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INVITED PAPER

Culturally adapted CBT – the evolution of psychotherapy adaptation frameworks and evidence

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Abstract

Culture plays a significant role in psychotherapy practice, with cultural adaptations being implemented more commonly as globalisation and cultural awareness increase. An abundance of systematic reviews, meta-analyses and randomised controlled trials exploring culturally adapted interventions have been published across the globe. In this paper, we present the historical background to cultural adaptation by summarising and evaluating previous frameworks, as well as reviewing current evidence for such adaptations and highlighting routes for further research. Around twenty cultural adaptation frameworks have been published, covering various population demographics and intervention types, providing general guidelines for the implementation of cultural adaptations to psychosocial interventions. Nearly all the frameworks used previous literature and research to develop models on culturally adapted interventions. Some even implemented stakeholder discussions, randomised control trials, and even pilot studies. A variety of cultural adaptation factors have been outlined and discussed; however, there is no agreement on which elements work and which do not. Existing evidence indicates that culturally adapted interventions are effective, regardless of intervention type or population. While cognitive behavioural therapy (CBT) was the most common intervention in trials, there are, at present, no high-quality comprehensive meta-analyses or systematic reviews on culturally adapted CBT which include all literature on this topic. This is needed in order to provide a holistic and detailed comprehension of where current understanding lies. We conclude our paper with recommendations for researchers, trainers and commissioners.

Key learning aims

(1) Current theoretical frameworks guiding the development of culturally adapted frameworks will be outlined. Gaps in current literature will be highlighted.
(2) An overview of the current literature of culturally adapted psychotherapies, specifically CBT and its efficacy in improving outcomes for patients, will be provided.
(3) The need for culturally adapted CBT and comprehensive guidelines for the development of these interventions will also be discussed, with clinical implications highlighted.

Keywords: CBT; cultural adaptations; mental illness; minority ethnic; psychotherapies

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Introduction

Culture has a significant impact on the way individuals interpret and engage with the world and those around them (Jandt, 2007). This set of customs, beliefs and traditions have far-reaching effects that influence psychopathology and psychotherapy across the globe (Naz *et al.*, 2019). In an effort to accommodate for such effects, various psychological interventions have been adapted to align with cultural impacts and this is often implemented through cognitive behavioural therapy (CBT). CBT is a common therapeutic approach, applied to a wide scope of disorders with high success rates (Hofmann *et al.*, 2012). Behaviourism was first developed in the early 1900s and therapies based on this rationale emerged in the mid-1950s (Thorndike, 1905; Watson, 1913). Interventions such as rational emotive behaviour therapy and CBT were developed with the aim of challenging dysfunctional thoughts and behaviours in individuals to reduce symptoms of psychopathology (Beck *et al.*, 1979; Ellis, 1995). CBT in particular has undergone several adaptations over the years. Initially, cognition was thought to be made up of retroactive structural processes over which one had limited control, but this view quickly changed, and the processes of self-knowledge and psychodynamics were recognised as influences on cognition (Ruggiero *et al.*, 2018). There is scope for CBT to be implemented with considerable adjustment, with flexibility relating to client goals and outcomes as well as inclusion of topics that hold importance for the client (Strunk *et al.*, 2021). The original model of CBT has gone through several adaptations to make it more suitable for various psychological conditions and the last two decades have seen an enormous drive towards the lateral spread of culturally adapted CBT through to non-Western European and non-North American cultures.

The need for cultural adaptation

Culture can be defined as 'the set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs' (IBE-UNESCO, 2008). This can encompass one's religious views, their ethnic or racial origin as well as their national identity, hence providing a holistic understanding of one's beliefs and backgrounds and the influence they exert. Within recent years, globalisation has rapidly increased, which has led to an influx of migration across the globe. Due to this, cultural, ethnic and racial diversity is becoming more recognised and acknowledged, which has led a drive towards providing equitable, culturally sensitive and effective clinical services to cultural minority groups across the Global North (the developed, affluent countries). In a similar fashion, the Global South (the low-income, marginalised countries) has seen an increased interest in modern psychotherapies. However, many observers noticed that CBT in its standard form is not suitable for individuals from non-Western backgrounds due to the ethnocentric nature of such psychosocial interventions which were developed based on Western cultural values (Naeem *et al.*, 2019).

Cultural adaptations are systematic modifications of various research-based interventions to include considerations of various cultural beliefs and ideas to ensure that such interventions are compatible for patient engagement (Bernal *et al.*, 2009). Culturally adapting CBT is vital to ensure relevance and effectiveness of such an intervention for the individual. CBT involves understanding and exploring the individual's dysfunctional thoughts and assumptions in order to challenge and change them (Beck *et al.*, 1979). As culture has such far-reaching effects into all aspects of one's life, it is important to remember that illness and psychopathology will also be influenced. Due to this, people from non-Western backgrounds may have difficulty adjusting to and trusting mental healthcare services (Rathod *et al.*, 2019). If interventions such as CBT are implemented without adaptation, individuals are likely to disengage and there is the risk of poor outcomes (Rathod *et al.*, 2005). A systematic review looking at the need to implement culturally adapted public health interventions revealed that 64.3% of individuals

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believed that adaptations are key requirements to ensure cultural appropriateness (Escoffery *et al.*, 2018). Laungani (2004) shared four core dimensions across which Asian and Western cultures differ: individualism-communalism, cognitivism-emotionalism, free-will-determinism, and materialism-spiritualism. These dimensions will cause variation in perception and understanding of experiences. Participants of African-Caribbean and South Asian descent attribute symptoms of psychosis and schizophrenia to supernatural experiences or wrongdoings in their past life, and are inclined to turn to faith healers for treatment and support (Rathod *et al.*, 2010). Similarly, patients from China stated that supernatural causes and family stress led to their symptoms of schizophrenia; again, they would often seek help from faith healers (Li *et al.*, 2017). Individuals with post-traumatic stress disorder (PTSD) from a Hispanic background believe that all events are uncontrollable and inevitable but also that experiencing excessive stress is normal which delays them seeking treatment and support (Ruef *et al.*, 2000). Finally, cultural adaptation of psychotherapy has been advocated from an ethical point of view (Pantalone *et al.*, 2010). In fact, it has been argued that 'delivering mental health services outside of one's area of competence constitutes an ethical infraction' (Ridley, 1985).

