to do so'.

The therapists who mentioned that they adapt their practice for ethnic minorities were asked which aspects of adaptations of their/ their organisation's practice has proved most useful in terms of outcomes for clients. Participants responded by selecting up to two options provided. Frequencies of each option selected are shown in Figure 1 below. The most common responses were 'Use of culturally significant idioms, images, and stories' and 'Techniques/implementation (e.g. use of assertiveness, problem-solving, behavioural techniques, socratic methods, normalisation, etc.)'. Slightly less common but still popular responses were 'Aspects of the therapeutic relationship' and 'Use of culturally relevant coping strategies (e.g. spiritual texts or ideology)'. A free response answer provided under the 'other' option was 'Incorporating culture into certain interventions e.g. Prayer time in activity scheduling'.

Figure 1.

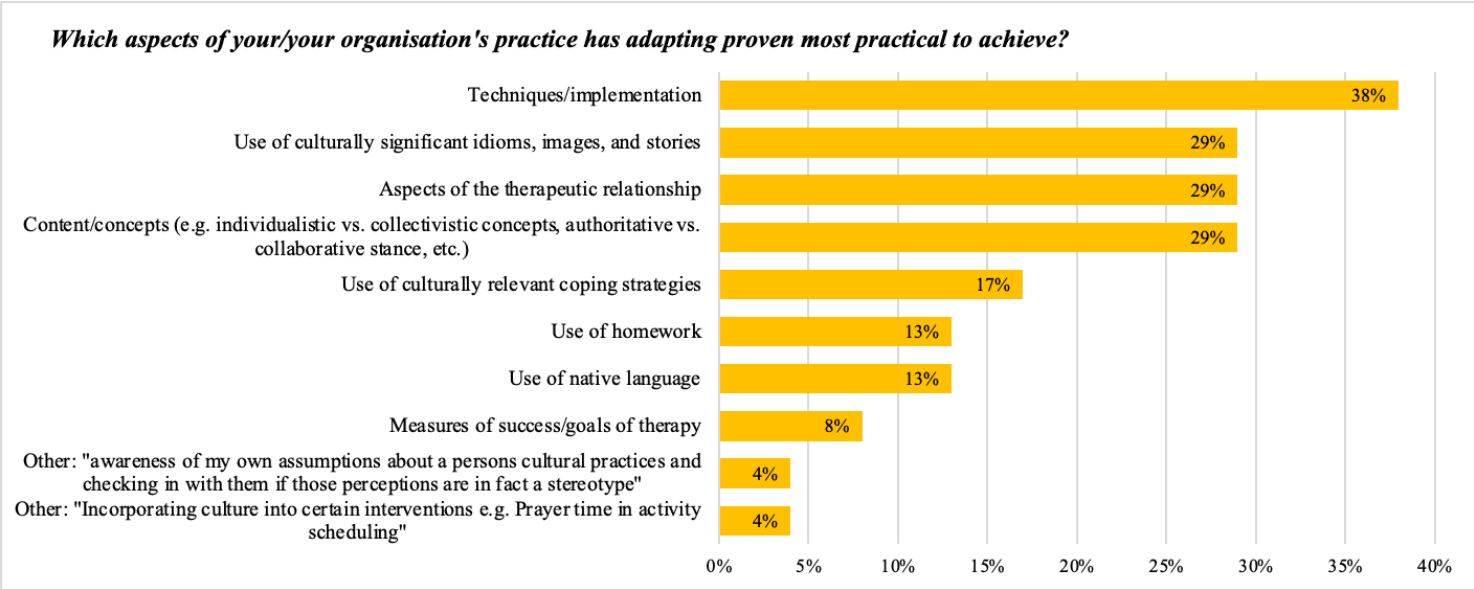
Which aspects of your/your organisation's practice has adapting proven most useful in terms of outcomes for ethnic minority groups?



When asked which aspects of adaptations of their/ their organisation's practice has proved most practical to achieve, participants responded by selecting up to two options provided. Frequencies of each option selected are shown in Figure 2 below. The most common responses were 'Techniques/implementation (e.g. use of assertiveness, problem-solving, behavioural techniques, socratic methods, normalisation, etc.)', 'Aspects of the therapeutic relationship', 'Use of culturally significant idioms, images, and stories', and 'Content/concepts (e.g. individualistic vs. collectivistic, authoritative vs. collaborative, etc.)'.

