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Research Paper

Perceptions of Practitioners on Methods, Current Practice, and Barriers: A Descriptive Analysis of Cultural Adaptation of CBT in India

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ABSTRACT

Background: Cognitive-behavior therapy (CBT) is noted as the gold standard first-line treatment for various psychopathologies. Nevertheless, the application and practice of CBT widely varies across countries and practitioners. There is little evidence surrounding scientific methods of culturally adapting CBT. This likely results in an overinclusive use of the term CBT and threatens ethical practice. **Aim:** To examine perspectives of Indian practitioners on CBT practices, beliefs, and attitudes towards cultural/language adaptation of CBT in India. **Methods:** Adopting an observational design, 83 (response rate of 46%) Indian CBT practitioners participated in an online survey. Information was collected across five-sections: current CBT practice, assessment, barriers, cultural adaption vs culture-focused, method of cultural/language adaptation. **Results:** 93% of all CBT sessions were for adults (aged 19-59 years). 90% of practitioners adopted eclectic approaches, out of which 94% mixed techniques most regularly from other therapies. 71% made structural changes to their practice of CBT and 70% reported conducting CBT alongside family therapy. Majority did not use any standardized tools for session progress/therapy-outcome. More than 90% considered cultural adaptation over culture-focused CBT. 69% preferred integrating top-down and bottom-up approaches to cultural/language adaptation with field testing in each state and 93.6% viewed collaboration among Indian CBT practitioners as the method of validation. More than 70% highlighted the lack of CBT research in India. **Conclusion:** The findings highlighted the need for practice/ethical guidelines for CBT in India, a standardised Indian CBT with rigorous

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field testing (using robust cultural and language adaptation methods) and due emphasis on CBT supervised practice during education and training.

Keywords: *CBT practice status, cultural adaptation, India*

Cognitive-behavior therapy (CBT) is the gold standard of treatment for various clinical disorders as it is adaptable across a wide range of mental health and medical conditions (David et al., 2018). It aims to identify and modify unhelpful patterns of thoughts, beliefs, emotions, and behaviors so as to improve adaptive coping and reduce psychological problems (*What Is Cognitive Behavioral Therapy?*, n.d.). Despite the popularity and widespread use of CBT in the last two decades, there are some concerns with respect to its application in non-European-American populations (Naeem, 2019).

Several cultural differences are noted in not just the content of cognitions, expression of emotions and illness beliefs and expectancies, but also in the training of professionals in CBT (Naeem, 2019). Research in India has noted 82% of psychology students believed the principles of CBT conflicted with their values and beliefs (Naeem et al., 2019), while 46% stated it clashed with their cultural and family values and 40% reported conflict with their religious belief. These findings highlight the need for cultural adaptations of CBT, so as to have a better fit between cultural nuances and CBT practice. As these factors impact client response and understanding of treatment, it would be important to consider adapting CBT to suit cultural needs, without altering its core aspects.

A literature review highlighted some general observations with respect to studies on the cultural adaptation of CBT conducted globally. First, there is a lack of detail with respect to method and framework used to conduct the adaptation in some studies. Instead these studies focus on details of the subsequent feasibility trials or explore culture-specific adaptation factors (Jalal et al., 2018; Kananian et al., 2017; Naeem et al., 2021). This lack of information on the adaptation method makes it difficult to critique its appropriateness or adequacy. Some adaptation studies have only used pre-post trials to test acceptability, feasibility and efficacy (Naeem et al., 2021; Pan et al., 2021). However, the lack of a control group makes it inadequate in testing the efficacy of the adapted CBT against the original CBT. For widespread adoption and increased reliability of the tool, it is crucial to establish the adapted CBT works better than existing alternatives. Additionally, no major systematic differences in Asian vs. non-Asian CBT adaptation studies were apparent. However, it was noted that cultures or populations based in Caucasian countries tend to have more instances of previous research and emerging themes which agree with previous findings (Bennett & Babbage, 2014; Hernandez et al., 2020; Kohn et al., 2002; Shea et al., 2016). In contrast, Asian studies tend to be pioneers of their field with little past literature to draw from (Hwang, 2009; Ishikawa et al., 2019; Murray et al., 2013; Pan et al., 2021).