Frameworks for culturally adapting psychotherapies: a short history

Methods for identifying frameworks

A vast number of frameworks to inform the development of culturally adapting therapies have been published. We acknowledge many more publications, which share insights on culturally adapting therapies of which a selection is chosen and reported in Table 1. All these frameworks provide guidelines on the processes and elements involved in culturally adapting therapies, some outlining more general procedures whilst others highlight specific demographics or therapies.

The first guidelines on culturally adapting psychotherapies, the Social Cognitive Framework, was proposed by López *et al.* (1989) and suggested that the process of cultural adaptation consists of three stages: (1) being unaware of cultural issues, (2) heightened awareness of cultural issues, and (3) cultural sensitivity. A few years later, the ecological validity model was published by Bernal and colleagues (1995) which highlighted eight key areas needing to be addressed in order for cultural adaptations to be successful. These were: language, persons, metaphors, content, concepts, goals, methods and context (Bernal *et al.*, 1995). This provided context and relevant examples to the specific areas and topics in which there are great differences between Western cultures and other minority cultures around the world. The multidimensional model mentions culture and structure as the two core elements which inform cultural responsiveness; this was believed to be enough adjacent to be culturally accommodating (Koss-Chioino and Vargas, 1992). Although this framework provides a variety of examples as to how cultural changes can be modified, it does not really explore the depth to the topic of culture and its far-reaching impacts. The adaptation framework developed by Tseng (1999) describes three levels of adaptation: technical, theoretical and philosophical. These branch of into a further nine areas which explore the breadth of impact culture has on various elements of therapy, including the therapeutic relationship and therapeutic model (Tseng, 1999). This model introduces new understanding of how cultural adaptations fit within therapy and the various elements that need to be addressed to develop an accommodating intervention.

Resnicow *et al.* (2002) explored the impact that culture has on the structure of therapies, looking at both surface level and deep level structure. Whilst this proposes similar understanding to Koss-Chioino and Vargas (1992), Resnicow *et al.* (2002) go on further to explain the various elements of culture that influence the target population and hence outcomes and engagement with therapy. The Cultural Adaptation Process Model introduced the idea of involving treatment developers and cultural adaptation theorists to make appropriate cultural adjustments to interventions whilst maintaining the feasibility and efficacy of the therapy and its outcomes

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Table 1. Frameworks for cultural adaptation of psychotherapies

Author(s) (year) **Framework and outline**	Details of framework	Evidence of implementation
López *et al.* (1989) **The Social Cognitive Framework** Three stages of cultural awareness: 1. Unaware of cultural issues 2. Heightened awareness of cultural issues 3. Cultural sensitivity	This model was developed through seminar discussions concerning mental health services and their involvement with culture. Students also provided written accounts of cultural factors they believed influenced therapy This framework was intended to be used by trainee therapists across all populations and therapy-types	This framework has informed other guidelines to inform aspects of cultural awareness (Bernal *et al.*, 1995; Brawer *et al.*, 2002; Santiago-Rivera *et al.*, 2002)
Bernal *et al.* (1995) **The Ecological Validity Model** Eight elements of cultural adaptation: 1. Language 2. Persons 3. Metaphors 4. Content 5. Concepts 6. Goals 7. Methods 8. Context	This model was based on the authors' own understanding, supporting by previous literature around important topics relevant to cultural adaptations This framework was initially developed for the Hispanic population, but the authors note its applicability to other ethnic groups. There was no stakeholder involvement in the development of this framework. It was intended to be used by all therapists and therapy-types	This framework has informed six randomized control trials (Nicolas *et al.*, 2009; Parra-Cardona *et al.*, 2017; Perera *et al.*, 2020; Rosselló *et al.*, 2008; Rosselló and Bernal, 1996; Soto *et al.*, 2018)
Koss-Chioino and Vargas (1992) **The Multidimensional Model for Understanding Culturally Responsive Psychotherapists** Two dimensions of cultural responsiveness: 1. Culture a. Cultural content b. Cultural context 2. Structure a. Process b. Form	This model highlights the importance of the therapeutic alliance in predicting therapeutic outcome. This framework was developed with the rationale that being culturally responsive was enough of an adjustment to accommodate for cultural diversity within therapy There was no stakeholder involvement in the development of this framework. It was intended to be used by all therapists and therapy-types	This framework has been used in two papers relating to cultural responsiveness in the past, with very little applicability to more recent research (Horton and Munoz, 2021; Kalibatseva and Leong, 2014)
Tseng (1999) **Influence of culture on therapies** Three levels and nine areas of cultural influences: 1. Technical 2. Theoretical 3. Philosophical a. Sociocultural settings b. Patient expectations c. Patient–therapist relationship d. Communication style e. Psychopathology f. Therapeutic model g. Universal therapeutic mechanisms h. Therapist values i. Goal of therapy	This model proposes that cultural influences must be considered when formulating an intervention from the client's perspective. Guidelines are also shared relating to the implementation of culturally relevant psychotherapy There was no stakeholder involvement in the development of this framework. It was intended to be used by all therapists and therapy-types	This framework has influenced other guidelines informing the processes of cultural adaptation within therapies and the relevant complexities related to this (Arundell *et al.*, 2021; Hays, 2008; Hinton *et al.*, 2005; Rathod *et al.*, 2019)
Resnicow *et al.* (2002) **The structural impact of culture** Two levels of structural adaptations: 1. Surface structures: aligning intervention materials with messages sent to target population	This model was based on previous literature outlining various implementations and understandings of cultural sensitivity Whilst this paper looked at substance abuse, there is scope for the proposals to be applied to alternate therapist and	This framework has been implemented in one RCT (Pallan *et al.*, 2019)

