2022

CLINICAL ADAPTATIONS OF COGNITIVE THERAPY, COGNITIVE BEHAVIORAL THERAPY, AND RATIONAL EMOTIVE BEHAVIOR THERAPY AS A RESULT OF CULTURE AND LANGUAGE

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A dissertation submitted in partial fulfillment
of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

to the faculty of the

DEPARTMENT OF PSYCHOLOGY

of

ST. JOHN'S COLLEGE OF LIBERAL ARTS AND SCIENCES

at

ST. JOHN'S UNIVERSITY
New York
by
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Date Submitted: 10/18/21 Date Approved: 10/18/21

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ABSTRACT

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Rebecca Wade

Cognitive Behavioral Therapies are frequently used and highly effective; however, most of the research is conducted on Western, Educated, Industrialized, Rich, and Democratic (WEIRD populations) who are relatively homogeneous. The present study evaluated the use and adaptations of Cognitive Therapy (CT), Cognitive Behavioral Therapy (CBT), and Rational Emotive Behavior Therapy (REBT) based upon WEIRD status, language, and cultural values as measured by Hofstede's country Comparison (2021). In a survey, therapists worldwide (n=129) reported their use and adaptation of the techniques within their therapeutic orientation. Although no significant differences were found between WEIRD or language groupings specific to CT, CBT, or REBT, language, Long-Term Orientation, and Indulgence were significant predictors when considering use and adaptations of general cognitive-behavioral techniques. Adaptations for both diverse and WEIRD practitioners to consider using with clients are discussed. Specific insight towards school psychologists is considered, as the adaptations required when working in a school and with children and adolescents may warrant additional adaptations.

ACKNOWLEDGEMENTS

To think it was nearly a decade ago when I first applied to St. John's University, and now ten years later, I am submitting my final paper brings up countless memories and people who have helped me through this journey. I'd like to thank both the friends from undergrad, who have been incredibly supportive of my continued studies and my cohort members – without our teamwork approach to this PsyD, I could not have come this far and learned to believe in myself so much.

To my professors, including my committee members Dr. DiGiuseppe and Dr. Ortiz, thank you for teaching me about school psychology while instilling in me how to be a true professional. I have learned best practices, how to remain current on best practices, advocate for students, and effectively communicate. With that, there is a huge thanks to Mark Terjesen, who helped me decide to stay at St. John's for the PsyD. Since the first day, he has been a true mentor, like one I've never had before. Thank you for pushing me to work to my potential and believe in my skillset. You have modeled and encouraged me to treat myself with kindness and find a balance between a graduate student's responsibilities and my mental health.

Last but certainly not least – I share the most profound gratitude to my parents. Your encouragement to pursue this degree, support during it, and kindness have made the most challenging task of my life one I was able to accomplish. You stood by me through all the late nights, anxiety, handstands to forget the nerves, commutes, and car breakdowns, and you showed me love and encouragement to keep going all the while. Your passion for being educated and independent has allowed the first doctorate to be given to the Wade name. I hope you feel as proud as I do when I wear it.

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CHAPTER 1

Introduction

Cognitive Behavioral Therapy (CBT) is one of the most widely practiced therapeutic approaches, with approximately one-third of mental health practitioners utilizing this methodology (Epp & Dobson, 2010). There is a robust empirical basis for the effectiveness of CBT approaches to treat numerous psychological disorders; however, most of the research has been conducted in Western, Educated, Industrialized, Rich, and Democratic (WEIRD) regions (Epp & Dobson, 2010; Kline et al., 2018). There have been increasing efforts to include more diverse people within psychological research by including various racial and ethnic groups within WEIRD regions (Hays, 2018). However, individuals and groups outside of the WEIRD criteria are still under-represented in empirical studies evaluating the effectiveness of CBT (Pantalone et al., 2010). Therefore, therapeutic interventions provided to such clients are limited in their empirical backing. Additionally, the concentration of research on Western populations has excluded diverse people, subsequently leading such clients to seek treatment less often, leaving some mental illnesses untreated (Tam et al., 2019).

At present, it is generally assumed that the basic techniques of CBT are relatable and efficacious with all populations (Pantalone et al., 2010). However, there has been little research within the field to evaluate this claim. The current study seeks to address this gap in the literature by gathering data from international mental health practitioners regarding their use and adaptation of CBT techniques within diverse global populations. This data will be useful to practitioners who practice within culturally diverse settings or

when working with culturally diverse clients, as it will offer empirical data for CBT techniques that relate best to diverse populations.

CHAPTER 2

Literature Review

Psychotherapy has shown robust growth in the past 50 years, with a myriad of changes, including the advent of the second wave of therapy, the Cognitive Behavioral Therapy (CBT) approaches (Dobson & Dozois, 2010). Beginning in the late 1950s, following the behaviorism and psychodynamic theories, researchers and clinicians from the United States of America (USA) and Europe began to advocate for cognitive-behavioral approaches which emphasize the connection between dysfunctional cognitions and maladaptive behaviors (Brown et al., 2011), as well as the ability to alter such dysfunctional cognitions and behaviors (Dobson & Dozois, 2010).

Since their development, cognitive and behavioral approaches to therapy have gained traction within the field compared to dynamic treatments and are presently the most widely practiced forms of therapy (Hays, 2009; Wampold & Imel, 2015). There are numerous evolutions of CBT that focus on coping skills, problem-solving, and cognitive restructuring, including Rational Emotive Behavior Therapy (REBT), Cognitive Therapy (CT), Self-Instructional Training, Self-Control Treatments, Stress Inoculation Training, and Problem-Solving Therapy (Dobson & Dozois, 2010). This study will focus on CBT, CT, and REBT approaches, as they were the hallmark developmental approaches of CBT and are commonly practiced today (Ruggiero et al., 2018).

Variations of Cognitive Behavioral Therapy

Cognitive therapy.

Cognitive Therapy (CT) is a therapeutic approach developed by Aaron Beck in 1963 at the University of Pennsylvania (Beck & Haigh, 2014; Dobson & Dezois, 2010).

This therapy model posits that individuals' emotions and behaviors are influenced by their cognitions or perceptions of events (Beck & Haigh, 2014; Fenn & Byrne, 2013; Meichenbaum & Mahoney, 1995). CT is considered a short-term, goal-focused treatment (Young & Beck, 1980). Research has shown CT is an effective line of treatment for a variety of patients, including those with depression, panic disorder, Generalized Anxiety Disorder (GAD), social phobias, posttraumatic stress disorders (PTSD), bipolar disorder, alcohol and substance use disorders, Obsessive-Compulsive Disorder (OCD), eating disorders, and sleep disorders (Beck & Haigh, 2014; Dobson & Dezois, 2010; Meichenbaum & Mahoney, 1995; Harvey et al., 2017).

Beck outlined three levels of cognition: core beliefs, dysfunctional assumptions, and Negative Automatic Thoughts (NATs) (Fenn & Byrne, 2013). Core beliefs, referred to as schemas, are firmly rooted, developed, and learned beliefs an individual has about oneself, the world, and/or the future that often contributes to their difficulties (Beck & Haight, 2014; Fenn & Byrne, 2013; Meichenbaum & Mahoney, 1995; Ruggiero et al., 2018). For example, a schema of a depressed patient may be, “the future is hopeless” or “my value depends on others’ evaluations of me” (Dobson & Dezois, 2010). An individual’s schema often provides meaning to their life experiences (Beck & Haight, 2014). Dysfunctional assumptions, or cognitive distortions, are thoughts individuals live by that are maladaptive (Fenn & Byrne, 2013). Distortions may include dichotomous thinking, overgeneralizing, selective abstraction, mind reading, catastrophizing, minimizing, and should statements (Meichenbaum & Mahoney, 1995). Finally, NATS are thoughts activated involuntarily in situations that focus on negative themes such as low self-esteem (Fenn & Byrne, 2013; Meichenbaum & Mahoney, 1995). Then, overall,

the model of CT proposes that these cognitions impact a client's behavioral and emotional responses (Harvey, 2017; Meichenbaum & Mahoney, 1995). That is, schemas, cognitive distortions, and NATS can lead to unhealthy emotions (e.g., depression, anger, anxiety) and behaviors (e.g., avoidance, performance) (Beck & Haigh, 2014; de Jonge et al., 2019).

While the focus of CT is on cognitions, several other skills are essential to the delivery of quality CT. Among these, a clinician should elicit behaviors, utilize guided discovery to assist patients in developing new perspectives, and integrate information to understand the problem (Dobson & Dezois, 2010, Young & Beck, 1980). In addition, a clinician should demonstrate interpersonal effectiveness, establish a collaborative relationship with the client, and gather feedback from clients regarding their reactions to therapy and comprehensions of interventions (Blackburn et al., 2001; Young & Beck, 1980).

Cognitive behavioral therapy.

Cognitive Behavioral Therapy (CBT) is one of the most extensively researched and utilized forms of psychotherapy (Butler et al., 2006). The model of CBT theorizes that psychological problems are based upon both unhelpful cognitions, unhelpful behaviors, and environmental factors (Dienes et al., 2011; Dobson & Dezois, 2010). Within this theoretical framework, individuals can learn better ways to cope with psychological distress and problem behaviors (Bass, 2014; Waller, 2012), ultimately learning to manage environmental changes and be their own therapist (Fenn & Byrne, 2013). Research has shown CBT is an effective treatment for numerous disorders, including depression, GAD, panic disorder, social phobia, PTSD, anger, OCD, eating

disorders, schizophrenia, substance abuse disorders, and marital problems (Butler et al., 2006; Epp & Dobson, 2010; Waller, 2012). Studies have also demonstrated that the effects of CBT can be long lasting for both child and adult patients (Bass, 2014; Butler et al., 2006).

The cognitive aspect of treatment builds off Beck's cognitive model and similarly conceptualizes a client's presenting problem. To modify thought patterns, cognitive restructuring is used, such that a client learns to recognize their thought distortions, test the validity of these thoughts, and change their evaluations based on gathering evidence that is contrary to their belief (Fenn & Byrne, 2013). In addition, CBT helps clients to understand the motivations and behaviors of others, problem-solve, and develop a greater sense of self-confidence (Dobson & Dezois, 2010). Finally, behavioral techniques are incorporated, such as exposures, role-playing, problem-solving techniques, assertiveness, and relaxation to modify maladaptive behaviors (Bass, 2014; Harvey, 2017; Hays, 2018). Like CT, CBT clinicians should work to foster a collaborative therapeutic relationship with the client. For example, the therapist and client should work together to set long-term and session-specific goals (Muse et al., 2014).

