Chapter 1
Global Adaptation and Practice of Cognitive Behavioral Therapy: An Introduction

Mark D. Terjesen, Kristene A. Doyle, and Rebecca L. Wade

Cognitive behavioral therapy (CBT) built upon the field of behavior therapy (BT) in efforts to understand the influence of cognition on behavior (Iwamasa & Hays, 2019). CBT operates on the assumption that thoughts, feelings, and behaviors are interrelated (Dobson & Dozois, 2019) with cognitions mediating the relationship between the environment and emotional and behavioral reactions (Beck & Dozois, 2011; Iwamasa & Hayes, 2019; Wampold, 2012).

CBT is often discussed along a developmental paradigm consisting of different "waves" of progression (David & Hofmann, 2013). The first waves were the primarily behavioral approaches to therapy that were based on principles of learning theory (i.e., classical conditioning, operant conditioning). This was followed in the 1950s and 1960s by the "second wave" of CBT, which included rational emotive behavior therapy (REBT) and cognitive therapy (CT). These approaches centered clinically on cognitive restructuring of automatic thoughts or irrational beliefs that considered maladaptive and lead to unhealthy affective and behavioral responses. The third wave includes clinical approaches such as acceptance and commitment therapy (ACT) and dialectical behavior therapy (DBT) with less of a focus on the cognitive restructuring component (David & Hofmann, 2013).

CBT has become more of a broad umbrella term to describe a variety of clinical approaches that focus on maladaptive cognitions (Hofmann et al., 2012; Matweychuk et al., 2019) and emotions that have a negative impact on functioning. Dobson and Dozois (2019) highlight the behavioral component of CBT involves clinical efforts to changing behavior, as well as indirectly change thoughts by applying behavioral

M. D. Terjesen (✉) · R. L. Wade
St. John's University, Jamaica, NY, USA
e-mail: terjesem@stjohns.edu

K. A. Doyle
Albert Ellis Institute, New York, NY, USA
e-mail: Krisdoyle@albertellis.org

M. D. Terjesen, K. A. Doyle, (eds.), *Cognitive Behavioral Therapy in a Global Context*, https://doi.org/10.1007/978-3-030-82555-3_1

techniques. This may include assessing behavior, teaching skills, and assigning homework to promote generalization (Lochman et al., 2011).

The overall field of CBT includes clinical interventions such as ACT, CT, DBT, and REBT (Matweychuk et al., 2019). While the models may differ in terms of what degree they focus on cognitive restructuring (i.e., working to directly change faulty cognitions), all assign cognitions as a primary factor in contributing to duress. For a more thorough review that breaks down the historical and philosophical underpinnings of the varied CBT models, the reader is referred to Dobson and Dozois (2010) and Dozois (2019).

While CBT is considered to be the "gold standard" of psychological treatment (David et al., 2018), is applicable across a wide-range of populations (Hofmann et al., 2012), and is taught and practiced worldwide (Dobson & Dozois, 2019), the challenge persists in understanding to what degree CBT is adaptable to reflect cultural and linguistic factors. Iwamasa and Hays (2019) discuss how multicultural therapy (MCT) has expanded to involve more minority cultures, but that MCT fails to be integrated into the major theories of psychotherapy, including CBT. While there has been an increase in the number of studies that have culturally adapted CBT, to what degree do these studies actually change core CBT strategies is still debatable (Chu & Leino, 2017).

This edited volume aims to reflect how the application of CBT has been influenced by a number of factors including geography and history of the country, systemic societal influences on the practice of psychotherapy, and the role of culture and language (Hays, 2009). As psychotherapy practice is guided by science, it is important to consider how, where, and with whom the research is conducted.

Psychotherapy, Culture, International Research, and Ethics

One of the biggest challenges that affects the bridging of the science-practice gap in psychotherapy is *where* the science is conducted. Over 90% of psychological research is conducted on groups which constitute approximately only 60–70% of the world (Keller, 2017; Kline et al., 2018). This leads to significant underrepresentation (less than 10%) of the psychological research for over 30–40% of the world (Wade, 2021). Wade describes that one of the bigger challenges in having a truly representative science to guide practice is the fact that the groups for whom the research has been conducted upon are relatively homogenous. The term Western, Educated, Industrialized, Rich, and Democratic (WEIRD) (Granqvist & Nkara, 2017; Hays, 2018; Kline et al., 2018) is used to describe the homogenous samples seen in psychology research and geographically is represented by the United States of America (USA), Canada, and Europe (Kline et al., 2018; Pantalone et al., 2010). Wade further points out that specific populations of diverse groups (i.e., Native Americans, Asian Americans, LGBTQ+) continue to be underrepresented in research studies (Pantalone et al., 2010). This leaves much of the world's population underrepresented in psychological literature. Pantalone and colleagues also propose

that populations may not utilize mental health resources as the WEIRD definitions and conceptualizations of mental health are not consistent with their views and may find WEIRD developed psychotherapy treatments invaliding and intrusive (Arora et al., 2016; Smith & Trimble, 2016). Given this, it is important to consider the application of CBT in non-WEIRD locations to help inform and possibly revise clinical methods (Miller, 2005).