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Table 1. (*Continued*)

Author(s) (year) **Framework and outline**	Details of framework	Evidence of implementation
2. Deep structure: cultural, social, historical, environmental, and psychological forces exerting influence on the target health behaviour within the target population	sample population as well as therapy-type. There was no stakeholder involvement	
Domenech-Rodriguez and Wieling (2005) **Cultural Adaptation Process Model** Three phases: 1. Setting the stage a. Establishing collaboration between treatment developer and cultural adaptation specialist b. Examining the fit of the intervention with relevant literature c. Meeting with key community leaders to examine interest and need for intervention d. Assessing community needs and gathering information that will inform adaptations to the intervention 2. Initial adaptations a. Measures b. Interventions 3. Adaptation iterations	This framework was formulated based on the integrations of ideas from treatment developers and cultural adaptation theorists to ensure the practical applicability of relevant theories of cultural adaptation to framework and therapies This model was developed around a parenting intervention for the Latino population. Treatment developers, community leaders and parents were involved as stakeholders. There is scope for this model to be applied to other types of interventions and populations using appropriate adjustments	This framework has influenced other guidelines informing the processes of cultural adaptation within therapies (Akyil, 2011; Blitz, 2006)
Castro *et al*. (2004) **Hybrid Prevention Program Model** Three areas for examination: 1. Program delivery staff 2. Administration 3. Community factors Three dimensions of cultural adaptation: 1. Cognitive information processing 2. Affective motivational characteristics 3. Environmental characteristics	This model intended to be used to create a culturally equivalent version of a pre-specified intervention, through which assessment and outcomes will measure and report the same factors. The only difference would be that the adapted intervention has alterations to include the patient's cultural norms Stakeholders were not directly involved in this literature. It was intended to be used by all therapists and therapy-types	This framework has been implemented in one RCTs and two guidelines informing the processes of cultural adaptation within therapies (Bernal *et al*., 2009; Eldredge *et al*., 2016; Pallan *et al*., 2019)
Lau (2006) **Selective and Directed Treatment Adaptation Framework** Two outlooks: 1. Selective 2. Directed	This framework was developed in the hope to target engagement with or outcomes of therapy in terms of cultural relevancy Stakeholders were not directly revolved in this literature. This model was developed around a parenting intervention; however, there is scope for the framework to be applied to all interventions and populations	This framework has been used to formulate guidelines in reviews and books about the applicability and relevancy of culturally adapted therapies (Castro *et al*., 2010; Pope and Vasquez, 2016; Stirman *et al*., 2013)
Barrera and Castro (2006) **The Heuristic Framework** Three core phases: 1. Engagement: awareness of and entry into therapy, participation in therapy and completion of therapy 2. Action theory: unique and common mediators 3. Outcomes: unique and common outcomes	The authors advise that stakeholder involvement, in the form of case studies and pilot studies, should be used at the stage of preliminary tests for an adapted framework This framework was intended to be used by all therapists and therapy-types with all populations	This has been implemented in reports and books highlighting the difficulties in culturally adaptive evidence-based interventions (Escoffery *et al*., 2018; Pina *et al*., 2019; Spanhel *et al*., 2021)

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Table 1. (*Continued*)

Author(s) (year) **Framework and outline**	Details of framework	Evidence of implementation
Hwang (2006) **The Psychotherapy Adaptation and Modification Framework** Six therapeutic domains (25 corresponding principles): 1. Dynamic issues and cultural complexities a. Two principles 2. Orienting clients to therapy a. Three principles 3. Understanding cultural beliefs about mental illness, its causes, and treatment a. Five principles 4. Client–therapist relationship a. Six principles 5. Expression and communication of distress a. Four principles 6. Addressing specific cultural issues a. Five principles	This framework was developed around the Chinese American population with no stakeholder involvement but can be altered and applied to other cultures too. The authors stated the importance of therapist awareness when it came to cultural adjustments, and for these changes to only be implemented when required	This framework has been used in reports and books highlighting the difficulties in culturally adaptive evidence-based interventions (Castro *et al.*, 2010; Hall *et al.*, 2021; Spanhel *et al.*, 2021)
Leong and Lee (2006) **The Cultural Accommodation Model** Three-step process of adaptation: 1. Identifying the cultural gaps in an existing theory 2. Selecting culturally specific concepts 3. Testing the culturally accommodated theory	This framework was developed around the Chinese American population. This model outlines detailed guidelines, explaining the cultural adaptation process. It highlights the importance of cultural specificity in ensuring effective outcomes, which was then applied to a case study to clarify applicability No stakeholders were involved. This framework was intended to be used by all therapists and therapy-types	This has been used to highlight the need for cultural adaptations, mainly applied to the Asian American and Latino American populations (Domenech-Rodriguez *et al.*, 2011; Lui, 2015; Rathod *et al.*, 2013)
Whitbeck (2006) **A Five-Stage Model of Cultural Theory Development** Five stage model of theory development: 1. Choosing a standard intervention 2. Review of research for the cultural minority 3. Cultural translation of intervention 4. Identify and measure cultural risk factors 5. Trial of the culturally adapted intervention	This was the only proposed framework looking at the Native American population. This framework highlights the importance of testing adjusted therapies within the target population to ensure applicability and effectiveness. The author highlights the importance of stakeholder involvement when adjusting for a cultural group	Implemented for understanding the need for cultural adaptations, mainly applied to the Native American population (Leach, 2014; Myhra, 2011; Vukic *et al.*, 2011)
Kumpfer *et al.* (2008) **Adaptation for Family Therapy**	This framework stresses the idea that fidelity of therapy included cultural adaptations but excludes modifications to key components or structure of the therapy. It states that there is a current lack of evidence-based programmes with cultural adaptations available in developing countries which should be the next aim for adjusted therapies to be accessible	This framework has been used to evaluate the availability of evidence relating to culturally adapted frameworks and how this can be overcome in public healthcare (Barrera *et al.*, 2013; Cabassa and Baumann, 2013; Castro *et al.*, 2010)