Rational emotive behavior therapy.

Rational Emotive Behavior Therapy (REBT) is another therapeutic approach that falls under the broad CBT umbrella developed by American psychologist Albert Ellis in 1957 (David et al., 2016; DiGiuseppe & David, 2015; Dobson & Dezois, 2010). REBT has been researched and applied within clinical, educational, and organization settings (Dobson & Dezois, 2010) for a variety of psychiatric conditions, including OCD, social phobia, depression, psychotic symptoms, parental distress, disruptive behaviors, and side

effects of physical illness (David et al., 2016; Sarracino et al., 2017). In addition, meta-analyses of REBT have demonstrated it is an effective line of treatment for both children and adults (David et al., 2016).

Recognizing that emotional problems or disturbances occur in a context, clinicians work with clients to develop a situational "ABC" framework (Sarracino et al., 2017) to understand the development of their dysfunctional behaviors and emotions. First, the Adversity (A), or aspect of the situation related to the disturbance is identified. Commonly, clients will describe the A's as inferences rather than observable features of an event (Dryden et al., 2010). For example, a client may state, "the party was so awkward" rather than "I talked to one person for two minutes during the three-hour party." Next, the beliefs (B) about the A are evaluated as either irrational or rational. For example, the client from the party may believe "no one likes me." REBT emphasizes an individual's tendency to have irrational beliefs that are rigid and extreme, illogical, inconsistent with reality, and prevents oneself from achieving their goals (DiGiuseppe et al., 2014). Irrational beliefs may place demands on oneself, others, or the world. Individuals who hold irrational beliefs may awfulize (i.e., make situations/adversities worse than reality demonstrates), deprecate, belittle themselves, others, or life conditions, or engage in distress intolerance, such that they believe that they are unable to manage life if the A actually does occur (Dryden et al., 2010). The final part of the model is the emotional, behavioral, and/or cognitive Consequences (Cs) of clients' beliefs (B) about A. Within the model of REBT, certain emotions are considered dysfunctional and are related to maladaptive behaviors and cognitions (David & Dezois, 2010). For example, the feelings of depression and despair are considered to be the effects of the client

holding irrational beliefs about A (David et al., 2016). Ellis had argued that individuals universally hold irrational beliefs deeply, such as a low level of self-acceptance (Bernard, 2009). Therefore, REBT focuses on modifying these unhealthy irrational beliefs into more healthy/adaptive rational beliefs. The therapeutic process of REBT aims to minimize the implications of the client's irrational beliefs, show clients how to change the activating event when possible, and develop and strengthen rational beliefs (David et al., 2016; DiGiuseppe, 2014).

Common factors amongst psychotherapy approaches.

Overall, there are similarities among most psychotherapies (Bass et al., 2014), including CT, CBT, and REBT (Wampold, 2012). Unlike some other models of psychotherapy treatment, CBT approaches emphasize the present, such that it looks to address a client's current presenting problems and state of functioning (Fenn & Byrne, 2013). Additionally, all models of CBT recognize that clients in therapy have maladaptive cognitive processes, which affect a client's functionality in work, interpersonal relationships, the community, and/or levels of internal distress (Dienes et al., 2011; Wampold, 2012). Further, CT, CBT, and REBT recognize that beyond cognitive techniques, behavioral principles can be effective for both case conceptualizations and treatment plans (Beck & Haight, 2014). During therapy, practitioners utilizing CBT approaches often teach their patients about treatment so they can use skills outside of sessions (Dobson & Dezois, 2010). Additionally, all therapeutic approaches rely on a strong rapport and alliance among therapist and patient (Meichenbaum & Mahoney, 1995; Wampold, 2012).

As outlined above, the differences lie in how significantly this cognitive aspect is emphasized and addressed during treatment. CT places the largest emphasis on modifying clients' often-distorted cognitions (Dienes et al., 2011; Dobson & Dezois, 2010; Meichenbaum & Mahoney, 1995). For example, clients who may think, "I am going to perform poorly on this test" may experience stress because of that thought. The process of CT would work in challenging the accuracy of that initial thought (Dobson & Dezois, 2010). CBT therapists work in line with CT to challenge the accuracy of client's thoughts while also including behavioral exercises to actively challenge the validity of their thoughts (i.e., exposure/response prevention, behavior modification) or their ability to cope with the distress (i.e., progressive muscle relaxation, problem solving) (Muse et al., 2014). While REBT practitioners recognize that clients may hold beliefs inconsistent with reality, therapy tends not to focus on challenging their assumption, but to learn how to cope with the implications of these assumptions if they were true (Dryden et al., 2010). That is, not challenging the initial inference (e.g., "I am going to perform poorly on this test") but rather the evaluation or demand the client has about that inference (e.g., "And IF I perform poorly, that would be terrible, I could not stand it, and it would just confirm that I am worthless") (Ruggiero et al., 2018). Therefore, REBT approaches tend to focus on this philosophical level rather than the emotional disturbances other CBT approaches often focus on (Dobson & Dezois, 2010).

Given the similarities and differences amongst CBT approaches in their approach to therapy and methodology, it is important to reflect how other factors such as culture, language, and location may further impact the implementation of CBT (Hays, 2009).

International Psychological Research and Culture

Over 90% of psychological research is conducted on groups that constitute approximately 60-70% of the world (Keller, 2017; Kline et al., 2018), leaving 30-40% of the world represented by less than 10% of the psychological research. Historically, psychological research has been conducted in relatively homogenous groups, such that they are Western, Educated, Industrialized, Rich, and Democratic (WEIRD) (Granqvist & Nkara, 2017; Hays, 2018; Kline et al., 2018). Geographically, this typically refers to the USA and Europe (Kline et al., 2018; Pantalone et al., 2010). However, even within the USA and Europe, diverse groups such as Native Americans, Asian Americans, LGBTQ+ populations have been underrepresented in research studies (Pantalone et al., 2010). This leaves much of the world's population underrepresented in psychological literature. Additionally, when people feel excluded from the definitions and conceptualizations of mental health, they often fail to utilize its resources (Pantalone et al., 2010). For example, many culturally diverse groups find WEIRD psychotherapy invaliding and intrusive, and subsequently may fail to seek treatment (Arora et al., 2016; Smith & Trimble, 2016). Given this, there is a need for researchers and clinicians to study the populations of non-WEIRD locations, to integrate this information into methods and theories of psychology (Miller, 2005), and to educate people regarding effective treatment options for them (Li et al., 2017). As such, recent research has begun to include more diverse peoples in a variety of geographic locations (Kananian et al., 2021).

Culture is commonly referred to in the psychotherapy literature (Tseng, 1999). For the purposes of the present study, culture should be thought of as a system of values, ideas, and practices that allow oneself to communicate and orient themselves in the world

(Psaltis, 2012). As such, one's culture has significant effects on their behaviors and orienting oneself in the world (Psaltis, 2012; Richerson & Boyd, 2005). In empirical studies, culture can be equated with a country (Keller, 2017), which can be problematic when considering various constructs within culture, as mentioned above. However, others argue country is an appropriate classification system (David et al., 2019). Further, psychological research regarding culture has been conducted from both a "top-down approach" and a "bottom-up" approach. This means researchers either create definitions and labels and attempt to fit groups or use interviews and qualitative reports to generate labels (Ung, 2015). Therefore, when considering culture in psychological research, it can be challenging to determine what factors are being measured (Cohen, 2006).

Research from Hofstede and colleagues has identified six themes of cultural dimensions: power distance, individualism versus collectivism, masculinity versus femininity, uncertainty avoidance, long-term orientation versus short term orientation, and indulgence versus restraint (Hofstede, 1983; Hofstede et al., 2010). The research was gathered based upon responses to items from individuals of 76 countries (Hofstede et al., 2010), beginning in the late 1960s within corporate settings to gain information regarding staff and consumer behaviors, and has expanded with time to reflect global societies (Lo et al., 2017). Analysis of responses has shown large-scale trends between countries and within countries (Moskowitz & Moskowitz, 2009). For example, it is common for Western cultures to hold some beliefs such as individualism, while in non-Western counterparts' collectivism prevails. Further, masculinity traits are high in European countries, including Germany and Austria, but not in Sweden (Moskowitz & Moskowitz, 2009). Additionally, the country scores developed have been correlated with behavioral

outcome data (i.e., individualism and mobility between social classes) (Moskowtiz & Moskowtiz, 2009). Although there are critiques of this approach for some assumptions made, such as the influence of non-cultural factors, the changing values of culture, etc., (Touburg, 2016), Hofstede's dimensions of culture remains the most frequently used to explain international differences in individuals' behavior (Swoboda & Hirschmann, 2017).

Barriers in conducting international research.

There are many barriers to researching culturally and ethnically diverse environments. One logistical barrier includes the location of the researcher. Most psychologists who engage in the psychological literature are located within WEIRD areas are share these features (Hays, 2018). The researchers' lack of geographical and cultural diversity creates logistical barriers for adapting clinical approaches and collecting data among other groups from various environments (i.e., Africa). Furthermore, in practice, given that so much research occurs in WEIRD cultures by WEIRD researchers, the data from these locations becomes what is "typical." Data that does not coincide with what is common to Europeans or Americans are considered "abnormal," even if it is from an entirely different cultural group (Kline et al., 2018). Therefore, there is a need for Western-based clinical researchers to expand their circle of colleagues to establish a "typical" that is reflective of the populations they refer to. As geographical barriers no longer inhibit sharing knowledge, values, and beliefs (Jensen, 2012; Kline et al., 2018), psychologists and mental health practitioners can collaborate and provide their information and perspectives reflecting the culture and language of those they serve.

Culture and mental health.

According to the Surgeon General's report (2001, p.23), "culture counts" in mental health as it shapes the relationship between the therapist and client, how therapists deliver services, how clients seek treatment, and how clients engage in health behaviors. Additionally, the American Psychological Association and the mental health field argue it's a therapist'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). Therefore, it is imperative that mental health practitioners consider clients' cultural beliefs in terms of how they conceptualize their thoughts, goals, and values and how this relates to treatment planning (Wampold, 2012).

Additionally, it is an ethical duty that mental health practitioners utilize the research base to inform their therapeutic interventions (American Psychological Association, 2016; Smith & Trimble, 2016). With this framework in mind, practitioners must consider the evidence base in implementing therapy in culturally diverse settings and with culturally diverse clients (Cabassa & Bauman, 2013). Cabassa and Baumann (2013) argue that interventions are commonly modified as they are implemented, as the interventionist brings their previous knowledge, attitudes, and practices into treatment.