An important factor to consider is the role of culture in the psychotherapy literature as one's culture may have a significant impact on their behaviors (Psaltis, 2012) and response to psychotherapy. While culture is often equated with a country (Keller, 2017), this may not be the best practice as countries may have many varied cultural constructs which serve to impact behavior. We have asked the authors in this edited volume to consider *broadly* culture and its role in mental health application.

Hofstede and colleagues identify a number of cultural dimension themes that we argue may be important for clinicians to consider in the application of CBT within the country and with diverse populations. These dimensions include individualism versus collectivism, indulgence versus restraint, long-term orientation versus short-term normative orientation, masculinity versus femininity, power versus distance, and uncertainty versus avoidance (Hofstede, 1983; Hofstede et al., 2010). In the research of individuals from 76 countries (Hofstede et al., 2010), there were a number of trends between and within countries as well as more large-scale trends (Moskowitz & Moskowitz, 2009). For example, it is common for Western cultures to hold certain beliefs such as individualism, while in non-Western counterparts, collectivism prevails (Wade, 2021). It may be important for clinicians to consider these dimensions in both their CBT practice and science.

Challenges in Conducting International Research

Barriers exist that limit the development of science among culturally and ethnically diverse environments (Wade, 2021). Among these barriers is the geographic location of the researcher as most who engage in psychological research are from areas which are considered to be WEIRD (Hays, 2018). The geographical and relatedly the probable lack of cultural diversity amongst the researchers will create logistical barriers for clinical adaptations (Wade, 2021). Furthermore, when adaptations of psychotherapy are *culturally specific*, the clinical intervention is more effective (Huey et al., 2014). However, these kinds of adaptations are seen less often, and as a result, the research and conclusions conducted in WEIRD cultures by WEIRD researchers become the "norm" and are more likely to guide clinical practice (Wade, 2021). However, as technology has assisted in the ability to collaborate and share knowledge and resources, these barriers are not as insurmountable as previously considered (Jensen, 2012; Kline et al., 2018).

Culture and Mental Health: The Role of Ethics in Practice and Science

It is a clinician's ethical duty to be aware of cultural differences and consider them within treatment (American Psychological Association, 2017; Pantalone et al., 2010; Smith & Trimble, 2016). Wampold (2012) argues that in the case of conceptualization, clinicians need to consider the cultural beliefs, goals, and values of clients as it relates to treatment planning. Further, mental health practitioners have an ethical duty to integrate evidence-based findings to guide clinical interventions (American Psychological Association, 2016; Smith & Trimble, 2016). As such, it is important for practitioners to be mindful of the evidence base in the clinical application in culturally diverse settings and with culturally diverse clients (Cabassa & Baumann, 2013; Wade, 2021).

Culturally adapted treatments are shown to be more effective than treatments that were not adapted (Hall et al., 2016; Huey et al., 2014). Further, the more that interventions are individualized to consider factors such as culture, language, and race, clients are more likely to remain, engage, and participate in treatment (Soto et al., 2018). However, adaptations may be influenced by the cultural beliefs and values of the clinician (Eklund et al., 2014) and as such there may be variability as a function of clinician within a specific culture. Awareness of clinician's potential biases is linked to stronger therapeutic alliance and better client outcomes (Eklund et al., 2014; Pantalone et al., 2010).

A number of general guidelines for adapting psychotherapies to be culturally sensitive are developed with related but distinct foci. Pantalone and colleagues suggest that in adapting psychotherapy for culturally diverse groups it is important that clinicians consider thematic differences – that is, communication styles, family structure, health beliefs, the concepts of individualism and collectivism, self-identification, and therapy goals (Pantalone et al., 2010). Similarly, Smith and Trimble (2016) recommend an ecological validity model that addresses concepts, content, context, goals, language, metaphors, methods, and persons. More specific to CBT, Hays (2018) suggests consideration of age/generation, developmental disabilities, disabilities acquired later in life, ethnic and racial identity, gender, indigenous heritage, national origin, religious and spiritual orientation, sexual orientation, and socioeconomic status.