Figure 2.

Which aspects of your/your organisation's practice has adapting proven most practical to achieve?



Participants who adapted their practices for ethnic minority clients shared their challenges by selecting every applicable option. The majority (71%) believed that a major challenge was the lack of resources to study the efficacy of new techniques. Of those, 70% worked in organisations or hospitals, indicating a systemic issue that needs to be resolved at a higher level than individual therapists. Other common challenges included lack of education/training in handling cultural diversity and lack of existing evidence-based adaptations. One participant voiced preference for specific therapy adaptations training, rather than generic multicultural awareness training. These responses highlight the therapists' clear preference for resources to study the efficacy of evidence-based adaptations and techniques, and to be trained in them.

Discussion

The disparity in mental health burden for ethnic minorities is not a new challenge for society (Mental Health Foundation UK, 2021). Coupled with a lack of the *right* care, the situation becomes doubly pressing. People of ethnic minority groups tend to be either underdiagnosed or misdiagnosed partly due to language barriers and cultural manifestations of symptoms (APA, 2017; Race Equality Foundation, 2019). Misdiagnoses can be dangerous

considering that treatments are decided on their basis, and incorrect treatment poses issues not only to the patient's state of mind, but also to their health in cases of worsening conditions and use of the wrong medications, not to mention they are a waste of time and resources on the service's part (Hillside Foundation, 2019). In short, unadapted psychotherapy has the potential to be disproportionately iatrogenic for ethnic minority groups. Improvement in quality of services for such groups is therefore a need of the hour.

A large portion of the sample in this study who had ethnic minority clients either adapted in some way, or if they did not adapt, it was largely because of the perceived lack of resources and lack of existing evidence-based adaptations. However, it should be noted here that this study used voluntary sampling and shared the aim upfront. Thus, it is possible that our sample was biased towards being culturally sensitive and that the study overestimates the number of therapists who currently take measures to adapt their practice.

Majority of our participants stated that ethnic minority clients who switched therapists tended to switch because of cultural reasons, highlighting that clients of these therapists value cultural competence as well. This fits with literature that shows that ethnic minority individuals do not feel understood by healthcare professionals, and cultural naivety acts as a barrier to seeking mental healthcare (Mental Health Foundation, 2021; Memon et al., 2016). According to our results, approximately 83% of participants who have ethnic minority clients said that they take measures to adapt their CBT practice. Interestingly, of the therapists who said they adapt the general method using available evidence-based guidelines or frameworks, approximately 56% said they believe there is a lack of existing evidence-based adaptations, which poses a challenge to them. Similarly 56% of the therapists who said they adapt based on each group separately also held the same belief. This points to a clear gap; therapists are trying to use existing frameworks to adapt their methods, but the majority of them still believes there is a dearth of evidence-based adaptations.

The literature suggests that there are frameworks and methods for adapting practice among certain groups, but due to heterogeneity among studies, it's hard to determine the most impactful approaches. Clinicians feel limited and need more research and established evidence-based adaptations to adapt their practice more effectively. Funding for research and incentives to replicate past research would strengthen the evidence base for existing interventions.

According to our study participants, the most impactful *and* feasible adaptations involve modifications to techniques and implementation and using culturally-relevant idioms and stories. This finding suggests that despite literature questioning the feasibility of making deep structure adaptations, participant therapists in this study find certain deep structure adaptations both impactful and practical to achieve. Literature also indicates that this deep structure approach of using culturally-relevant idioms and stories was very commonly used (Arundell et al., 2021). Thus, the gap is that there don't seem to be enough resources to study different deep structure adaptations for different groups though arguably it seems to be the most common, effective, and even practical approach to adaptation. Being trained in deep structure cultural adaptations would allow therapists to have a repertoire of techniques and specific cultural background to use as needed.

Currently, the onus seems to be on the therapists themselves to acquire necessary training, often requiring personal time and resources, which would likely not even be efficacious (Naz et al., 2019). This predicament is not surprising given the scarcity of research on meaningful adaptations. The current study does underscore therapists' efforts to adapt their practices based on whatever guidance is available, yet they do stress that available guidance and support from the system in terms of resources or available research is largely inadequate as it stands today.