Numerous studies report using culturally adapted treatments and have found them more effective than un-adapted treatments (Hall et al., 2016; Soto et al., 2018). Further, research has found that the more individualized treatments are for factors such as culture, language, race, etc., the more likely a client is to engage, remain, and participate in treatment (Soto et al., 2018). However, there is a lack of consensus on what or who is responsible for the adaptation of therapy (Cabassa & Baumann, 2013). For example,

cultural interventions can require the adaptation of therapeutic techniques or treatment protocols beyond a practitioner's conventional scope of practice (Smith & Trimble, 2016). Through this adaptation process, difficulties arise balancing treatment to be client-centered, culturally relevant, and implemented with fidelity (Hall et al. 2016; Smith & Trimble, 2016).

Some researchers have put forth general guidelines for adapting psychotherapies to be culturally sensitive. For example, one such approach to adapting psychotherapy argues that clinicians should consider thematic differences, such as health beliefs, self-identification, communication styles, individualism and collectivism, therapy goals, and family structure (Pantalone et al., 2010). Similarly, others have suggested an ecological validity model addressing language, persons, metaphors, content, concepts, goals, methods, and context (Smith & Trimble, 2016). Yet, others provide domains in which culture should be considered, including age/generation, developmental disabilities, disabilities acquired later in life, religious and spiritual orientation, ethnic and racial identity, socioeconomic status, sexual orientation, indigenous heritage, national origin, and gender (Hays, 2018).

Another approach for culturally competent CBT suggests that when empirical evidence is unavailable for groups, therapists first consider their own biases and blind spots, and then do CBT as usual (Pantalone et al., 2010). First, there is strong support in the literature for a clinician to recognize their own biases to establish a stronger therapeutic alliance, as it ultimately results in better outcomes for the patient (Eklund et al., 2014; Pantalone et al., 2010). Much of the research regarding cultural sensitivity is based upon providing a framework for clinicians to be mindful of how their own culture

may differ from their clients (Hays, 2009). However, these recommendations are made for WEIRD practitioners practicing with diverse clients and fails to address when both the clinician and client are from non-WEIRD locations. Second, although the argument for doing CBT as usual is based upon empirical studies that demonstrate the principles behind CBT are effective within WEIRD populations, researchers have *hypothesized* the basic techniques of CBT will be effective for diverse clients without evidence to support these claims (Pantalone et al., 2010).

Overall, there is a lack of consensus regarding culturally adapted therapies. There is agreement that culture should be considered (Smith & Trimble, 2016; Soto et al., 2018), but the actual methodology in adapting techniques of CBT and with whom has failed to be clearly articulated. A recent meta-analysis found that 42% of cultural adaptations to therapy were guided by research or theory (Smith & Trimble, 2016), indicating that over half of the research regarding cultural adaptations of therapy are not evidence-based or theory-driven. Furthermore, many studies regarding culturally adapted therapy have significant limitations (Hall et al., 2016). For example, studies will either fail to describe how treatments were adapted (Soto et al., 2018) or fail to evaluate the effectiveness of adapted treatment to non-adapted treatment (Hall et al., 2016). While language and culturally relevant metaphors are most commonly adapted (Cabassa & Baumann, 2013; Soto et al., 2018), besides these factors, the research is inconclusive as to what techniques are adapted, how they are adapted, and how effective they are as a function of culture and language.

There is agreement that practitioners should only adapt techniques when necessary because the more closely treatment procedures are followed, the more effective

it is (Smith & Trimble, 2016). However, this can be a challenge when considering adaptations of techniques. In a non-published survey (Wade, Lundgren & Terjesen, 2018), international practitioners were asked to rate the frequency they use and adapt CT, CBT, and REBT techniques. Results from a small pilot study (n=10) suggest that adaptations are being made to therapeutic approaches as a function of culture and language, and, as such, there is a deviation from specific recommended treatment practices. The present study seeks to expand this survey to a broader array of international mental health practitioners to understand how they utilize and adapt CBT approaches when working with culturally and linguistically diverse clients.

CHAPTER 3

Hypotheses

Based upon the reviewed literature, this study addresses three hypotheses with regard to the adaptation of CT, CBT, and REBT.

1. It is hypothesized there will be more overall adaptations of therapeutic techniques in non-WEIRD countries compared to WEIRD countries.
2. It is hypothesized there will be more overall adaptations of techniques in languages different from English.
3. It is hypothesized that within countries, similar rates of adaptation will be reported. That is, the therapists from the same nations will make similar adaptations as a function of culture and language.

In addition, exploratory analyses will be performed to determine whether relationships exist between WEIRD versus non-WEIRD groups, language, and cultural values, with both use and adaptation of therapeutic techniques.

CHAPTER 4

Method

Design and Procedure

Before beginning data collection, St. John's University's Institutional Review Board approved all procedures. Mental health practitioners' professional organizations, universities, and academic journal editors were contacted and requested to disseminate the online survey. Participants completed the survey through Qualtrics, where confidentiality of the responses was preserved. Participants were provided informed consent (see Appendix A), where they were informed their participation is voluntary, individual responses will be kept confidential, and results will be used to identify ways therapeutic techniques can be adapted to a wide range of cultural populations. Participants were given the contact information of the researchers and the St. John's University Institutional Review Board should they have any additional questions.

Upon providing informed consent, participants were asked to select their primary theoretical orientation (CT, CBT, or REBT); definitions of each were provided. Upon self-identification of their primary orientation, participants were automatically directed to the corresponding survey, where they completed demographic information (see Appendix B), and a rating scale assessing how frequently they use and adapt the primary therapeutic techniques CT, CBT, or REBT (see Appendices C-E, respectively). Definitions of each technique of CT, CBT, and REBT are provided within each respective survey. After the survey, participants could provide their contact information to enter the raffle for an Amazon gift card.

Survey

Demographic information.

Participants completed a short demographic questionnaire (see Appendix B) measuring their age, gender, training level, years of practice, training location, and practice location. In addition, participants answered questions regarding the population they generally serve, including languages spoken, age range, disorders commonly treated, and in what setting (e.g., clinic, hospital, university) they work. Individuals were categorized as WEIRD if they were from the USA, United Kingdom, Australia, France, Germany, Switzerland, the Netherlands, or Canada (Henrich et al., 2010). Lastly, one question regarding each cultural domain was asked based upon Hofstede's Six Dimensions of National Culture, which were established and analyzed based upon research conducted in over 70 countries (Hofstede et al., 2010; Moskowitz & Moskowitz, 2009). The values used for each participant in data analyses were based upon their nation's normed score based upon Hofstede's data (see Table 1).

The United States' Foreign Services Institute (FSI) has outlined languages similarity to English. Their groupings outline classification levels of similarity to English. First, Spanish, French, Portuguese, Italian, Romanian, Danish, Dutch, Afrikaans, Swedish, and Norwegian are considered Category 1, languages most similar to English. Next, German, Indonesian, Malay, and Swahili, are considered Category 2, languages that take longer to master. Then, Greek, Hebrew, Hindi, Persian, Polish, Russian, Thai, and Turkish are considered Category 3, languages with considerable linguistic and cultural differences from English. Lastly, Arabic, Cantonese, Japanese, Korean, and Mandarin are considered Category 4, languages very different from English due to their varying writing styles.

Table 1

Cultural Values by Country

Country	PD	INDIV	MAS	UNC	LTO	INDULG
Argentina	49	46	56	86	20	62
Canada	39	80	52	48	36	68
Dominican Republic	65	30	65	45	13	54
Estonia	40	60	30	60	82	16
Greece	60	35	57	100	45	50
Guatemala	95	6	37	98	-	-
Hong Kong	68	25	57	29	61	17
India	77	48	56	40	51	26
Indonesia	78	14	46	48	62	38
Ireland	28	70	68	35	24	65
Israel	13	54	47	81	38	-
Italy	50	76	70	75	61	30
Japan	54	46	95	92	88	42
Moldova	90	27	39	95	71	19
Nepal	65	30	40	40	-	-
New Zealand	22	79	58	49	33	75
Pakistan	55	14	50	70	50	0
Paraguay	70	12	40	85	20	56
Peru	64	16	42	87	25	46
Puerto Rico	68	27	56	38	0	90
Romania	90	30	42	90	52	20
Sweden	31	71	5	29	53	78
Turkey	66	37	45	85	46	49
United Kingdom	35	89	66	35	51	69
United States	40	91	62	46	26	68
Vietnam	70	20	40	30	57	35

Note. PD=Power Distance, INDIV=Individualism, MAS=Masculinity, UNC=Uncertainty, LTO=Long-Term Orientation, INDUL=Indulgence. If no score is listed, there is currently no score for this country on this dimension.

Country Comparison. Hofstede Insights (2021, June 21). https://www.hofstede-insights.com/country-comparison

Participants self-identified the language(s) they provide therapy within, which was later coded based upon these groupings. If participants reported providing treatment in English and another language, the language code for the other was used. If participants reported providing treatment in multiple languages outside of English, the language most like English was coded to make conservative comparisons.

Adaptation questionnaires.

The CT Adaptation Questionnaire (see Appendix C) is a 13-item scale based upon the Cognitive Therapy Scale-Revised (CTS-R) (Blackburn et al., 2001). This measure outlines 12 cognitive therapy techniques that therapists should utilize within sessions, including agenda setting & adherence, eliciting appropriate emotional expression, guided discovery, homework setting, etc. Blackburn and colleagues (2001) provide definitions and examples of each technique. The scale has high internal consistency ($\alpha = .92$), good interrater reliability (Intraclass Correlation Coefficient =.80), and validity, overall supporting the CTS-R as a more useful tool than the original Cognitive Therapy Scale by Young and Beck (Blackburn et al., 2001). The CT Adaptation Questionnaire asks participants to rate on a Likert scale (0-4 and 0-3, respectively) the frequency of which they *use* and *adapt* each technique from its description by Blackburn and colleagues (2001). Participants will also be able to enter qualitative information regarding adaptations of specific techniques or the therapeutic process as an entirety.