While adapting psychotherapy, and more specifically CBT interventions for culture, is logically a principle that most would support (Smith & Trimble, 2016; Soto et al., 2018), the *how* to do this is still not clear. Arguing that the basic interventions and strategies of CBT will be effective for diverse clients without scientific evidence is problematic (Pantalone et al., 2010). In their meta-analytic review, Smith and Trimble (2016) point out that 42% of cultural adaptations to therapy were guided by research or theory, or in other words, over half of the published work regarding cultural adaptations of therapy are *not* from an evidence-based perspective (Wade, 2021). Further, Wade points out that when studies do not describe *how* treatments were adapted (Soto et al., 2018) or fail to compare an adapted treatment to a

non-adapted treatment (Hall et al., 2016), we may not be learning much in terms of how to adapt for clinical care.

Recently, David and colleagues (David et al., 2019) proposed that we re-consider the model of CBT from an individual level to one seen more within a cross-cultural context, that is, examining countries and cultures as a unit of analysis rather than the individual. From a scientific and applied perspective, this may be an important model to guide the field. The CBT model has been disseminated globally and has had a significant impact on the practice of psychotherapy. By best understanding the intersection of culture, language, and clinical interventions, the field of psychotherapy may be best able to ascertain *what* clinical applications work for *which* clients under *what* conditions. Working with in-country practitioners, we may be at a better place to develop scientific models and applications of CBT within country, and as such be more confident in avoiding post-hoc explanations for change (or lack thereof). Understanding what mediating factors that reflect culture and language impact on the effectiveness of specific CBT interventions will lead to better serving our clients and advancing the science and practice of CBT.

References

American Psychological Association. (2016). Revision of ethical standard 3.04 of the "*Ethical Principles of Psychologists and Code of Conduct*" (2002, as amended 2010). *American Psychologist, 71*, 900.

American Psychological Association. (2017). *Multicultural guidelines: An ecological approach to context, identity, and intersectionality*. Retrieved from: http://www.apa.org/about/policy/multicultural-guidelines.pdf

Arora, P. G., Metz, K., & Carlson, C. I. (2016). Attitudes toward professional psychological help seeking in South Asian students: Role of stigma and gender. *Journal of Multicultural Counseling & Development, 44*(4), 263–284. https://doi.org/10.1002/jmcd.12053

Beck, A. T., & Dozois, D. J. (2011). Cognitive therapy: Current status and future directions. *Annual Review of Medicine, 62*, 397–409.

Cabassa, L. J., & Baumann, A. A. (2013). A two-way street: Bridging implementations science and cultural adaptations of mental health treatments. *Implementation Science, 8*(90), 1–14. https://doi.org/10.1186/1748-5908-8-90

Chu, J., & Leino, A. (2017). Advancement in the maturing science of cultural adaptations of evidence-based interventions. *Journal of Consulting and Clinical Psychology, 85*(1), 45.

David, D., & Hofmann, S. G. (2013). Another error of Descartes? Implications for the "third wave" cognitive-behavioral therapy. *Journal of Cognitive and Behavioral Psychotherapies, 13*(1), 115–124.

David, D., Cristea, I., & Hofmann, S. G. (2018). Why cognitive behavioral therapy is the current gold standard of psychotherapy. *Frontiers in psychiatry, 9*, 4.

David, D., Ştefan, S., & Terracciano, A. (2019). Cognitive-behavioral therapy in the cross-cultural context: An extension of the standard paradigm from individual to country/culture level—A brief introduction into a new research line. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 37*(2), 172–184.

Dobson, K., & Dozois, D. (2010). *Historical and philosophical bases of the cognitive-behavioral therapies*. In *Handbook of cognitive behavioral therapies* (3rd ed.). The Guilford Press.

Dozois, D. J. A. (2019). *Historical and philosophical bases of the cognitive-behavioral therapies* (p. 9). Faculty Publications. https://ir.lib.uwo.ca/huronpsychologypub/9

Dozois, D. J., Dobson, K. S., & Rnic, K. (2019). Historical and philosophical bases of the cognitive-behavioral therapies. *Handbook of cognitive-behavioral therapies*, 3–31

Eklund, K., Aros-O'Malley, M., & Murrieta, I. (2014). Multicultural supervision: What difference does difference make? *Contemporary School Psychology, 18*, 195.

Epp, A. M., & Dobson, K. S. (2010). The evidence base for cognitive-behavioral therapy. In *Handbook of cognitive behavioral therapies* (3rd ed.). The Guilford Press.