Overall, based on the literature and this study, the issues with the system currently in place seem to include a lack of regulation and mandating of cultural competence across the board, lack of understanding of cultural issues which impede ethnic minority individuals from

seeking help, lack of research to establish evidence-based deep structure adaptations that therapists can use, a lack of resources being afforded to studying the impact of adaptations on the ground, and a lack of quality and efficacious training in cultural competence and specific cultural adaptations. All these issues together make it extremely hard for therapists to provide the level and quality of care that ethnic minority individuals may truly need, creating disparities in mental healthcare at a systemic level for such populations.

To specifically tackle issues relating to research and training in specific cultural adaptations, as Arundell and colleagues suggest, it would be useful to conduct research focused on specific adaptation types to improve understanding of where the greatest impact lies (2021). Eventually such research could be replicated and knowledge and training could become more refined. This study fortunately points to a few adapted elements that therapists find to be useful for clients and can be used to direct future research of this kind. Eventually the processes need to be more homogenised by replicating studies of specific adaptations and their combinations that show promise for an ethnic group. Once this is accomplished and there is a rich pool of evidence for certain adaptations, training programs can be modified, tested, and refined. The authors of this study would go so far as to suggest that once this work is underway, such training can and should be incorporated into higher education counselling and clinical psychology programs, provided the work is well-regulated. While integrating culturally sensitive practices into mental health services is, as elucidated before, valuable and important work, clearly there is a lot to be done and such work will take time, effort, incentive, and resources. Thus, an important step to achieving this great feat is provision of sufficient resources and support from policymakers and service managers.

Conclusion

Ethnic minority communities face higher rates of and unique mental health issues, are less likely to be diagnosed correctly leading to wrong treatments and adverse outcomes, and even if treated, are left to a system that may not cater to their cultural needs well enough, again

leading to poor outcomes and even worsening conditions. Ethnic minority individuals constitute large proportions of the population in the UK, and with inadequate focus on cultural competence, continue to face healthcare injustice. When advocating mental health awareness and encouraging related conversations across the world, it is therefore vital that the topic of cultural considerations within clinical psychology not be neglected, and instead be prioritised within healthcare systems globally.

Limitations

While this study fits with existing literature and provides insight into clinicians' use of cultural adaptations and their challenges in doing so, there are some limitations that must be noted. First is the voluntary nature of sampling. Future studies could attempt to use random sampling methods for a less biased dataset. Moreover, the sample was not large enough for accurate enough conclusions to be made with confidence. This study was exploratory in nature and further studies could use this information to create more holistic questionnaires as well as make use of qualitative methods to obtain richer, more in-depth data regarding clinicians' current use of adaptations.

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Appendix A: Survey Questions

	Question	Choices
1.	What is your ethnicity?	a. White: British+Irish b. White: Other White c. Mixed/Multiple EthnicWhite: British Groups d. Asian/Asian British: Indian e. Asian/Asian British: Pakistani f. Asian/Asian British: Bangladeshi g. Asian/Asian British: Chinese h. Asian/Asian British: Other Asian i. Black/Black British: Black African j. Black/Black British: Black Caribbean k. Black/Black British: Other Black l. Other Ethnic Group: ___
2.	Do you:	a. Have your own private practice b. Work with an organisation c. Work at a hospital d. Other: ___
3.	Do you practice some form of CBT?	a. Yes b. No
4.	Which type of CBT do you practice? (select all that apply)	a. Mindfulness-Based Cognitive Therapy (MBCT) b. Cognitive Processing Therapy (CPT) c. Cognitive Therapy (CT) d. Dialectical Behaviour Therapy (DBT) e. Acceptance and Commitment Therapy (ACT) f. Other: ___
5.	What age range do you mostly see? (select up to two age ranges)	a. 12-16 b. 17-25 c. 26-40 d. 40-60 e. Above 60
6.	Do you counsel ethnic minorities (non-white	a. Yes b. No