The CBT Adaptation Questionnaire (see Appendix D) is a 23-item scale based upon the Assessment of Core CBT Skills (ACCS) User Manual (Muse et al., 2014). This measure outlines eight domains of CBT that therapists should utilize within sessions including, agenda setting, formulation, CBT Interventions, and homework. Within

domains, specific techniques of CBT are also included. For example, within CBT Interventions, techniques include setting intervention targets, selecting suitable interventions, explaining the rationale for the intervention, implementing the intervention, and reviewing interventions. The ACCS has good internal consistency (α = .90), good interrater reliability (Intraclass Correlation Coefficient =.74), and validity (*r*=.65) (Muse et al., 2017). The CBT Adaptation Questionnaire asks participants to rate on a Likert scale (0-4 and 0-3; respectively) the frequency they *use* and *adapt* each technique from its description by Muse and colleagues. Similar to the CT questionnaire, participants can enter qualitative information regarding adaptations of specific techniques or the therapeutic process as an entirety.

The REBT Adaptation Questionnaire (see appendix E) is a 25-item scale based upon the REBT Competency Scale (Dryden, Beal, Jones & Trower, 2010). The original measure outlines 21 aspects of REBT that therapists should utilize within sessions, including agreeing on a problem, assessing the activating event, assessing irrational beliefs, and questioning beliefs. While the scale and accompanying manual are quite detailed in evaluating specific REBT techniques, the authors did not provide any psychometric data. A small unpublished pilot study of the REBT Competency Scale asked experts in the field to give feedback on the items, definitions, and ability to evaluate the therapeutic approach. Feedback indicated the scale was clear, understandable, and appropriate (Wade et al., 2017). The REBT Adaptation Questionnaire in the present study asks participants to rate aspects and sub-aspects of REBT techniques separately (i.e., overall use of questioning irrational beliefs, and then utilizing empirical questioning, logical questioning, and pragmatic questioning). Dryden

and colleagues (2010) provide definitions and examples of each technique, which are included within the questionnaire. The REBT Adaptation Questionnaire asks participants to rate on a Likert scale (0-4 and 0-3; respectively) the frequency they *use* and *adapt* each technique from its description by Dryden and Colleagues (2010). Similar to the other questionnaires, participants can also enter qualitative information regarding adaptations of specific techniques or the therapeutic process as an entirety.

Participants

Professional organizations, universities, and journals.

Survey respondents were recruited via membership within professional 262 identified Psychological and Mental Health Organizations (see Appendix F), 343 universities (see Appendix G), and nine journals' editorial boards' (see Appendix H), which resulted in contacting another 428 individuals. To gain a representative sample of international practitioners, universities were identified based upon the USA's FSI categorization of language and corresponding population size. Based upon the FSI's list of languages, up to four countries where the language was designated an official language were contacted. If more than four countries identified a given language as an official language, the four countries with the largest population were contacted (Statista, 2020). Organizations and universities were contacted via email on three occasions requesting distributing to their members.

Of the 605 professional organizations and universities identified, 28 replied to the emails indicating they distributed the survey to their members. Further, some organizations (*n=12)* provided a rationale for why they could not distribute the survey (i.e., would only distribute for a monetary fee, only distributes for members of the

organization, or the organization does not distribute research requests). The remaining organizations did not reply to email attempts. Organizations were excluded if they requested a monetary fee to distribute the survey.

Survey respondents.

Participants of the current study were 129 mental health practitioners worldwide who reported delivering CT, CBT, or REBT to clients. In all, 28, 172, and 35 practitioners completed the CT, CBT, and REBT surveys, respectively. However, 15, 76, and 13 responses from the CT, CBT, and REBT surveys were excluded from data analysis due to missing items. Therefore, 11, 96, and 22 CT, CBT, and REBT responses were used in data analysis. No significant differences were found between participants who completed the survey versus those with missing based on visual analysis of demographic information.

Of the 129 participants (see Table 2), 78 (60.5%) were from WEIRD locations. The majority of participants practice within the USA (51.9%), followed by Barbados (5.4%), Peru (4.7%), the United Kingdom (3.9%), and Israel (3.9%). Similarly, most participants received their professional training within the USA (59.7%), followed by Israel (3.9%), Argentina (3.9%), the United Kingdom (3.1%), and Canada (3.1%). Most participants' primary language is English (65.1%). Utilizing the FSI's language similarity to English as noted above, 25 participants (19.4%) reported practicing in a language closely related to English. One participant (.8%) reported practicing in a language that takes a little longer to master, 15 participants (11.6%) practice in a language with significant linguistic and/or cultural differences from English, and 4 participants (3.1%) practice in a language which is exceptionally difficult for native English speakers. Given

Table 2

Participant Demographics

Demographic	*n*	%
WEIRD status		
WEIRD	78	60.5
Non-WEIRD	51	39.5
Country of Practice[a]		
United States of America	67	51.9
Barbados	7	5.4
Peru	6	4.7
United Kingdom	5	3.9
Israel	5	3.9
Other	39	30.2
Primary Country of Training		
United States of America	77	59.7
Israel	5	3.9
Argentina	5	3.9
United Kingdom	4	3.1
Canada	4	3.1
Other	34	26.4
Gender[b]		
Cisgender Female	82	63.6
Cisgender Male	36	27.9
Primary Theoretical Orientation		
Cognitive Behavioral Therapy	96	74.4

Demographic	*n*	%
Rational Emotive Behavioral Therapy	22	17.1
Cognitive Therapy	11	8.5
Language		
English	84	65.1
Category I	25	19.4
Category II	1	0.8
Category III	15	11.6
Category IV	4	3.1
Practice Setting [c]		
Private Practice	54	41.9
Outpatient	44	34
School	38	29.5
University	25	19.4
Inpatient Hospital	21	16.3
Other	7	5.4

Note. (N = 129). WEIRD = Western, Educated, Industrialized, Rich, Democratic nations. [a] The 5 countries with the highest frequencies are listed. [b] Values and percentages account for (*n*=11) missing responses [c] *n* is greater than 129 as participants were able to select all that apply.

only one participant was within Category 2, for data analyses, this language was recoded to Category I.

In regard to participants workplace(s), participants were able to select multiple practice settings, if applicable. As such, 41.9% practice within a private practice, 34% practice within an outpatient setting, 29.5% practice within a school setting, 19.4% practice within a university, 16.3% practice within an inpatient hospital, and 5.4% practice within a different setting (i.e., prison, consulting, non-governmental organization). Participants varied between 22 and 76 years of age (*Mean* = 41 years old); 63.6% were female.

CHAPTER 5

Results

The first three sections in this chapter review the analysis of the three hypotheses. The final section reviews exploratory data collection regarding WEIRD status, language, and cultural values relationships with the use and adaptation of therapeutic techniques. Before analyzing adaptations of CT, CBT, and REBT and specific techniques within each approach, the use of the clinical interventions are also compared to gain insight towards general use of therapy techniques. Given the quantity of therapeutic techniques varied within the CT, CBT, and REBT surveys, a total mean use and mean adaptation score was used to create a standardized metric that could compare respondents of each respective survey with one another. All data was analyzed using IBM SPSS Statistics version 27.

Adaptations Based on WEIRD Versus non-WEIRD

The first hypothesis stated that there will be greater adaptation of techniques in non-WEIRD countries than WEIRD countries. To assess this hypothesis, a one-way ANOVA was performed to compare the effect of WEIRD status on use and adaptations of CT, CBT, and REBT (see Table 3). A one-way ANOVA revealed that there was only a statistically significant difference in mean adaptations of cognitive therapy between the groups ($F(1,9) = 5.947$, $p = .037$). This suggests that individuals from WEIRD locations adapted CT more frequently than their non-WEIRD colleagues. There were no statistical differences in the use and adaptation of CBT use and adaptation of REBT and use of CT.

Further, to examine the differences regarding the use and adaptation of specific techniques within CT, CBT, and REBT based upon WEIRD versus Non-Weird status, an independent samples *t*-test was conducted on the mean responses of each item of the CT,

Table 3

Use and Adaptations in WEIRD versus Non-WEIRD locations

Mean Score	WEIRD		Non-WEIRD		F	η^2
	M	*SD*	*M*	*SD*		
CT Use [a]	4.13	.922	3.93	.792	F(1,9)=.162	.018
CT Adaptation [b]	3.40	.557	2.68	.423	F(1,9)=5.947	.398
CBT Use [a]	4.16	.488	4.10	.443	F(1,94=.295	.003
CBT Adaptation [b]	2.77	.530	2.76	.438	F(1,94)=.032	.000
REBT Use [a]	4.52	.323	4.49	.316	F(1,20)=.038	.002
REBT Adaptations [b]	2.26	.265	2.43	.433	F(1,20)=1.121	.053

Note. CT = Cognitive Therapy, CBT = Cognitive Behavioral Therapy, REBT = Rational Emotive Behavior Therapy.

[a] Response options ranged from 1 (Never) to 5 (Always). [b] Response options ranged from 1 (Do not adapt) to 4 (Always).

CBT, and REBT scales. Levene's test for homogeneity of variances was calculated for each item, and when there was a violation, a *t*-test not assuming homogenous variances was reported.

Within CT techniques, there were no significant differences in use of specific therapeutic techniques; however, there were significant differences in adaptation (see Tables 4 and 5). Unexpectedly, participants from WEIRD locations reported more adaptations in numerous techniques. Within CBT, use and adaptation of some specific techniques depended upon participants WEIRD status (see Tables 6 and 7). Participants from WEIRD locations were more likely to implement interventions and have greater time management within sessions compared to non-WEIRD participants. On the other hand, participants from non-WEIRD locations were more likely to plan homework and review homework. Despite the differences in use of techniques, only one statistically significant difference was observed in adaptation of specific CBT techniques as participants from non-WEIRD locations were more likely to adapt implementing measures.

Within REBT, there were no significant differences in overall use and adaptation, as well as when looking at specific techniques (see Tables 8 and 9). As such, these results suggests that the use and adaptations of REBT is the most consistent, independent of country factors.

Therefore, based upon these findings, hypothesis 1 can be rejected. In fact, participants from WEIRD locations are more likely to adapt Cognitive Therapy than non-WEIRD locations. However, based on the limited number of participants, these results are preliminary findings.