The overall process of creating an adapted CBT manual is somewhat similar across most studies. Initially, qualitative data is collected from key stakeholders, domain experts and important members of the community via focus group discussions or semi-structured interviews. This stage is conducted in either a top-down approach where input is sought primarily from experts or bottom-up where key stakeholders and community are consulted predominantly. The data is then combed over using a method of choice to grasp emerging themes and coded before being organized into wider themes. The information gleaned is used as the basis for adapting specific components of CBT so that it is more acceptable and

accessible to the target population. This adapted manual is subsequently compiled and trialed on a smaller scale before final additions are made and large field testing is conducted. There is a consensus that CBT can be used effectively with modest cultural adaptations as long as the parental architecture is maintained (Naeem, 2019; Selvapandiyan, 2019). As India is a largely globalized country and practitioners are primarily located in cities, their accessibility and acceptability of western guidelines is high. Hence, culturally adapting CBT instead of creating entirely new and localized therapy appears logical (Selvapandiyan, 2019). Moreover, in view of low-resource health settings adapting the existing CBT is more cost-effective.

There is a paucity of research on the cultural adaptation of CBT to the Indian population. Some of the possible reasons for this could be a preference by clinicians to work with existing model, making small modifications as required in practice or because CBT is rarely used (Kuruvilla, 2000; Sudhir et al., 2019). The second is that Indian values differ significantly from Western ones, and the difference in philosophies is too great to overcome without major changes to the implementation of CBT (Kumar & Gupta, 2012). One such proposed change is the altering of the therapeutic alliance in CBT to mirror that of the 'guru-chela' paradigm which is a more familiar, culturally-rooted way of learning and relating to authority figures. However, this directive approach is often demonstrated to undermines the core aspects of CBT (Kumar & Gupta, 2012; Selvapandiyan, 2020). A final reason may simply be that any research not published in non-indexed journals could not be uncovered due to the limited scope of the search to indexed research.

There is a lack of clarity regarding the fundamental underpinnings of CBT and the important of adhering to it in India which may make CBT adaptation challenging. Firstly, there is an overinclusive use of the term CBT to include interventions like deep breathing, video feedback, coping skills training, stress management, social skills training, relaxation and self-imagery, assertiveness training, distraction techniques, etc. instead of cognitive restructuring alone (Selvapandiyan, 2019). A further issue is use of various terms and descriptions of procedures, lack of proper case conceptualization and non-existent session or outcome ratings which makes it difficult to review and determine the exact nature of CBT delivered.

Thus, to explore the attitudes and practices of Indian CBT practitioners as well as clarify their beliefs regarding the cultural adaptation of CBT and its suitability for the Indian context, this study aimed to survey them about their experiences and beliefs about CBT and its adaptation.