	native or immigrant populations)?	
7.	If yes, then approximately what percentage of your clients are from ethnic minority groups?	a. Less than 10% b. 10-30% c. 30-50% d. 50-70% e. More than 70%
8.	If yes, then approximately what percentage of your clients are immigrants (non-native U.K. residents)?	a. Less than 10% b. 10-30% c. 30-50% d. 50-70% e. More than 70%
9.	If you don't see one or either of the above (ethnic minorities or immigrants), then why might that be? (select all that apply)	a. I don't feel comfortable in my abilities to provide quality service to ethnic minority groups b. Individuals from ethnic minorities don't seek therapy with me c. I have not been trained in any diversity competencies d. Other: ___
10.	Has there ever been a situation where an ethnic minority client or immigrant wanted to switch therapists to someone of the same ethnic background?	a. Yes b. No
11.	If so, what reason did they state?	a. They wanted someone who understood their background/cultural values b. Reason not pertaining to cultural competency c. They did not state a reason d. Other: ___
Next set of questions are only for those who see ethnic minority clients.		
12.	Do you/your organisation prioritise or take any	a. Yes, I/we take specific measures to address client cultural diversity

	measures to use cultural adaptations of CBT?	b. No, I/we mostly stick to non-culturally adapted forms of CBT for all clients
13.	*If "*No, I/we mostly stick to non-culturally adapted forms of CBT for all clients" *is selected above, then show following question:* If you are not adapting your practice to ethnic minority cultures, then what are the obstacles preventing you from doing so? (select all that apply)	a. Lack of education/training in handling cultural diversity b. Lack of resources to try and study the efficacy of new techniques for different cultures c. Lack of existing evidence-based adaptations d. I/we do not feel like there is a pressing need to do so e. Other: ___
14.	*If "*Yes, I/we take specific measures to address client cultural diversity" *is selected above, then show following questions:*	
a.	How are you adapting your CBT practice for ethnic minority groups? (select all that apply)	a. I/we adapt based on each group differently b. I/we adapt the general method with all groups using certain evidence-based adaptation guidelines, or available theoretical frameworks c. I/we adapt methods in informal or unstandardised ways with each group d. I/we refer the client to a suitable therapist who understands their cultural values e. Other: ___
b.	*If "*I/we adapt the general method with all groups using certain evidence-based adaptation guidelines, or available theoretical frameworks" AND/OR "I/we adapt methods in informal or unstandardised ways with each group" *is selected above, then show the following question:* Which specific methods	a. Awareness of the client's culture b. Consulting experts of the culture c. Considering cultural issues during the assessment and engagement phase (culturally adapted assessments, etc.) d. Adapting therapeutic content to fit the client's cultural context e. Adapting and iterating therapeutic content in collaboration with community members of that culture f. Learning more about the clients' cultures and their symptomatic manifestations

	of adaptations do you use?	g. Reflecting on my/our own culture, beliefs, and possible resulting biases using therapy or other methods h. Other: ___
c.	Which aspects of your/your organisation's practice has adapting proven most <u>useful</u> in terms of outcomes in ethnicity minority groups?	a. Content/concepts (e.g. individualistic vs. collectivistic concepts, authoritative vs. collaborative stance, etc.) b. Use of native language c. Use of culturally significant idioms, images, and stories d. Techniques/implementation (e.g. use of assertiveness, problem-solving, behavioural techniques, socratic methods, normalisation, etc.) e. Use of culturally relevant coping strategies (e.g. spiritual texts or ideology) f. Use of homework g. Aspects of the therapeutic relationship h. Measures of success/goals of therapy i. Other: ___
d.	Which aspects of your/your organisation's practice has adapting proven most <u>practical to achieve</u>?	a. Content/concepts (e.g. individualistic vs. collectivistic concepts, authoritative vs. collaborative stance, etc.) b. Use of native language c. Use of culturally significant idioms, images, and stories d. Techniques/implementation (e.g. use of assertiveness, problem-solving, behavioural techniques, socratic methods, normalisations, etc.) e. Use of culturally relevant coping strategies (e.g. spiritual texts or ideology) f. Use of homework g. Aspects of the therapeutic relationship h. Measures of success/goals of therapy i. Other: ___
e.	What have been the biggest challenges to adapting CBT for ethnic minority groups?	a. Lack of education/training in handling cultural diversity b. Lack of resources to try and study the efficacy of new techniques for different cultures c. Lack of existing evidence-based adaptations

		d. Fear of causing harm by adapting in unverified ways e. Other: ___