Table 4

Cognitive Therapy Use

Therapeutic Technique	Non-WEIRD (n=6 [a])		WEIRD (n=5 [a])		t	p	Cohen's d
	M	*SD*	*M*	*SD*			
Conceptual Integration [b]	3.50	3.50	4.40	.548	1.26	.252	-.704
Efficient Pacing and Use of Time	3.50	3.50	4.00	1.00	.804	.442	-.487
Interpersonal Effectiveness	4.33	4.33	4.60	.894	.517	.618	-.313
Elicit Behaviors	3.67	3.67	4.00	1.41	.452	.662	-.274
Set an Agenda with Adherence	4.00	4.00	4.20	.837	.408	.694	-.258
Work Collaboratively with the Client	4.17	4.17	4.40	.894	.365	.724	-.221
Elicit Cognitions	4.17	4.17	4.00	1.22	.316	.759	.191
Homework Setting [b]	4.00	4.00	3.80	1.64	.258	.803	.156
Application of Change Methods	3.83	3.83	4.00	1.00	.251	.808	-.152
Provide Client with Feedback	4.17	4.17	4.20	.837	.070	.946	-.042
Elicit the Appropriate Emotional Expression	4.17	4.17	4.20	1.09	.048	.962	-.029
Use of Guided Discovery	3.83	3.83	3.80	1.30	.042	.968	-.025

Note. Response options ranged from 1 (Never) to 5 (Always).

[a] Indicates the number of participants. [b] This item failed Levene's test for homogeneity and as a result the value for equal variances not assumed is reported.

Table 5

Cognitive Therapy Adaptations

Therapeutic Technique	Non-WEIRD (n=6 [a])		WEIRD (n=5 [a])		t	p	Cohen's d
	M	*SD*	*M*	*SD*			
Efficient Pacing and Use of Time	2.50	.548	3.60	.548	3.31	.009	-2.01
Homework Setting [b]	2.33	.516	3.40	.548	3.32	.009	-2.01
Elicit Cognitions	2.50	.548	3.40	.548	2.71	.024	-1.64
Work Collaboratively with the Client	2.83	.408	3.60	.548	2.66	.026	-1.61
Elicit Behaviors	2.67	.516	3.40	.548	2.28	.048	-1.38
Conceptual Integration	2.50	.105	3.60	.548	2.10	.065	-1.28
Set an Agenda with Adherence	3.00	.632	3.60	.548	1.66	.131	-1.01
Application of Change Methods	2.83	.753	3.40	.548	1.39	.196	-.846
Elicit the Appropriate Emotional Expression	2.67	.516	3.20	.837	1.30	.226	-.787
Use of Guided Discovery	2.33	.516	3.00	1.22	1.22	.254	-.739
Interpersonal Effectiveness	2.83	.408	3.20	.837	.953	.365	-.577
Provide Client with Feedback	3.17	.753	3.40	.548	.576	.579	-.349

Note. Response options ranged from 1 (Do not adapt) to 4 (Always).

[a] Indicates the number of participants. [b] This item failed Levene's test for homogeneity and as a result the value for equal variances not assumed is reported.

Table 6

Cognitive Behavioral Therapy Use

Therapeutic Technique	Non-WEIRD (n=33 [a])		WEIRD (n=63 [a])		t	p	Cohen's d
	M	*SD*	*M*	*SD*			
Time Management	3.70	.728	4.13	.735	2.73	.007	-.590
Implementing Interventions	4.12	.650	4.42	.588	2.26	.026	-.489
Reviewing Homework [b]	4.15	.755	3.63	1.27	2.51	.014	.466
Interpersonal Style [b]	4.67	.595	4.85	.355	1.66	.103	-.416
Planning Homework [b]	4.12	.820	3.63	1.37	2.18	.031	.407
Pace	4.03	.684	4.29	.687	1.75	.082	-.379
Suitable Items [b]	3.79	.992	4.10	.756	1.69	.093	-.364
Feasible Agenda	3.76	.751	4.02	.707	1.66	.099	-.358
Choosing Suitable Interventions	4.24	.663	4.45	.645	1.49	.139	-.321
Choosing Suitable Homework [b]	4.03	.847	3.69	1.26	1.37	.172	.296
Empathetic Understanding [b]	4.73	.452	4.84	.371	1.21	.230	-.278
Collaboration	4.30	.684	4.51	.766	1.28	.202	-.278
Appropriate Intervention Targets	4.42	.708	4.26	.745	1.05	.295	.277
Choosing Suitable Measures	3.73	.977	3.92	.911	.954	.342	-.206
Rationale for Interventions	4.33	.736	4.46	.673	.836	.405	-.181
Implementing Measures	3.61	.998	3.74	.886	.681	.498	-.147
Maintained Focus	4.12	.740	4.21	.681	.585	.560	-.126
Reviewing Interventions	3.94	.827	4.03	.795	.536	.593	-.116
Reflective Summaries	4.03	.984	3.92	.946	.537	.593	.116
Patient Feedback	4.30	.770	4.39	.776	.504	.615	-.109
Rationale for Homework	3.94	1.031	3.81	1.27	.526	.600	.108

Therapeutic Technique	Non-WEIRD	WEIRD (n=63 [a])	t	p	Cohen's d

	(*n*=33 [a])						
	M	*SD*	*M*	*SD*			
Coherent and Dynamic Formulation	4.15	.870	4.19	.820	.216	.829	-.047

Note. Response options ranged from 1 (Never) to 5 (Always).

[a] Indicates the number of participants. [b] This item failed Levene's test for homogeneity and as a result the value for equal variances not assumed is reported.

Table 7

Cognitive Behavioral Therapy Adaptations

Therapeutic Technique	Non-WEIRD (n=33 [a])		WEIRD (n=63 [a])		t	p	Cohen's d
	M	*SD*	*M*	*SD*			
Implementing Measures	2.85	.667	2.45	.592	2.97	.004	.641
Choosing Suitable Measures	2.85	.667	2.60	.689	1.71	.090	.369
Empathetic Understanding	2.58	.751	2.84	.706	1.69	.094	-.364
Rationale for Homework	2.66	.602	2.44	.760	1.42	.157	.311
Interpersonal Style	2.73	.719	2.95	.756	1.40	.165	-.302
Patient Feedback	2.58	.663	2.76	.694	1.23	.219	-.267
Coherent and Dynamic Formulation	2.85	.667	2.98	.689	.922	.135	-.199
Planning Homework [b]	2.69	.592	2.56	.802	.842	.402	.167
Suitable Items	2.91	.678	3.02	.684	.729	.468	-.157
Reviewing Interventions	2.76	.708	2.66	.599	.700	.486	.151
Pace	2.76	.792	2.87	.735	.697	.488	-.150
Implementing Interventions	2.85	.667	2.94	.597	.649	.518	-.140
Collaboration	2.76	.663	2.84	.682	.557	.579	-.120
Choosing Suitable Homework [b]	2.73	.574	2.65	.812	.572	.569	.111
Maintained Focus	2.70	.585	2.76	.717	.420	.675	-.091
Appropriate Intervention Targets	2.91	.631	2.95	.612	.319	.750	-.069
Feasible Agenda	2.85	.667	2.81	.644	.278	.782	.060
Choosing Suitable Interventions	2.91	.579	2.93	.574	.204	.839	-.044
Time Management	2.73	.719	2.76	.740	.195	.846	-.042
Rationale for Interventions	2.88	.696	2.90	.646	.171	.865	-.037
Reviewing Homework [b]	2.58	.614	2.59	.864	.094	.926	-.018

Therapeutic Technique	Non-WEIRD (*n*=33)		WEIRD (*n*=63)		*t*	*p*	Cohen's *d*
	M	*SD*	*M*	*SD*			
Reflective Summaries	2.55	.666	2.55	.645	.021	.983	-.004

Note. Response options ranged from 1 (Do not adapt) to 4 (Always).

[a] Indicates the number of participants. [b] This item failed Levene's test for homogeneity and as a result the value for equal variances not assumed is reported.

Table 8

Rational Emotive Behavior Therapy Use

Therapeutic Technique	Non-WEIRD (n=12 [a])		WEIRD (n=10 [a])		t	p	Cohen's d
	M	*SD*	*M*	*SD*			
Connect the Irrational Belief and Consequences [b]	5.00	.000	4.70	.483	1.96	.081	.926
Logical Empirical, and Pragmatic Questioning of the Rational Belief	3.82	1.07	4.50	.527	1.80	.086	-.790
Ask for a Specific Example of the Target Problem [b]	4.83	.389	4.40	.699	1.74	.103	.787
Facilitate the Working Through Process	3.92	.900	4.40	.699	1.38	.182	-.592
Assess the Emotional and/or Behavioral Consequences [b]	4.92	.289	4.70	.483	1.24	.233	.558
Use of Logical Disputation	4.00	.739	4.40	.699	1.29	.210	-.555
Define and Agree Upon the Target Problem	4.00	.953	4.40	.516	1.18	.249	-.508
Use of Pragmatic Disputation	4.67	.492	4.30	.949	1.16	.257	.500
Negotiate a Homework Assignment	4.58	.515	4.30	.675	1.11	.277	.478
Check the Homework Assignment	4.67	.492	4.40	.699	1.04	.307	.449
Ask for a Problem	4.58	.515	4.78	.441	.909	.375	-.401
Teach the Belief-Consequence Connection	4.92	.289	5.00	.000	.909	.374	-.389
Assess the Activating Event	4.75	.452	4.90	.316	.883	.388	-.378
Agree on a Goal	4.67	.492	4.50	.527	.766	.453	.328
Encourage the Client to become his/her own therapist	4.33	.985	4.60	.699	.718	.481	-.307
Help the Client to see the Link between the problem-as-defined goal and the problem-as-assessed goal	3.92	.900	4.10	.994	.454	.655	-.194
Teach the Rational Beliefs	4.83	.389	4.90	.316	.435	.668	-.186
Agree Upon a Goal with Respect to the Problem as Assessed	4.25	.965	4.40	.699	.409	.687	-.175
Use of Empirical Disputation	4.43	.515	4.30	.823	.406	.689	.174
Preparing the Client to deepen their Conviction in the Rational Belief	4.33	.651	4.20	.919	.398	.695	.170

Therapeutic Technique	Non-WEIRD (n=12 [a])		WEIRD (n=10 [a])		t	p	Cohen's d
	M	*SD*	*M*	*SD*			
Question Irrational and Rational Beliefs	4.58	.900	4.70	.483	.367	.717	-.157
Check the Validity of the Activating Event	4.00	.853	3.90	.994	.254	.802	.109
Assess the Irrational Belief	4.83	.389	4.80	.422	.193	.849	.082
Bond with the Client	4.92	.289	4.90	.316	.129	.899	.055
Identify and Assess any Meta-Problems	4.42	.793	4.40	.699	.052	.959	.002

Note: Response options ranged from 1 (Never) to 5 (Always).