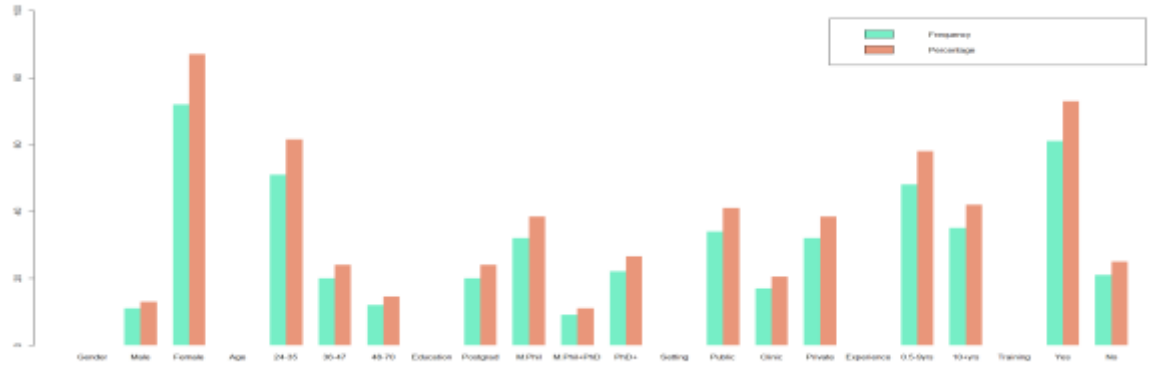
METHODOLOGY

Participants (Figure-1)

CBT practitioners (*N* = 83, *Age* range = 24-70 years; *M* = 35.8, *SD* =9.1*)*, of which 87.5% were female, were recruited from governmental and private sector settings across India. Data was collected via convenience sampling through social and electronic media. Out of 140 practitioners registered by the Rehabilitation Council of India and 40 practitioners through key informants, only 83 valid data sheets were considered for inclusion. Response rate was 46.1%. There was an almost equal distribution of practitioners from governmental and private sectors. Of the total sample, 60% had between one to nine years of work experience and 40% had 10-29 years of experience. Exclusion criteria was limited to those who did not practice CBT, so, 16 practitioners were excluded. Participation was voluntary, could be

withdrawn at any time and informed online consent was obtained prior to any involvement. Figure 1 presents details of other socio-demographic variables.

Figure 1 Count and proportion of socio-demographic factors



Survey Description

The survey was designed to allow participants to select whether they were practicing CBT before proceeding. If one was not a CBT practitioner, then the participant would exit from the survey. Following this the consent form was presented.

In addition to demographic information, the survey contained a total of 5 sections namely, CBT practice, assessment, barriers, culture-focused vs cultural adaptation, and cultural adaptation methods, with each section focusing on items pertaining to the subject. A combination of open-ended and multiple-choice were included. The response pattern was in a Likert rating varying from 3–7-point scale rating.

Procedure

An observational design was used to administer an online survey to recruited clinical psychologists via Google forms. The survey took about 15 minutes to complete and was completed by participants in their own time. However, within 6 weeks of receipt of the survey, a reminder e-mail and/or WhatsApp message was sent. Before closing the survey, a final reminder was also sent.