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Table 1. (*Continued*)

Author(s) (year) **Framework and outline**	Details of framework	Evidence of implementation
Naeem *et al.* (2009) **The Southampton Adaptation Framework** Three major areas of adaptation and 24 minor areas are presented: 1. Awareness of important cultural issues and treatment preparation 2. Assessment and engagement 3. Adjustments and modifications (Please see Table 2 and Fig. 1 for further details)	The process through which adaptation takes place has been clearly described. This framework has provided guidance on how it can be applied and adjusted to various populations, ensuring its efficacy and acceptability with the recipients of the intervention This framework focuses on CBT as a specific intervention, and has been used to culturally adapt CBT for the South Asian, African Caribbean, Chinese, Middle Eastern and African populations. There was immense stakeholder involvement throughout the development process, including input from patients, families, caregivers, therapists, community leaders and health managers	This framework has been tested and implemented in 22 RCTs (Amin *et al.*, 2020; Aslam *et al.*, 2015; Habib *et al.*, 2015; M. I. Husain *et al.*, 2015; M. I. Husain *et al.*, 2017, 2021; M. O. Husain *et al.*, 2017, 2021; N. Husain *et al.*, 2014, 2016; N. Husain, Kiran, Fatima *et al.*, 2021; N. Husain, Kiran, Shah *et al.*, 2021; Latif, Awan, *et al.*, 2021a; Latif *et al.*, 2021b; Naeem *et al.*, 2011; Naeem *et al.*, 2014; Naeem, Gul, *et al.*, 2015; Naeem, Saeed, *et al.*, 2015; Notiar *et al.*, 2021; Rathod *et al.*, 2013)
Cardemil (2010) **A Four-Component Model of Cultural Adaptation** Four components for adaptation: 1. Program structure 2. Program content 3. Program delivery 4. Provider behaviour Four components of evaluation: 1. Acceptability 2. Outcomes 3. Comparatives 4. Mechanisms	This framework looks at gaps in previous frameworks and literature and highlights the need for evaluating therapies in terms of their applicability and efficacy to ensure outcomes are being produced appropriately This mainly involves a theoretical approach, homing in on previous literature. There is no stakeholder involvement	This provides a theoretical insight into cultural competency within papers and reviews (Gone and Trimble, 2012; Soto *et al.*, 2018)
Domenech Rodriguez *et al.* (2011) **The Cultural Adaptation Process Model** Three phases of adaptation: 1. Setting the stage: activities to undertake before intervention 2. Adaptation through engaging the community of interest 3. Activities during the intervention trials where adaptations are iterative	This framework focuses on parent training interventions with Latino parents. There was stakeholder involvement throughout the development process, including community cultural adaptation specialists and intervention developers to ensure culture is being appropriately adjusted for, whilst maintaining the feasibility and efficacy of the intervention. The framework was tested and evaluated through pilot study and focus groups to refine and adjust the intervention accordingly	This model has been used in various studies and reviews on parent intervention training but also within the education sector (Barrera *et al.*, 2013; Gueldner *et al.*, 2020; Parra-Cardona *et al.*, 2017)
Chu and Leino (2017) **The Cultural Treatment Adaptation Framework** Two main elements of adaptation: 1. Core components: changes, additions, or modifications 2. Peripheral components: engagement and treatment	This model proposes a unifying framework for cultural adaptation, discussing the important topic of fidelity in terms of treatment components and adjustments There is no specific patient or therapist population for this framework and no stakeholder involvement. The model is based on literature review	This has been used as a theoretical basis for two evidence-based culturally adapted psychological interventions (Soto *et al.*, 2018; Wiltsey Stirman *et al.*, 2017; Wiltsey Stirman *et al.*, 2019)
Rathod *et al.* (2019) **The Cultural Adaptation Framework** This framework is based on model proposed by Tseng (1999) with the addition of one more area,	This framework clearly outlines all areas relating to culture which need to be considered when adapting therapies. It covers all possible influences which could affect therapy engagement and outcomes for the patient. It proposes changes in	This has been used to test CBT for psychosis in a pilot RCT (Rathod *et al.*, 2013)

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Table 1. (*Continued*)

Author(s) (year) **Framework and outline**	Details of framework	Evidence of implementation
'practical considerations of social and health related factors'	the therapy, therapist and discussions with the patient to ensure are completely suitable and accommodating intervention This framework was developed to culturally adapt CBT for psychosis, through stakeholders' engagement, with the South Asians and African Caribbean as the target population	

Table 2. Components of the Southampton Adaptation Framework

Major areas	Minor areas
Awareness of cultural knowledge	1. Cause and effect model of mental illness used by the population in focus 2. Language and terminology (literal translations do not work) 3. Communication styles, idioms of distress and personal boundaries 4. Family and caregivers' involvement 5. Health system related issues (for future implementation) (number of therapists, resources, distance from the treatment facility) 6. Considerations of gender and sex-related issues 7. Pathways to care (with a focus on help from traditional healers) 8. Coping strategies and cultural strengths
Assessment and engagement	9. Self-awareness in therapists about their own belief system 10. Common presenting complaints and concerns 11. Assessment of acculturation and immigration status 12. Racism and racial or other trauma 13. Stigma, shame, and guilt 14. Barriers to seeking therapy and engagement with therapy 15. Awareness of illness, its causes, and its treatment 16. Beliefs about illness, its causes, and its treatment
Adjustments in therapy	17. Culturally acceptable patient–therapist relationship (attitude towards authority in a given culture) 18. Cultural variations in dysfunctional beliefs 19. Acceptable therapy settings and style 20. Adjustments or modifications required in therapy settings 21. Use of culturally favourable communication strategies such as stories or images 22. Understanding barriers in therapy such as how to ensure homework assignments are completed 23. Psychoeducation and access to therapy 24. Adjustments in therapy techniques

(Domenech-Rodriguez and Wieling, 2005). Again, stakeholders were involved, but this time it was community leaders with whom the need for interventions was shared and the needs of the community were discussed (Domenech-Rodriguez and Wieling, 2005). Castro *et al.* (2004) moved away from the focus on the patient and more towards the programme delivery staff, programme administration and community factors, stating the need to understand the impact of these. They also went on to highlight two specific internal cognitive processes and how these may exert influence, rather than looking at the individual and their cultural influences overall (Castro *et al.*, 2004). The Selective and Directed Treatment Adaptation Framework proposed that cultural adaptation was not needed consistently, but only when outcomes of standard un-adapted interventions produced significantly poorer outcomes compared with adaptations (Lau, 2006). It also mentions when adaptations can either enhance engagement by creating an appropriate link with the cultural group or can provide more relevant context to the intervention (Lau, 2006). Barrera and Castro (2006) build further on Lau's (2006) work, exploring the development of equivalent, yet culturally relevant, scales and outcome measurements.