[a] Indicates the number of participants. [b] This item failed Levene's test for homogeneity and as a result the value for equal variances not assumed is reported.

Table 9

Rational Emotive Behavior Therapy Adaptations

Therapeutic Technique	Non-WEIRD (n=12 [a])		WEIRD (n=10 [a])		t	p	Cohen's d
	M	*SD*	*M*	*SD*			
Bond with the Client	2.83	.937	2.20	.422	2.09	.052	.844
Negotiate a Homework Assignment	2.67	.651	2.20	.422	1.94	.066	.834
Assess the Irrational Belief [b]	2.50	.674	2.10	.316	1.82	.086	.736
Use of Logical Disputation [b]	2.67	.778	2.20	.422	1.78	.091	.726
Assess the Emotional and/or Behavioral Consequences [b]	2.42	.515	2.10	.316	1.76	.094	.725
Identify and Assess any Meta-Problems [b]	2.58	.793	2.20	.422	1.44	.166	.587
Agree Upon a Goal with Respect to the Problem as Assessed [b]	2.33	.492	2.10	.316	1.34	.195	.553
Question Irrational and Rational Beliefs	2.58	.515	2.33	.500	1.11	.279	.491
Check the Homework Assignment [b]	2.42	.515	2.20	.422	1.08	.291	.456
Teach the Belief-Consequence Connection	2.25	.452	2.10	.316	.883	.388	.378
Logical Empirical, and Pragmatic Questioning of the Rational Belief	2.25	.866	2.50	.527	.796	.435	-.341
Preparing the Client to deepen their Conviction in the Rational Belief	2.50	.674	2.30	.483	.784	.442	.336
Facilitate the Working Through Process	2.25	.622	2.10	.316	.690	.498	.296
Ask for a Specific Example of the Target Problem [b]	2.33	.492	2.20	.422	.674	.508	.289
Encourage the Client to become his/her own therapist	2.08	.515	2.20	.422	.573	.573	-.246
Use of Pragmatic Disputation	2.33	.651	2.20	.422	.556	.584	.238
Teach the Rational Beliefs	2.42	.515	2.30	.483	.544	.592	.233
Define and Agree Upon the Target Problem	2.58	.669	2.50	.527	.320	.753	.137
Agree on a Goal	2.58	.669	2.50	.527	.320	.753	.137
Assess the Activating Event	2.25	.452	2.20	.422	.266	.793	.114
Connect the Irrational Belief and Consequences	2.25	.452	2.20	.422	.266	.793	.114

Therapeutic Technique	Non-WEIRD (n=12 [a])		WEIRD (n=10 [a])		t	p	Cohen's d
	M	*SD*	*M*	*SD*			
Check the Validity of the Activating Event	2.25	.452	2.30	.483	.250	.805	-.107
Use of Empirical Disputation	2.33	.651	2.30	.483	.134	.895	.057
Help the Client to see the Link between the problem-as-defined goal and the problem-as-assessed goal	2.42	.515	2.40	.516	.075	.941	.032
Ask for a Problem [b]	2.67	.985	2.67	.500	.000	1.00	.000

Note: Response options ranged from 1 (Do not adapt) to 4 (Always).

[a] Indicates the number of participants. [b] This item failed Levene's test for homogeneity and as a result the value for equal variances not assumed is reported.

Adaptations Based on Language

The second hypothesis predicted there will be more overall adaptations of techniques in languages different from English. Given that only one participant reported a language as Category II (Languages that take a little longer to master than Category I languages), this participant's language was recoded to Category I to provide a more conservative analysis. A one-way ANOVA was performed to compare the effect of language on the use and adaptation of CT, CBT, and REBT (see table 10). A one-way ANOVA revealed no significant differences in use or adaptation of CT, CBT, or REBT between the language groups (see Table 10). Given there were no statistically significant results, post-hoc analyses are not reported. As such, the second hypothesis can be rejected.

Adaptations within Countries

The third hypothesis intended to compare rates of adaptations within specific countries. For example, the rate of adaptations between the USA and China could be compared to see how adaptations varied between nations. However, given the small *n* in every country but the USA, such analyses were not conducted. Future studies with larger sample sizes within countries may be better able to address this hypothesis.

Predictors of Mean Use and Adaptation

Lastly, to determine if relationships exist between WEIRD versus non-WEIRD status, language, cultural values, and use and adaptation of therapeutic techniques exploratory analyses were conducted. To be able to incorporate the greatest number of participants, the mean value of use and adaptation was used across all therapeutic

Table 10

Use and Adaptations by Language

Mean Score	English		Category I		Category III		Category IV		F	η^2
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*		
CT Use	4.10	.811	-	-	3.17	.471	4.58	.589	F(2,8)=1.895	.321
CT Adaptation	3.05	.540	-	-	2.72	.442	2.71	.412	F(2,8)=.291	.070
CBT Use	4.15	.476	4.15	.482	3.99	.421	4.59	.514	F(3,92)=1.087	.034
CBT Adaptation	2.75	.426	2.87	.463	2.72	.442	2.98	.804	F(3,92)=.544	.017
REBT Use	4.51	.307	4.49	.332	-	-	-	-	F(1,19)=.038	.002
REBT Adaptations	2.24	.263	2.47	.431	-	-	-	-	F(1,19)=1.685	.081

Note. Language Categories are based upon the Foreign Service Institutes (FSI)'s categorization of languages similarity to English.

CT = Cognitive Therapy, CBT = Cognitive Behavioral Therapy, REBT = Rational Emotive Behavior Therapy.

techniques. These results provide insight towards general cognitive-behavioral therapy approaches rather than specific to a modality (CT, CBT, or REBT).

First, a hierarchical linear regression was used to test if WEIRD versus non-WEIRD status, language, or cultural values significantly predicted use of therapeutic techniques, as measured by the overall mean score of therapy use items for each participant (see Table 11). The overall regression model using all predictive factors (model 3) was statistically significant (R^2 = .150, F (8,103) = 2.269, p = .028). In this model, the dimensions of Long-Term Orientation (β = .493, p = .002) and Indulgence (β = .505, p = .001) significantly predicted use of cognitive-behavioral therapy techniques. Of note, the correlation with therapy technique use (see Table 12) is low for both Long Term Orientation (r = .162) and Indulgence (r = .106). As such, emphasis on these factors as significant predictors is limited. Therapy technique use increased by .075 points for being within a non-WEIRD location and decreased by .048 points for each category higher on the differences to English continuum (0 = English, 1 = most similar to English, 3 = considerable linguistic and cultural differences, 4 = very different from English). The other predictors, WEIRD status, language category, and the cultural dimensions of Power Distance, Individualism, Masculinity, and Uncertainty did not significantly predict the use of therapeutic techniques.

Next, a multiple linear regression was used to test if WEIRD versus non-WEIRD status, language, or cultural values significantly predicted therapy adaptations. The overall regression was statistically significant (R^2 = .146, F(8,103) = 2.209, p = .033) (see Table 13). Therapy adaptation increased by .120 points for being within a non-WEIRD location and increased by .159 points for each level higher on the differences to English

Table 11

Regression Results of Use of Therapeutic Techniques

Predictor	t	b	β	sr^2	F	df	p	Adj. R^2
Model 1					.157	1,110	.693	-.008
WEIRD	.396	.042	.038	.001			.693	
Model 2					.200	2,109	.819	-.015
WEIRD	.087	.011	.010	<.001			.931	
Language	.495	.027	.055	.002			.622	
Model 3					2.269	8,103	.028	.084
WEIRD	.271	.075	.067	<.001			.787	
Language	-.778	-.048	-.099	.005			.438	
Power Distance	1.149	.008	.211	.011			.253	
Individualism	.596	.003	.185	.003			.553	
Masculinity	-.553	-.003	-.061	.003			.582	
Uncertainty	1.101	.004	.146	.010			.273	
Long Term Orientation	3.261	.017	.493	.088			.002	
Indulgence	3.496	.016	.505	.101			.001	

Note. WEIRD = Western, Educated, Industrialized, Rich, Democratic

Table 12

Correlations amongst WEIRD, Language, Cultural Dimensions, and Use of Therapy

Variable	*M*	*SD*	1	2	3	4	5	6	7	8
1. Use [a]	4.213	.515								
2. WEIRD [b]	.30	.462	.038							
3. Language [c]	.57	1.054	.060	.510						
4. Power Distance [d]	46.071	13.517	.066	.777	.338					
5. Individualism [d]	73.723	27.184	.001	-.911	-.477	-.854				
6. Masculinity [d]	59.312	10.322	.073	-.343	-.072	-.267	.427			
7. Uncertainty [d]	53.476	17.441	.073	.695	.377	.612	-.627	-.129		
8. Long Term Orientation [d]	31.742	15.016	.162	.349	.536	.186	-.209	.007	.220	
9. Indulgence [d]	62.634	16.058	.106	-.532	-.360	-.402	.470	.281	-.400	-.662

Note. WEIRD=Western, Educated, Industrialized, Rich, Democratic.

[a] Response options ranged from 1 (Never) to 5 (Always). [b] Locations were coded as 0 (WEIRD location) or 1 (non-WEIRD). [c] Responses were coded as 0 (English), 1 (languages most similar to English), 2 (languages that take longer to master), 3 (languages with considerable linguistic and cultural differences from English), or 4 (languages very different from English due to their varying writing styles). [d] Values range from 0 to 100.

Table 13

Regression Results of Adaptations of Therapy

Predictor	t	b	β	sr^2	F	df	p	Adj. R^2
Model 1					.059	1,110	.808	-.009
WEIRD	-.244	-.024	-.023	<.001			.808	
Model 2					.887	2,109	.415	-.002
WEIRD	-.878	-.101	.115	.007			.382	
Language	1.309	.066	.050	.015			.193	
Model 3					2.209	8,103	.033	.080
WEIRD	.467	.120	.116	.002			.642	
Language	2.731	.159	.348	.062			.007	
Power Distance	-.557	-.004	-.102	.003			.579	
Individualism	.348	.002	.108	.001			.729	
Masculinity	-1.158	-.006	-.128	.011			.250	
Uncertainty	-1.571	-.006	-.208	.020			.119	
Long Term Orientation	-2.881	-.014	-.436	.069			.005	
Indulgence	-1.491	-.006	-.216	.018			.139	

Note. WEIRD = Western, Educated, Industrialized, Rich, Democratic

continuum (0 = English, 1 = most similar to English, 3 = considerable linguistic and cultural differences, 4 = very different from English). More specifically, it was found that languages difference from English (β = .348, p = .007) and Long Term Orientation (β = -.436, p = .005) significantly predicted adaptation of therapy. Again, the correlation with adaptations (see Table 14) is low for both Language (r = .095) and Long Term Orientation *(*r = -.155). WEIRD status and the other cultural dimensions did not significantly predict adaptations of therapy.