Table 1 Response rate and proportions by socio-demographic factors

		Do you mix techniques from other therapies?			How frequently do you assess cognitive distortions/errors and core beliefs?						Do you do structural changes in your CBT therapy?			Do you share the findings of psychological assessments with your clients?						Do you follow any specific guideline/manual/intervention module/book for CBT?	
		Yes	No	Sometimes	Always	Very Often	Often	Frequently	Sometimes	Rarely	Yes	Sometimes	No	Always	Very often	Often	Frequently	Sometimes	Rarely	Yes	No
Education	M.Phil	18(56.3)	1(3.1)	13(40.6)	-	11(34.4)	9(28.1)	9(28.1)	3(9.4)	-	10(31.3)	13(40.6)	9(28.1)	-	18(56.3)	7(21.9)	1(3.1)	6(18.8)	-	25(78.1)	7(21.9)
	PhD and above	14(63.6)	1(4.5)	7(31.8)	1(4.5)	10(45.5)	4(18.2)	5(22.7)	2(9.1)	-	4(18.2)	12(54.5)	6(27.3)	-	7(31.8)	9(40.9)	2(9.1)	4(18.2)	-	16(72.7)	6(27.3)
	M.Phil and PhD	5(55.6)	-	4(44.4)	-	2(22.2)	5(55.6)	-	2(22.2)	-	3(33.3)	2(22.2)	4(44.4)	-	2(22.2)	4(44.4)	1(11.1)	2(22.2)	-	7(77.8)	2(22.2)
	Postgraduate	8(40.0)	3(15.0)	9(45.0)	-	12(60.0)	2(10.0)	4(20.0)	1(5.0)	1(5.0)	3(15.0)	12(60.0)	5(25.0)	-	8(45.0)	4(20.0)	3(15.0)	2(10.0)	2(10.0)	13(65.0)	7(35.0)
Work Setting	Private	19(59.4)	1(3.1)	12(37.5)	1(3.1)	10(31.3)	7(21.9)	10(31.3)	3(9.4)	1(3.1)	9(28.1)	16(50.0)	7(21.9)	-	18(56.3)	8(25.0)	2(6.3)	3(9.4)	1(3.1)	23(71.9)	9(28.1)
	Public	19(55.9)	1(2.9)	14(41.2)	-	14(41.2)	11(32.4)	6(17.6)	3(8.8)	-	7(20.6)	17(50.0)	10(29.4)	-	10(29.4)	12(35.3)	3(8.8)	9(26.5)	-	26(76.5)	8(23.5)
	Clinic	7(41.2)	3(17.6)	7(41.2)	-	11(64.7)	2(11.8)	2(11.8)	2(11.8)	-	4(23.5)	6(35.3)	7(41.2)	-	8(47.1)	4(23.5)	2(11.8)	2(11.8)	1(5.9)	12(70.6)	5(29.4)
Experience	0.5 – 9 yrs	29(60.4)	1(2.1)	18(37.5)	-	17(35.4)	13(27.1)	13(27.1)	4(8.3)	1(2.1)	13(27.1)	22(45.8)	13(27.1)	-	22(45.8)	13(27.1)	4(8.3)	8(16.7)	1(2.1)	34(70.8)	14(29.2)
	10+ yrs	16(45.7)	4(11.4)	15(42.9)	1(2.9)	18(51.4)	7(20.0)	5(14.3)	4(11.4)	-	7(20.0)	17(48.6)	11(31.4)	-	14(40.0)	11(31.4)	3(8.6)	6(17.1)	1(2.9)	27(77.1)	8(22.9)

Practice of CBT

CBT was used by practitioners frequently (19.3%), often (25.3%) or very often (51.8%). Nearly 93% of all CBT sessions were conducted with adults of both genders (19-59 years of age). Further 90% of practitioners used CBT most regularly in their practice alongside other approaches like behavioural therapy, eclectic approaches, yoga, meditation, relaxation etc.

Over half (52.4%) of the practitioners believed psychological sophistication was not in proportion to academic background with the remaining divided evenly on 'yes' and 'cannot comment'. Around 56% stated they often considered the educational level of the client when planning for CBT. The disorder was noted to be the most important consideration when a decision to use CBT was being made. This was followed by willingness of the client, psychological sophistication, severity of the disorder and then educational background and age.

About half (51.8%) of participants reported conducting 8-12 sessions with each client, with 15.7% reporting less than 8 sessions and the remaining took over 12 sessions. CBT was most commonly used for depression, anxiety, OCD, somatoform and PTSD. A fair number of CBT cases included substance-abuse, couple-focused, preventative or promotive.

About 55% participants reported they modified the structure of CBT based on clients' needs, another 27.7% chose to adjust or follow strict guidelines on a case-to-case basis and a further 13.3% administered CBT completely eclectically. Of modifications used, integrating an eclectic approach was most popular, followed by adjusting session number, changing assessment and session duration. 71% practitioners made structural changes to their CBT therapy and 94% mixed techniques from other therapies. 70% had conducted CBT alongside family therapy 42% had frequently or more often used local idioms during CBT.

Over half stated older clients did not have trouble following CBT or reaching resolution. Only 21.7% reported a 75-100% completion rate for the number of sessions planned with client. 30% stated attrition rate was higher than 1 in 2. Common reasons for attrition were stigma, belief any layman could provide counselling, people preferring faster solutions via medication, cost, confusion in differentiating counselling and psychotherapy, long wait times and limitations of poor socio-economic backgrounds.