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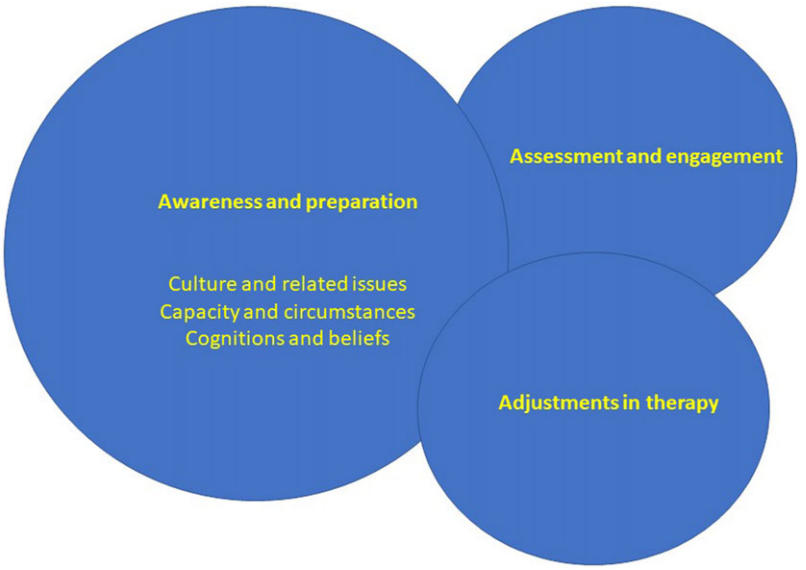

Figure 1. Fundamental areas of adaptation.

Hwang (2006) provided a detailed framework, outlining six core domains which need to be addressed for adaptations; these were explained further through various principles. This framework mentions the complexities of cultural adaptation, stating it is important to gain context and understand the issues around adjustment before implementation (Hwang, 2006). Leong and Lee (2006) and Whitbeck (2006) build on previous understanding by highlighting the need to identify gaps in current cultural-adaptation literatures and the importance of testing the adapted interventions for feasibility and efficacy before implementation. Kumpfer *et al.* (2008) suggested making small changes to interventions and testing at each point through pilot studies and focus groups. This can ensure that the intervention does not change too much from the original than needed, helping to maintain cultural equivalence of outcome measures (Kumpfer *et al.*, 2008). Rathod *et al.* (2019) developed the Cultural Adaptation Framework (CAF) through revisions of previous models based on evidence and literature (Rathod *et al.*, 2015; Tseng *et al.*, 2005). Cardemil (2010) looked at gaps in the literature relating to the structure and delivery of adapted interventions, reiterating the need for changes to be made in a holistic manner for them to be culturally appropriate. The importance of testing and evaluating the efficacy of adapted interventions is also repeated (Cardemil, 2010). The Cultural Adaptation Process Model and the Cultural Treatment Adaptation Framework both include the majority of the concepts already mentioned in previous frameworks: the need to consult previous literature, the use of stakeholders in pilot studies, and assessing outcomes post-intervention (Chu and Leino, 2017; Domenech-Rodriguez *et al.*, 2011).

The cultural adaptation frameworks: current understanding

The Southampton Adaptation Framework was the first framework developed for culturally adapting CBT (Naeem *et al.*, 2009). This framework however, involved immense stakeholder involvement, providing insight into the adjustment and engagement processes of adapted interventions (Naeem *et al.*, 2009). This was one of the first cultural adaptation frameworks to be tested in a randomised controlled trial (RCT), stressing the importance of testing adjusted interventions to ensure they produce positive outcomes (Naeem *et al.*, 2009) (see Fig. 1). The framework proposes a 'bio-psycho-socio-spiritual' model of causation of illness, instead of a

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bio-psycho-social model. The framework consists of three major areas (the triple A principle) of concern: (1) cultural awareness, (2) assessment and engagement, and (3) adjustments in therapy. Cultural awareness can be further can be divided into three areas: (1) culture, religion and spirituality, (2) context and capacity of the system, and (3) cognitions and beliefs. Please see Table 2 for further details. This framework has been used to adapt CBT for depression and anxiety in Saudi Arabia (Algahtani *et al.*, 2019) and Morocco (Rhermoul *et al.*, 2017) and psychosis in China (Li *et al.*, 2017) and for and emotional dysregulation in learning disability in Canada (McQueen *et al.*, 2018). Currently, the framework is being used in Canada to adapt CBT for depression and anxiety for the South Asian population (Naeem *et al.*, 2021). The framework has been used to adapt and test CBT for a variety of issues such as depression (Naeem, Gul, *et al.*, 2015), schizophrenia (Naeem, Saeed, *et al.*, 2015) and OCD (Aslam *et al.*, 2015) self-harm (Husain *et al.*, 2014).