Table 14

Correlations amongst WEIRD, Language, Cultural Dimensions, and Adaptations of Therapy

Variable	*M*	*SD*	1	2	3	4	5	6	7	8
1. Adaptation [a]	2. 740	.481								
2. WEIRD [b]	.30	.462	-.023							
3. Language [c]	.57	1.054	.095	.510						
4. Power Distance [d]	46.071	13.517	-.075	.777	.338					
5. Individualism [d]	73.723	27.184	.000	-.911	-.477	-.854				
6. Masculinity [d]	59.312	10.322	-.156	-.343	-.072	-.267	.427			
7. Uncertainty [d]	53.476	17.441	-.126	.695	.377	.612	-.627	-.129		
8. Long Term Orientation [d]	31.742	15.016	-.155	.349	.536	.186	-.209	.007	.220	
9. Indulgence [d]	62.634	16.058	.025	-.532	-.360	-.402	.470	.281	-.400	-.662

Note. WEIRD=Western, Educated, Industrialized, Rich, Democratic.

[a] Response options ranged from 1 (Do not adapt) to 4 (Always). [b] Locations were coded as 0 (WEIRD location) or 1 (non-WEIRD). [c] Responses were coded as 0 (English), 1 (languages most similar to English), 2 (languages that take longer to master), 3 (languages with considerable linguistic and cultural differences from English), or 4 (languages very different from English due to their varying writing styles). [d] Values range from 0 to 100.

CHAPTER 6

Discussion

The purpose of the current research was to understand the uses and adaptations of cognitive-behavioral therapeutic approaches internationally. Once an understanding of the use of therapies is understood, a closer look at the adaptations and factors that influence adaptations is warranted to provide clinicians with insight and guidance towards working with diverse clients. Implications of findings, ideas for future research, and limitations of the current study will be discussed.

Implications of WEIRD versus non-WEIRD

First, a review of the results suggests that the general use of therapeutic techniques within CT, CBT, and REBT did not significantly differ between WEIRD versus non-WEIRD participants. Further, a review of specific technique usage scores indicated that all techniques are used at least "sometimes." In fact, some techniques are used more frequently in non-WEIRD locations, such as asking for specific examples of problems, disputing thoughts, providing reflective summaries, planning homework, and reviewing homework. Therefore, it does not appear that any particular techniques are culturally inappropriate to use. This is consistent with the literature which recommends a therapist do CBT as they usually would, with an awareness of cultural values, based upon the strong empirical evidence of CBT with a myriad of populations and disorders. (Pantalone et al., 2010).

Regarding adaptations, opposite to the researchers' expectations, greater adaptations were reported by WEIRD CT practitioners than non-WEIRD CT practitioners. To learn more about this difference, a review of specific adaptations within

CT techniques revealed that WEIRD practitioners were more likely to adapt pacing and use of time, eliciting cognitions, eliciting behaviors, and setting homework. Within CBT, practitioners from WEIRD locations more frequently adapted implementing interventions and pacing, while non-WEIRD participants were more likely to adapt implementing measures and techniques related to homework: the rationale for homework, planning homework, and choosing suitable homework. No significant differences in adaptations were noted within REBT; however, there were more adaptations in non-WEIRD groups as observed through the negative effect sizes of most techniques. Overall, themes regarding adaptations to the timing of sessions, agenda adherence, and use of homework are apparent across the surveys. As themes were noted across the three surveys, it is possible that these are the "common factors" within CBT similar to how there are common factors amongst therapies (Wampold et al., 2012).

In the context of the current study, pacing and time management within sessions refers to limiting discussion of topics that are either peripheral to the agenda or unproductive while pacing the session according to the patient's needs. In both CT and CBT, practitioners from WEIRD countries were more likely to adapt and use efficient pacing and use of time in sessions. Further, they were more likely to limit conversations that did not adhere to the agenda actively. A therapist's competencies in time management and agenda adherence skills have often been related to a therapist's experience – novel therapists tend to have negative assumptions regarding interrupting a client, or therapists with prior training in nondirective approaches (i.e., dynamic) prefer to allow sessions to "naturally unfold" (Waltman et al., 2016, p.7). However, in a review of qualitative responses from the survey, respondents provided more specific information

regarding their adaptations, which were related to patients' expectations. For example, a participant from Italy (non-WEIRD) reported that his Italian patients “expect less structure” and “less homework,” so he may proceed “more loosely … to not risk the therapeutic alliance.” Further, a participant from Romania (non-WEIRD) reported patients are not familiar with “the very structured approach of CBT, especially with homework forms… so I choose a more relaxed approach”. While a participant from Canada (WEIRD) reported he “slows down the pace of the session or speeds it up depending on the needs of the client.” Overall, a review of the qualitative responses suggests that adaptations are occurring to serve the needs of the patient, rather than a therapist’s experiences. It is noted that non-WEIRD participants generally prefer less structure within sessions than those from WEIRD locations, which may explain some of the high levels of adaptation to time management and agenda adherence.

Despite these reasons for adaptations, setting an agenda and remaining on task in sessions results in more efficient sessions (Frankel et al., 2013), and as such, a consideration of how to remain culturally competent while orienting patients towards these techniques is warranted. Agenda setting is an assertive behavior, whether the therapist, client, or pair sets the agenda (Leahy, 2001). As such, if some people are less inclined towards structured/assertive behaviors in sessions, this may indicate why these approaches within cognitive behavioral approaches are less used or adapted.

There is specific guidance for therapists to help clients who are opposed to agenda adherence and pacing (Leahy, 2001); however, the recommendations towards cultural factors are vague. For example, if a client has opposition towards the agenda or pacing within sessions, research recommends addressing these factors as clinical issues within

sessions (Leahy, 2001). Further, when determining how much structure to have in sessions, clinicians can refer to the literature, which shows effective strategies include clearly explaining the structure of cognitive behavioral therapy, establishing session patterns early on, and asking for client feedback often (Leahy, 2001; Waltman et al., 2016). However, more research towards these specific techniques with diverse groups is needed, as the recommendation for culturally diverse adaptations is to adapt treatment delivery to remain congruent with the culture (Okamoto et al., 2019). For example, finding strategies to allow patients to see agenda setting as collaborative rather than assertive may help a client's engagement. In addition, increased psychoeducation regarding the purpose of the agenda may help (Leahy, 2001). However, research is needed within diverse groups, who may have cultural factors that naturally oppose these techniques, to determine if such adaptations are effective.

In addition, barriers towards homework compliance are a consistent theme noted in qualitative responses to this survey and within the literature (Baruch et al., 2011, Kazantzis et al., 2016, Stirman et al., 2018). Although therapy aims to balance the individual patient's needs with the therapeutic framework (Bernard et al., 2009), homework promotes the generalization of skills learned in therapy to a client's natural life (Kazantzis et al., 2016). Further, homework compliance is related to attrition in therapy (Stirman et al., 2018). Therefore, it is important to consider how to promote acceptance of homework as a treatment technique and improve compliance with it. There are numerous factors which influence why treatment compliance is low, including lack of motivation, disregard for the importance of homework, desire to see immediate results, and avoidance of the inconvenience of homework (Kazantiz et al., 2016).

Beyond this, there are cultural differences in rates of homework completion. For example, Chinese and Latino clients tend to complete CBT homework at lower rates than Caucasians (Aguilera et a., 2018; Guo & Hanley, 2015). Regarding the Chinese culture, reasons for this lower completion rate include the value of emotional restraint, so some homework assignments (i.e., a thought diary) may be avoided as they encourage effort and time to understand emotions (Guo & Hanley, 2015). Further, Chinese culture values achievement and performing positively – recording negative life experiences, thoughts, and feelings may also be avoided to avoid the shame associated with these events. Lastly, they also value authority figures in high regard, including therapists, and may assume homework is not needed for change (Guo & Hanley, 2015). Therefore, it is apparent that homework adherence is a complicated process that incorporates many cultural values. In qualitative responses to the current survey, the theme of cultural values or preferences impacting homework adherence was apparent. Respondents reported that when patients prefer a less structured approach within sessions, they too are less oriented towards homework, and subsequently, techniques regarding homework are adapted. Further research may consider how adaptations can either orient patients towards the structure of cognitive-behavioral therapies or adapt therapeutic techniques such as timing and homework to occur in a more person-centered manner to maintain the clinical efficacy of these short-term, time-oriented treatments (Young & Beck, 1980).

An additional factor relevant to the present study is the location of participants training and practice. More participants were from WEIRD locations (60.5%) than non-WEIRD locations. Of note, an even greater percentage of participants were trained within WEIRD countries (66%). Although the difference is small, it is worth noting that some

practitioners were trained within countries that do not share the same qualities or cultural values as the countries where they practice. For example, 7% of respondents indicated that they were trained within the USA but do not practice within the USA. Therefore, although this study intended to compare non-WEIRD participants to WEIRD participants, this grouping may not be truly dichotomous. Therefore, as much as research should continue to expand to a variety of non-WEIRD settings, efforts should be made to ensure clinicians are prepared to work with a variety of populations, too. The APA advocates for developing cultural competence within therapists during their training (Fuentes et al., 2021). The importance for such is noted as work with ethnic minorities required adaptations 60% of the time (Chu & Lieno, 2017). Factors to be addressed include sociocultural factors, cultural skills, and psychoeducation (Chu & Lieno, 2017); however, the APA's guidelines are vague in how to actually develop cultural competence (Fuentes et al., 2021). As such, research such as the current study should continue to determine which specific adaptations are needed to help develop culturally competent clinicians. Once a consensus is reached, organizations such as the APA can implement more specific standards in the training of culturally competent clinicians.

Implications of Language

Language was a weak yet significant predictor of therapy adaptations when therapy types (CT, CBT, and REBT) were collapsed to a mean adaptation score while cultural interactions were added to the regression. This suggests that language alone may not be a strong indicator of the need to adapt therapy; however, when considered with cultural values, meaningful information regarding the need to adapt treatments is

observed. Given that patients always bring their cultural values to therapy, practitioners should language when preparing for adaptation in cognitive behavioral treatments.