Assessment in the practice of CBT

On the use of culturally acceptable translated CBT materials, 60.2% reported using them sometimes and 21.7% stated they translated what was needed by themselves. 53% reported frequently changing the language of standardised tests to language the client was proficient in. Self-report inventories, individual tests, projective techniques, and batteries of different tests were commonly administered before CBT. 80.7% practitioners reported often sharing the findings of the psychological assessments with their clients.

Majority of participants (65.1%) stated they often assessed cognitive distortions and core beliefs. Only 28.9% conducted CBT specific assessments before the therapy, with 60.2% preferring to do them before, after and during the therapy. 73.2% reported monitoring changes in client each session and 83.9% stated they assessed progress in outcomes using rating scales, objective tools or both.

Barriers to Practice CBT

Over 77% participants agreed psychotherapy was under-utilised in India with 67.5% confirming CBT was also under-utilised. 84.3% agreed lack of training in psychotherapy, especially CBT, caused deficits in confidence and skill which was the main reason for its under-utilisation.

Only a third of the practitioners believed the existing health infrastructure in India was inadequate to the practice of CBT with the remaining considering the infrastructure adequate or stating infrastructure did not influence ability to practise CBT. The main barriers to cultural adaptation of the CBT were identified to be high cultural and linguistic diversity across India, high attrition rates, lack of psychological mindedness, low levels of literacy or sophistication in clients.

Culture-focused CBT VS Cultural Adaptation of CBT

Over 90% practitioners stated they had not used any existing CBT interventions that were culturally adapted for Indian populations due to unavailability. However, 73.5% did report following a specific guideline/manual for CBT. Only 26.5% of practitioners had done any research on CBT therapy.

Over 96% agreed cultural adaptation of CBT in India was required with 61.7% confirming that adapting western guidelines and then field testing them in Indian population was appropriate. 30.9% were unsure about appropriate adaptation as they believed each practitioner used CBT in their own way. The key objectives of cultural adaptation of CBT were identified as establishing cultural variations in CBT for scientific progress, increasing acceptability of CBT among practitioners, addressing practical barriers to care such as limited literacy, improving feasibility of CBT delivery to Indian patients and addressing other cultural considerations like language. 93.6% believed validation of an Indian CBT could be made possible with collaboration among Indian CBT practitioners. Key parameters for a culturally adapted Indian CBT were as follows: addressing locally salient cognitions about symptoms and local syndromes; using cultural and religion specific metaphors, proverbs, stories and analogies to convey information and create positive expectancy; addressing the whole person instead of only parts; using socratic questions cautiously so as not to hurt client sentiment; presenting CBT information and techniques with regard to local psychology, religion, physiology and spiritual/cultural traditions (e.g. marriage/death/birth rituals); promote self-esteem, self-efficacy, cognitive and emotional flexibility as well as reduce self-caused stigma in culturally appropriate manner; and culturally appropriate termination.

Cultural Adaptation Method

Nearly 69% of participants preferred a combination of top-down and bottom-up approaches in the cultural adaptation of the CBT. Within top-down approach, adaptation workshops with current CBT practitioners, language translation, integrating culture specific materials, field testing, integrating stakeholder feedback and randomized controlled trials were preferred. Within bottom- up approach, much of the same as well as generating information collaborating with stakeholders and integrating it to theory, empirical and clinical knowledge were important.

95.2% CBT practitioners believed cultural and language adaptation of a CBT intervention manual and relevant worksheets should occur simultaneously. Around 66% agreed regional

CBT manuals (for east, north, west, south, north-east) should be adapted and field tested before creating state/language-specific versions.