Granqvist, P., & Nkara, F. (2017). Religious and spiritual development are determined 100% by nature, and 100% by nurture: A playful response to Boyatzis. *British Journal of Developmental Psychology, 35*(1), 162–165. https://doi.org/10.1111/bjdp.12175

Hall, G., Ibaraki, A., Huang, E., Marti, C., & Stice, E. (2016). A meta-analysis of cultural adaptations of psychological interventions. *Behavior Therapy, 47*(6), 993–1014. https://doi.org/10.1016/j.beth.2016.09.005

Hays, P. A. (2009). Integrating evidence-based practice, cognitive-behavior therapy, and multicultural therapy: Ten steps for culturally competent practice. *Professional Psychology: Research and Practice, 40*(4), 354–360. https://doi.org/10.1037/a0016250

Hays, P. A. (2018). Introduction. In *Culturally responsive cognitive behavior therapy: Practice and supervision* (2nd ed.). APA.

Hofmann, S. G., Asnaani, A., Vonk, I. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive therapy and research, 36*(5), 427–440.

Hofstede, G. (1983). Cultural dimensions for project management. *International Journal of Project Management., 1*(1), 41–48. https://doi.org/10.1016/0263-7863(83)90038-8

Hofstede, G., Hofstede, G. J., & Minkov, M. (2010). *Software of the mind: Intercultural cooperation and its importance for survival*. McGraw-Hill.

Huey, S. J., Jr., Tilley, J. L., Jones, E. O., & Smith, C. A. (2014). The contribution of cultural competence to evidence-based care for ethnically diverse populations. *Annual review of clinical psychology, 10*, 305–338.

Iwamasa, G. Y., & Hays, P. A. (2019). *Culturally responsive cognitive behavior therapy: Practice and supervision* (pp. xi–348). American Psychological Association.

Jensen, L. A. (2012). Bridging universal and cultural perspectives: A vision for developmental psychology in a global world. *Child Development Perspectives, 6*(1), 98–104. https://doi.org/10.1111/j.1750-8606.2011.00213.x

Keller, H. (2017). Culture and development: A systematic relationship. *Perspectives On Psychological Science: A Journal of the Association for Psychological Science, 12*(5), 833–840. https://doi.org/10.1177/1745691617704097

Kline, M. A., Shamsudheen, R., & Broesch, T. (2018). Variation is the universal: Making cultural evolution work in developmental psychology. *Philosophical Transactions of the Royal Society of London. Series B, Biological Sciences, 373*(1743). https://doi.org/10.1098/rstb.2017.0059

Lochman, J. E., Powell, N. P., Boxmeyer, C. L., & Jimenez-Camargo, L. (2011). Cognitive-behavioral therapy for externalizing disorders in children and adolescents. *Child and Adolescent Psychiatric Clinics, 20*(2), 305–318.

Matweychuk, W., DiGiuseppe, R., & Gulyayeva, O. (2019). A comparison of REBT with other cognitive behavior therapies. In *Advances in REBT* (pp. 47–77). Springer.

Miller, J. G. (2005). Essential role of culture in developmental psychology. *New Directions for Child & Adolescent Development, 109*, 33–41.

Moskowitz, S., & Moskowitz. (2009). Hofstede's five dimensions of culture. In C. Wankel (Ed.), *Encyclopedia of business in today's world*. Sage.

Pantalone, D. W., Iwamasa, G. Y., & Martell, C. R. (2010). Cognitive-behavioral therapy with diverse populations. In *Handbook of cognitive behavioral therapies* (3rd ed.). The Guilford Press.

Psaltis, C. (2012). Culture and social representations: A continuing dialogue in search for heterogeneity in social developmental psychology. *Culture & Psychology, 18*(3), 375–390. https://doi.org/10.1177/1354067X12446233

Smith, T. B., & Trimble, J. E. (2016). *Foundations of multicultural psychology: Research to inform effective practice*. American Psychological Association.

Soto, A., Smith, T. B., Griner, D., Rodriguez, M. D., & Bernal, G. (2018). Cultural adaptations and therapist multicultural competence: Two meta-analytic reviews. *Journal of Clinical Psychology, 74*, 1907–1923.

Wade, R. (2021). *Clinical adaptations of cognitive therapy, cognitive behavioral therapy, and rational emotive behavior therapy as a result of culture and language.* Unpublished doctoral dissertation, St. John's University.

Wampold, B. E. (2012). Humanism as a common factor in psychotherapy. *Psychotherapy, 49*(4), 445–449.

Wampold, B. E., & Imel, Z. E. (2015). History of medicine, methods, and psychotherapy: Progress and omissions. In *The great psychotherapy debate: The evidence for what makes psychotherapy work* (2nd ed., pp. 1–36). Routledge.