Implementation of culturally adapted CBT in existing services remains a challenge. The Improving Access to Psychological Therapies (IAPT) programme in England has a 5-stage outline for adjusting interventions to the needs of the individuals in order to facilitate effective treatment outcomes (Clark, 2011). Individuals from minority ethnic backgrounds tend to have a disparate experience of mental health services. To combat this, IAPT have enabled self-referrals to reduce discriminations in accessing mental health services but now there is a need to understand and address the shortcoming of therapeutic interventions themselves (Rathod *et al.*, 2020). To further support the work of the IAPT programme, the BAME Service User Positive Practice guide was developed in 2019 (Beck *et al.*, 2019). It outlined key targets and guidelines that IAPT services needed to incorporate to ensure better access and outcomes for minority ethnic patients (Rathod *et al.*, 2020). Whilst IAPT services are trying to become more accommodating, there are very few culturally adapted interventions currently being offered such as culturally adapted IAPT services for individuals from a Tamil background (Bahu, 2019). Action must be taken in this area to directly improve engagement and outcomes for individuals from minority ethnic backgrounds.

Culturally adapted psychotherapies – the evidence

What works? Types of adaptations

A systematic review of culturally adapted psychological treatments found that most alterations were made in the implementations rather than content of the intervention (Chowdhary *et al.*, 2014). For example, adaptations to language, context and therapist were common implementations. Likewise, Degnan *et al.* (2017) identified 9 core themes around which cultural adaptations were based including family, communication, therapeutic alliance, and treatment goals. This was beneficial as it ensured fidelity was maintained of the intervention itself, whilst accommodating for cultural applicability (Chowdhary *et al.*, 2014). Chowdhary *et al.* (2014) evaluated cultural adaptation using the Medical Research Council framework (Craig *et al.*, 2008) and Bernal and Saez-Santiago's model (Bernal and Sáez-Santiago, 2006) to describe the nature of adaptation, while Degnan *et al.* (2017) used qualitative methodology to evaluate the nature of cultural adaptations. Griner and Smith (2006) classified adapted interventions based on an explicit statement of culture, matched race or ethnicity between the client and the therapist, use of the client's preferred language, incorporation of cultural values and worldview into sessions, collaboration with cultural others, appropriately localized services, and relevant spirituality discussion. Interventions that were adapted for specific cultural groups were 4 times more effective than interventions adapted for ethnic minority groups as a whole; however, adapted treatments for collective minority groups were still effective compared with un-adapted interventions (Griner and Smith, 2006).

Numerous studies have reported that cultural adapted interventions implement changes in the following domains: language, family, content, context and access (Aujla-Sidhu, 2020; Lehman and Bordlein, 2020; Rojas-Garcia *et al.*, 2014; Wright *et al.*, 2020). Implementing interventions at

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home, as well as introducing psychoeducation is also an effective technique to increase beneficial outcomes (Rojas-Garcia *et al.*, 2014). Similarly, Degnan *et al.* (2017) reported interventions were more successful when patients attended with relatives rather than alone. Multiple reviews found age as a predictor of the effect of culturally adapted interventions whilst other studies reported shared language between client and therapist to improve the effectiveness of the interventions (Griner and Smith, 2006; Hall *et al.*, 2016; Smith *et al.*, 2011; Sutton, 2015).

Family is a core factor within many communal societies when it comes to help-seeking and treatment engagement. Therefore, interventions involving the patient and their family are likely to bolster treatment outcomes as core cultural values have been considered when implementing treatments (Naeem *et al.*, 2019). Family members would also be able to support homework completion, again increasing positive outcomes for the patient (Naeem *et al.*, 2019). CBT recommendations for individuals with psychosis outline the need to incorporate family interventions within treatment plans to ensure improved outcomes, and this has been supported by a large body of evidence (Ma *et al.*, 2020; Naeem *et al.*, 2019; National Institute for Health and Care Excellence, 2015; Sitko *et al.*, 2020). A systematic review studying the effectiveness of culturally adapted CBT interventions also incorporated family interventions within their analyses (Degnan *et al.*, 2017). Most of the reviewed interventions acknowledged the importance of family involvement in patient treatment and recovery, which involves adjustments such as home visits, family sessions, or extra homework activities (Degnan *et al.*, 2017). Treatment goals were also modified in 28% of studies to ensure that achievements aligned with cultural values (Degnan *et al.*, 2017). These included and considered managing family expectations and meeting the needs of the family as a unit, as well as keeping family integrated in the remission process (Degnan *et al.*, 2017).

How effective is it?

So far, multiple systematic reviews and meta-analyses of culturally adapted psychosocial interventions have been published. Various mental health conditions have been considered through different patient demographics (e.g. age, gender, ethnicity) and also different psychosocial interventions. Although studies have been carried out in a systematic and rigorous manner, the evaluations contained several flaws, including methodological heterogeneity. The authors reported several biases, such as the effect of risk biases, including publication bias, blinding of outcome assessors, and attrition bias. This would of course affect the validity, applicability and generalizability of the results and conclusions.

Chowdhary *et al.* (2014) conducted a systematic review and meta-analysis on culturally adapted interventions for ethnic minority groups with depressive disorders. The analysis revealed that adapted treatments significantly improve patient symptoms compared with unadjusted interventions (standardized mean difference (SMD) = –0.72, 95% CI –0.94 to –0.49). A systematic review and meta-analysis on culturally adapted interventions for schizophrenia revealed that adapted interventions presented significant improvements in overall symptom severity ($g = -0.39$, 95% CI –0.36 to –0.09) as well as positive ($g = -.056$) and negative ($g = -0.39$) symptoms (Degnan *et al.*, 2017). This research did not uncover sufficient evidence to support the claim that culturally adapted interventions are more advantageous compared with unadapted treatments (Degnan *et al.*, 2017). The meta-analysis by Griner and Smith (2006) revealed a moderate effect size ($d = .45$), indicating that culturally adapted interventions provide beneficial outcomes for patients. Adapted interventions aimed at women with perinatal depression were all effective, providing a significant reduction in depressive symptoms (–0.44, 95% CI –0.67 to –0.22) (Rojas-Garcia *et al.*, 2014). Rojas-García *et al.* (2014) also found that culturally adapted interventions were twice as effective with Asian Americans compared with other cultural minorities. However, another review reported a lower efficacy of outcomes for the Chinese population (95% CI $g = -1.50$ to –0.47), compared

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with other ethnic groups ($g = -0.56$, 95% CI −0.85 to −0.26), following adapted interventions targeting schizophrenia (Degnan *et al.*, 2017).