DISCUSSION

CBT Practice

CBT was used regularly among most practitioners. This finding contradicts literature stating CBT use in India is still quite tenuous, however, the sample was comprised entirely of CBT practitioners (Kumar & Gupta, 2012). This suggested that practitioners who do have CBT training prefer to use it over other existing therapies or alongside them, demonstrating it is a flexible and useful intervention for clients. This is also consistent with literature suggesting CBT is used variably in India, most often by integrating a multitude of other therapies to suit client needs (Selvapandiyan, 2019). Whilst this manner of implementation may be favoured by Indian clinicians due to environmental or training factors, a vast majority likely use this approach as there is no current standardised manual for Indian CBT (Gupta & Aman, 2012). Though some evidence suggests this eclectic use of CBT may undermine the parental architecture of CBT and negatively affect its efficacy, a US study revealed there were no significant differences in treatment outcomes between exclusively-CBT, non-CBT and eclectic CBT practitioners (Creed et al., 2016). This was because a practitioner's declared orientation did not correlate with their competency in delivering therapy. It is likely while adherence to established norms and manuals is an important factor, therapist's competency and receiving any psychological intervention are more influential to efficacious treatment for clients (Baardseth et al., 2013).

Participants reported rather high drop-out rates with a third of practitioners reporting 50% attrition. Considering average international CBT attrition is roughly 15% pre-treatment and 26% during treatment, the rates are very elevated in Indian populations (Fernandez et al., 2015). However, 50% of the participants worked at large public-sector hospitals where clients come from neighbouring states across the country and generally belonged to lower-middle socio-economic background. Thus, social migration, socio-economic status, literacy, psychological sophistication, transportation, etc. could be influencing the high attrition rates reported. Nevertheless, it is imperative to address and monitor this concern in future CBT work adaptations.

The sample included a range of practitioners with differing training i.e. those who received CBT training in their masters and/or M.Phil degree, individuals with and without a PhD, with international training or without any training outside of their tertiary course which could lead to many differences in exposure to supervised clinical practice of CBT. Findings (Table 1) did not suggest these demographic factors contributed systematically to differences in CBT practise which is consistent with previous literature (Pfeiffer et al., 2020). However, since the majority practiced and adapted CBT in their own way, assessment and intervention would greatly vary, threatening scientific practise of CBT. Therefore, immediate attention should be brought to formulate practice and ethics guidelines for Indian CBT.

CBT Assessment

Survey responses revealed a lack of regularity regarding formal CBT assessment, with only 65% confirming they assessed cognitive distortions and core beliefs despite its importance to CBT formulation (David et al., 2018). More than 80% of practioners shared the findings of the assessment tools with their clients indicating good practise. However, most reported

doing on-spot language translation of the tools whenever needed, thus cultural and language adaptation of the translated tools remained major issue. This is most likely due to both the lack of Indian standard practise CBT guidelines for various disorders and the many differences in the training and educational background of CBT practitioners (Sudhir et al., 2019).

Barriers

Lack of training was identified as a significant factor challenging increased psychotherapy utilisation similar to other studies (Manickam, 2010; Shamasundar, 2008), Current health infrastructure was not identified as a significant barrier by a majority of the practitioners. This is an interesting finding as it is estimated India has 0.75 psychiatrists per 100,000 people, with the ratio disparity increasing for psychologists (Garg et al., 2019). So, it is possible participants did not consider human resource as a component of health infrastructure.

Culture-focused CBT vs. Cultural Adaptation of CBT

All practitioners confirmed there are no existing adaptations of any western CBT intervention manuals in India and use of manual plays an important role in cultural adaptation of CBT. Consequently, over 70% choose to use a CBT manual of their preference to guide their practice and nearly 30% did not use any manual. A study using CBT for panic disorder noted that though there were advantages to individualisation of CBT, there was no difference in treatment outcomes at a global level compared to manual-adherence (Hauke et al., 2014). A review clarifies that manuals encourage focused intervention and facilitate training and guidance of therapists, however, may lack practical and "therapist-friendly" details that can prevent them from helping a variety of people (Wilson, 1998). Thus, manuals can be used most effectively by practitioners if they are flexible with due consideration for individual factors (Wilson, 1998). Hence, cultural adaptation of manuals and practice guidelines are the way forward.