A meta-analysis by Soto *et al.* (2018) revealed a moderately strong effect size ($d = .50$) across 99 studies, suggesting that culturally adapted interventions result in increased positive outcomes. Using a Latino population, a systematic review of 60 adapted CBT interventions was carried out (Hernandez Hernandez *et al.*, 2020). New findings revealed that both adapted and unadapted CBT provided the same beneficial outcomes for effectiveness and retention rates in Latin American populations (Hernandez Hernandez *et al.*, 2020). Large effect sizes ($d = 1.00$) were prevalent across most non-adapted CBT studies; adapted CBT effect sizes range from $d = 0.13$ to 4.18, with 75% retention and mid- to high-quality studies (Hernandez Hernandez *et al.*, 2020). This led to the suggestion of whether clinicians should be encouraged to improve their delivery of CBT to ensure consistent positive outcomes rather than adapting CBT for different ethnic groups (Hernandez Hernandez *et al.*, 2020). Again, within the Latino population, interventions aimed at individuals with depression or anxiety revealed that those who engaged with adapted interventions reported outcomes 0.344 standard deviations above control groups, indicating very high outcomes (Nelson *et al.*, 2020). A systematic review looking at the effect of adapted narrative exposure therapy on reducing trauma symptoms in refugees found a significant reduction across all studies (−0.59, 95% CI −1.19 to −0.31) (Wright *et al.*, 2020).

Aujla-Sidhu (2020) conducted a systematic review examining culturally adapted interventions for a South Asian population with depression. The results of this study displayed a significant reduction in outcome measure scores for individuals engaging with CBT, highlighting the effectiveness of adapted interventions in reducing depressive symptoms (Aujla-Sidhu, 2020). A comprehensive systematic review by Anik *et al.* (2021) also found statistically significant effects promoting the use of culturally adapted interventions for depression in comparison with control groups (SMD = −0.63, 95% CI −0.87 to −0.39), which is in line with previous findings and reviews (Chowdhary *et al.*, 2014). Subgroup analysis did reveal when implementing an intervention with a majority ethnic group that the effect was much larger (Anik *et al.*, 2021). If the therapist and client share ethnic background, the effects are successful in CBT and are amplified further (Anik *et al.*, 2021).

Discussion

Culturally adapted psychotherapy frameworks have evolved over the past 30 years. These frameworks provide some guidance on culturally adapted psychosocial interventions. Some frameworks promoted more surface adaptations, which provided a basis to formulate more concrete suggestions and recommendations (Koss-Chioino and Vargas, 1992; López *et al.*, 1989). As time progressed, frameworks began to focus on the intricacies of culture and the various elements which can affect an individual. This led to the development of more comprehensive framework, which focused on implementing core adaptations to interventions (Kumpfer *et al.*, 2008; Hwang, 2006; Rathod *et al.*, 2019). Similarly, frameworks generally avoid changes in the theoretical or philosophical underpinnings of therapy. Making changes in the theoretical basis of therapy risk deviation from the core model of a particular therapy. Most frameworks were developed and published in North America, based on the therapist's personal experience or, at times, based on a literature review. As the need for culturally adapted intervention is becoming more prominent, frameworks and guidelines are being implemented and tested in various research and literature. All frameworks mentioned above have been utilized in books, guidelines and research articles, all focusing on adapted interventions (Barrera and Castro, 2006; Bernal *et al.*, 1995; Hwang, 2006). Many of the recent frameworks have also been tested through pilot studies and RCTs to ensure further validity and efficacy (Castro *et al.*, 2004; Domenech-Rodriguez and Wieling, 2005; Naeem *et al.*, 2009; Rathod *et al.*, 2019; Tseng, 1999). Whilst systematic reviews

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looking at adapted interventions have been carried out, there has been no comprehensive review including all scientific evidence relating to culturally adapted CBT. This lack of scientific rigor in developing and testing adaptation frameworks needs to be addressed.

Current evidence suggests that culturally adapted interventions can be effective. Most meta-analyses showed a moderate to large effect for culturally adapted interventions. However, most of these meta-analytic reviews lacked methodological rigor and other problems, such as poor consideration of theoretical underpinning and cultural issues. The overall approach in cultural adaptation studies seems to compare western European and North American to non-western cultures as a whole, without realizing the diversity and sub-cultures within the non-western groups. While most studies included in meta-analyses used CBT for adaptation, currently, no comprehensive systematic review and meta-analysis is available that encompass all implementations of culturally adapted CBT and its effectiveness.

Frameworks have outlined various core elements which are needed to culturally adapt interventions to make then relevant for an ethnic minority population. The main elements mentioned across models and frameworks are: language, persons, metaphors, content, concepts, goals, methods, context, therapeutic relationship, and community involvement (Barrera and Castro, 2006; Bernal *et al.*, 1995; Cardemil, 2010; Castro *et al.*, 2004; Domenech-Rodriguez and Wieling, 2005; Hwang, 2006; Koss-Chioino and Vargas, 1992; Kumpfer *et al.*, 2008; Naeem *et al.*, 2009; Rathod *et al.*, 2019; Tseng, 1999). What is needed now is a comprehensive and inclusive framework or guidelines which encompass all research aspects of cultural adaptations to ensure appropriate adjustments are being made. Pilot studies which involve stakeholders will provide evidence for relevancy and applicability to minority ethnic populations whilst RCTs will uncover levels of efficacy and fidelity of interventions and outcome measures.

Implications and future directions

The field of cultural adaptations of psychological interventions, including CBT, is an emerging field, and therefore research into the relevancy, fidelity and efficacy of adaptations needs to be carried out to ensure interventions are providing beneficial outcomes for patients. The current political environment is conducive to the implementation of culturally adapted interventions (Naeem *et al.*, 2016). Future research should evaluate the effectiveness of adapted interventions using robust designs and improved methods, with the need to compare culturally adapted therapy with non-adapted interventions as opposed to usual care. Most importantly, there is a need to conduct economic evaluation studies to determine how beneficial culturally adapted interventions are compared with standard therapies.