Interestingly, almost all participants agreed there was a need for adaptation of CBT to the Indian context, thus contradicting previous findings of resistance to CBT adaptation (Kumar & Gupta, 2012; Kuruvilla, 2000). A possible reason may be that all participants were regular CBT practitioners and likely faced day-to-day limitations in their practice without culturally adapted resources. This suggests there may be a divide between the attitudes of clinician-researchers and clinicians in India, which was not explored in this study.

Additionally, about a third of practitioners did not consider adapting existing western guidelines as a suitable approach. Literature identifies this is as a recurring concern for professionals in India, however, considering around 60% stated this was a suitable approach and also use western manuals to guide their practice, it is likely the basic framework of western guidelines should be applicable to Asian populations (Selvapandiyan, 2019). In fact, a Japanese study used the same technique to create a successful CBT intervention for adolescents with anxiety (Ishikawa et al., 2019). Similarly, a different study adapted an existing trauma-focused CBT for Indian American and Native Alaskan children (BigFoot & Schmidt, 2010). Since prior examples demonstrate the feasibility of this approach, it is logical to attempt with an Indian population as well.

Cultural Adaptation Method

Majority of practitioners stated a preference for integrating top-down and bottom-up approaches to adaptation. Considering top-down approaches are more economical, whilst bottom-up approaches are able to more holistically address adaptation needs of diverse populations, it is logical practitioners believe integrating the two approaches will produce better results which has been previously evidenced by a Chinese study (Hwang, 2012).

Although nearly all practitioners believed cultural and language adaptation should be conducted simultaneously and regional manuals were identified as a first priority, it is important to consider which languages should be used in the regional manuals. Since India is so linguistically diverse, with regions having many different languages, adaptation works should consider identifying key languages to adapt the initial manuals to such that they benefit most practitioners and clients in that area. Yet, it is also important to consider whether it is feasible to cater to all of the linguistic diversity present in India, and to what extent should cultural adaptation occur (Joshi et al., 1993). For example, there may be marked cultural differences between Andhra Pradesh and Kerala which are both in the Southern region of India. However, it is not feasible to create a separate manual for each state. Thus, whilst challenging, a generic Indian CBT manual with set practice and ethical guidelines which can later undergo language adaptation for each state seems the most optimal direction for future work.

Limitations

To the best of the authors' knowledge, this study is the first of its kind to investigate attitudes, beliefs and practices of CBT and its adaptation. This helps bridge a major gap in literature about practitioners' attitudes towards CBT use and adaptation and is a novel foundational study and in guiding the direction of future CBT research. For example, responses regarding CBT adaptation inform future direction of work in the area, like a preference for development and field testing of regional CBT manuals.

The study was not without limitations., Although, the participants were from various states of India, the sample was not entirely representative of all Indian therapists as only CBT practitioners were included, and thus, may not accurately reflect all perspectives on CBT practice and adaptation. Further, the sample included practitioners with differing levels of education, training, and clinical experience which reflected the reality of CBT training and practice in Indi, yet may have introduced very conflicting beliefs and practises (Bedi et al., 2021). In addition, information on various items followed 3-7-point Likert scale, which limited ability to encompass actual field practice.

CONCLUSION

Lack of consistency in CBT training was due to the lack of standardised Indian CBT Guidelines for different illnesses, and diverse education and training of practitioners. Further, lack of formal assessment protocols, validated translated resources etc. indicated CBT is practiced on a largely flexible and eclectic basis with limited practitioner conformity. Clarity and standardisation for clinicians must be emphasized in CBT content and delivery method to enable better scientific comparison and robust assessment of efficacy.

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Conflict of Interest

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