One major gap identified in the literature in relation to adaptation frameworks is the lack of stakeholder involvement during the formulation processes. Very few frameworks incorporated stakeholders but it would be insightful to gain their experience and understanding. Alongside providing a supportive role in framework development, stakeholders could also be involved in the pilot testing through RCTs to ensure applicability and fidelity of the adapted interventions. One way in which this can be done is through implementation mapping (IM) which aims to actively engage stakeholders in the developmental stages of intervention development (Majid *et al.*, 2018). There are six main steps which should involve relevant stakeholders to ensure any interventions are adapted to be appropriate for the according patient population and these are: assess needs and barriers, establish objectives, select theory-informed interventions, design and pilot-test the intervention, implement and assess fidelity of the intervention, and evaluate the impact of the intervention (Majid *et al.*, 2018). Despite implementing the IM framework in research, over 25% of the reviewed papers failed to include stakeholders; the research that did have stakeholder involvement shared its methodology only half of the time (Majid *et al.*, 2018). Likewise, the Consolidated Framework

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for Implementation Research (CFIR) reiterates the importance of nested process evaluations to enable better understanding and efficacy of adapted interventions, especially when involving a complex concept such as culture (Damschroder *et al.*, 2009; Palmer *et al.*, 2016; Consolidated Framework for Implementation Research, 2022). The CFIR outlines five major domains through which patients, as stakeholders, can share their perspectives and experiences which would aid the formulation of culturally adapted interventions (Damschroder and Lowery, 2013). These main domains are: intervention characteristics, outer setting, inner setting, characteristics of individuals, and the process (Damschroder and Lowery, 2013; Naeem *et al.*, 2016). Due to the complexity of culture, it is important to have such frameworks and guidelines which provide detailed understanding of how to apply appropriate adjustments and implementations to interventions (Damschroder and Lowery, 2013). Naeem *et al.* (2016) have also proposed that the first step of the CBT adaptation process involves stakeholders to enable high-quality, detailed understanding of a culture from the experience and perspective of individuals belonging to that culture.

Currently, there is no agreement on components of cultural adaptation that work. Too many frameworks provide general and often vague guidelines, and few focus on parent interventions or CBT more specifically. Outcome measures and parameters for judging research quality are inadequate for assessing those related to ethnic minority groups due to the ethnocentric environment under which they were developed. There is a need for a universally accepted framework that would ideally be supported by the International Association for CBT to ensure global agreement on adaptation processes. Such a framework can use data from existing literature to provide a common evidence-based framework that could guide clinicians and researchers in adapting different therapies through a standardized procedure. There is also a need for updated high-quality meta-analyses as current literature is almost 10 years old, consisting of various psychosocial therapies from a wide range of theoretical backgrounds. Future meta-analyses should focus on specific ethnic and diagnostic populations, with intervention types sub-analysed, instead of combining participants from various backgrounds and analysing different types of interventions together regardless of their varied theoretical underpinning. In terms of CBT, a framework specific to each element of the therapy would be required. As CBT runs on the three main principles of core beliefs, dysfunctional assumptions, and negative automatic thoughts, it would be necessary for any cultural adaptation guidelines to refer specifically to these elements and how these can be adjusted whilst maintaining fidelity and effective outcomes (Beck *et al.*, 1979). On a similar note, there are significant differences between various psychological therapies, all of which consist of different underlying principles. It would therefore be impractical to apply one universal framework or guideline to all types of psycho-interventions. On another note, it is important to bear in mind that there are still gaps in the adaptation of outcome measures and their appropriate validation for cultural minorities. For these goals to be accomplished, a diverse workforce is essential for meeting the needs of cultural minorities and providing culturally appropriate mental health services to these individuals alongside implementing culturally sensitive training and supervision to those healthcare professionals working with these populations.

Implications for researchers

(1) Research on culturally adapted CBT should be an immediate priority to ensure up-to-date, detailed understanding of the topic area.
(2) Researchers need to focus on improving the guidelines for culturally adapting interventions, but also outcome measures.
(3) Researchers should also focus on innovative and cost-effective ways to increase the accessibility of culturally adapted CBT.
(4) Researchers need to focus on improving current frameworks with the aim of developing comprehensive guidelines on how to conduct research in the field of culturally adapting interventions.

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Implications for trainers and supervisors

(1) Regular re-assessment and re-examination of the cultural backgrounds of patients to ensure clinicians have up-to-date understanding of the experiences and perspectives of their patients.
(2) Ensure psychological intervention aligns well with the patient's ethnic background through the use of accommodating language and methods, keeping the cultural norms in mind to help formulation direction of sessions as well as treatment goals.
(3) Take a sensitive and respectful stance when dealing with cultural issues to help improve patient outcomes and bolster therapeutic alliance; ask for feedback relating to the cultural appropriateness of the adjustment made to the intervention.
(4) Clinicians should remain self-aware and recognize their own biases and perspectives that may differ from that of their patients'

Implications for commissioners and managers

(1) Where support with mental health services is offered at an occupational level, culturally adapted interventions, especially CBT, are currently not implemented at the organizational level. If there is availability, this has not been shared.
(2) There is a need to develop training packages for existing therapists in psychological services to improve their cultural competence in delivering CBT.
(3) The routine evaluation of psychological services should include cultural competence in delivering CBT as a regular check to ensure clients are receiving culturally sensitive interventions.

Key practice points

(1) This paper has highlighted the need for culturally adapted psychotherapies, especially CBT, to be implemented for individuals of minority ethnic backgrounds as previous research has shown outcomes to be advantageous.
(2) The next aim for researchers would be to develop a framework, tested through pilot studies and RCTs, which would aid clinicians in adapting interventions to ensure high outcomes.
(3) For CBT therapists, a comprehensive and detailed framework needs to be published which encompasses all elements of culture and its effects on psychopathology and interventions.

Further reading

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