To understand the level of adaptations needed, the results of the current study suggest that the more a language is different from English, the more adaptations that will occur. All theoretical orientations in the present study were developed within the English language. As such, the vocabulary used to describe the core concepts was developed within the English language (i.e., cognitions, irrational beliefs, negative automatic thoughts). A factor outside the scope of the current study, but of interest for researchers to consider is the language that practitioners are trained in versus the language they deliver treatment. More specifically, are CBT researchers translating texts to other languages for diverse therapists, or, are practitioners being trained in the English language, and then translating the concepts within sessions. Given textbooks are translated, it is likely that there is a combination of both factors here. However, it is important to note that how concepts developed within the English language are translated to maintain meaning.

It is essential to note that language provides meaning and influences how one develops meaning, and as such, the words we use to describe concepts should be considered carefully (van Ness et al., 2010). As such, translating information and meanings to another language is complicated. In a qualitative response to the survey, a Spanish-speaking participant reported that he is aware of the connotations associated with words he uses, so he chooses the most culturally appropriate words for each client. For example, he reported using the term *counseling* instead of *therapy* because it has a less negative stigma. This is one example of being aware of the meaning associated with

particular words. Further, a participant from the United States who provides services in English with bilingual clients, namely English Language Learners, reported "language barriers" occur in sessions. To mitigate these barriers, he "provid[es] materials in native languages" when possible.

Metaphors are frequently used to assist one's understanding; however, metaphors vary from culture to culture (Deignan, 2009). For example, a French-speaking participant reported she uses the client's "own words" and then utilizes metaphors and images that may resonate best with the particulate client. Practitioners need to be prepared for language barriers and be aware of the implications of the terms they use (Pantalone et al., 2010). Some strategies to assist with this include using concrete language (rather than colloquiums or idioms that do not translate easily), having patients restate ideas in their own words to confirm understanding, using visuals to support language, and arranging for in-vivo learning during sessions (Whitsett & Hubbard, 2009). Therefore, it is reasonable to conclude that differences in language impact treatment and require adaptations to helping clients understand the core concepts of cognitive behavioral therapies with increasing importance with languages that are more different from English.

Ultimately, having the client and therapist communicate in the same language is preferred to mitigate what meaning may be lost when translating from one language to another (van Ness et al., 2010). This allows for the therapist and client's connotation and expression shared to be preserved. Therefore, the focus of adaptation relies on the precise translation of the core therapeutic techniques to the non-English language. However, additional adaptations are needed when a client and therapist are not fluent in the same language or rely on an outsider to translate. Although this will likely only occur in select

contexts (i.e.., emergencies in hospital settings, schools) rather than traditional therapeutic settings (i.e., weekly outpatient therapy), these are still important factors to consider when in such a setting. One helpful method is having staff available to translate or materials ready in numerous languages.

Beyond this, one's language can serve as a barrier to finding suitable treatments for their mental illness. Researchers note that an inability to find a therapist in one's preferred language or cultural group may prevent some individuals from coming to therapy (Dingfedler, 2005). When therapists and providers share cultural values or language, they will inherently be aware of some of the factors mentioned above (i.e., stigmas associated with particular vocabulary) and provide more culturally responsive treatment. However, if patients do not feel a strong alliance and understanding with their therapist based upon language (and cultural values), patients may not seek or remain in treatment (Dingfedler, 2005). There is a need for a more diverse clinician base, especially within the USA, as a recent study indicated that only 10% of psychiatrists within the USA are people of color (Wyse et al., 2020). There have been initiatives to diversify mental health fields, including psychiatry, psychology, school psychology, and social work (Proctor & Romano, 2016). Yet, the need remains to diversify the field of practitioners and grow the cultural competence of current practitioners (Wyse et al., 2020). As the field diversifies, there may be more remarkable adaptations made within therapy to be culturally responsive.

Cultural Dimensions Implications

Cultural dimensions are important in understanding individuals' behavior. Based upon the preliminary results of this study, they can help practitioners understand

adaptions of therapy and provide suggestions for future researchers. To start, higher scores on long-term orientation were correlated, albeit weakly, with therapy technique use. Therapy promotes making positive changes to help create a healthier life (Meichenbaum & Mahoney, 1995). As such, it is logical to conclude that nations who value preparation for the future would be likely to use cognitive-behavioral therapy techniques, such as agreeing on therapeutic goals, having a case formulation, and eliciting emotions. When looking at societies with the highest Long-Term Orientation scores, Asian countries score the highest. However, this is an unexpected finding, as Asian societies typically underuse therapy based on cultural values (Gee et al., 2020; Guo et al., 2014). Similarly, the current studies' results suggest that more indulgent societies (as defined by Hofstede) use cognitive-behavioral therapeutic techniques more often. Higher scores on indulgence indicate that a society values human motivations, including enjoying life and having fun. Countries with the highest indulgent scores are mainly from Latin America (Dressing, 1996). This knowledge is important for researchers as the most significant and highly correlated results supporting the use of therapeutic techniques came from societies where research is lacking (Epp & Dobson, 2010; Kline et al., 2018). If individuals from these locations have cultural values which align with cognitive-behavioral therapies, it is essential to conduct research with these populations to ensure the treatments available are evidence-based.

In addition, it is well-known in the literature that therapy can have long-term positive effects on treating mental illness (Beck & Haigh, 2014; Butler et al., 2006; David et al., 2016; Dobson & Dezois, 2010; Epp & Dobson, 2010; Harvey et al., 2017; Meichenbaum & Mahoney, 1995; Sarracino et al., 2017; Waller, 2012). Therefore, those

who are more indulgent or who have a long-term orientation may be more inclined to engage and remain in cognitive-behavioral therapy. Unfortunately, dropout in therapy is a common problem, occurring nearly 40% of the time (Fernandez et al., 2015). Of note, ethnic minorities are more likely to drop out (de Haan et al., 2018). A review of the current research regarding treatment adherence and attrition shows that diagnosis, treatment format, treatment settings, and a number of sessions correlate with dropout (Fernandez et al., 2015). In addition, socioeconomic status, ethnic minority status, and the therapeutic alliance can predict dropout (de Haan et al., 2018). However, the research within this domain generally occurs within the USA, and as such, protective and risk factors for dropout need to be studied in more diverse areas. Cultural values are one suggested area of future research, as long-term orientation and indulgence are positively correlated with therapy technique use; they may be factors that prevent drop out.

On the other end of the long-term orientation continuum is short-term orientation. These individuals tend to view life events in the short term, where they may not see the connection between events of the past and circumstances from the present (Hofstede, 2010). Given that cognitive-behavioral therapies operate on assumptions of life events impacting a person, as observed through the theories of schemas, irrational beliefs, etc., individuals with short-term oriented mindsets may naturally oppose therapy. Not only may this be related to drop out as discussed above, it may have meaningful relationships with mental illness. Long-term orientation is related to the construct of future thinking, or the ability to mentally simulate future events, with a positive, negative, or neutral valence (Hallford et al., 2018). Notably, depressed and suicidal individuals tend to have reduced ability to think towards the future, particularly thinking positively about the future

(Gamble et al., 2019). However, the literature regarding the causes and treatments for the reduced capacity of future thinking is inconclusive (Hallford et al., 2018). Therefore, it may be worthwhile for future research to consider if cultural values mediate the relationship between future thinking and mental illness.

Further, participants from restraint societies were less likely to use CT, CBT, and REBT therapeutic techniques. These societies prefer to maintain traditions and time-honored ways to approach change (Hofstede, 2010). According to Hofstede's data, the most restrained societies are generally Arab nations and the middle east. This is consistent with previous literature; Tam and colleagues (2019) report therapeutic interventions are lacking in the middle east. A common barrier to treatment for mental illness in these areas is reliance on religious and traditional healers, a more time-honored approach. One participant of the current study reflected a similar dissonance that occurred and described their adaptations. This Saudi-Arabian participant reported his patients are more traditional and rely on religion to help make sense of their life. To adapt, the therapist "respect[s] traditional rules" by using "religion-based concepts" to help challenge "distorted cognitions." Consideration or utilization of religious principles has been noted in previous literature as a method individuals use to cope with life stressors, particularly within non-WEIRD settings (Ghuloum et al., 2010). As such, incorporating religion is one example of an adaptation practitioners can make with more restraint-oriented individuals. With this adaptation, groups who might commonly avoid mental health services can instead be invited into therapy.

Additionally, low scores on masculinity were correlated with more adaptations of techniques. Low masculinity refers to traditionally feminine traits, such as modesty,

empathy, and agreeableness. These traits are lowest in Nordic countries (Denmark, Sweden, Norway), and this study suggests that those with low masculinity are more likely to have adaptations occur in therapy. Masculinity has been a topic frequently referenced in psychotherapy, indicating that traditional masculinity (i.e., authoritative, high-achieving, competitive) may be a barrier to treatment. Some suggested adaptations of therapy include emphasizing the collaborative nature of the treatment, using nonclinical language (i.e., "coaching" rather than "therapy"), and incorporating physical activities within sessions; however, the actual empirical evidence supporting adaptations is limited (Spendelow, 2015). Interestingly, the current study results suggested the opposite, that more adaptations occur with those who are more agreeable and empathic. It is unclear why this correlation was observed. It may reflect an adaptation required to engage low masculine patients to be view changes in therapy as an achievement or a larger societal shift towards masculinity as a less domineering trait. This uncertainty itself reflects the need for future research in this domain.

Overall, cultural dimensions should be studied in future research, as the current study provides some insight towards psychotherapy in non-WEIRD locations, but questions remain. Cultural values such as long-term orientation, restraint, and masculinity are useful to consider if cognitive behavioral approaches will be used or accepted by clients. Practitioners reported responding to the dissonance between cultural values and therapeutic techniques by adapting treatments. Still, there is a greater need in the literature for information about how and when to adapt therapy based upon cultural traits, such as masculinity and long-term orientation. Without the research, treatments cannot be empirically evaluated, and more importantly, delivered with fidelity (Waller et al., 2012).

Ultimately, this matters most so that all mental illnesses can be addressed. As practitioners know, without effective treatments, outcomes for patients are worse.

Future Directions

The current study provides preliminary insights towards the widespread use of cognitive-behavioral therapy techniques and adaptations of therapy globally. This study utilized dichotomous groupings of WEIRD versus non-WEIRD; a future survey could compare the individual facets of Western, Educated, Industrialized, Rich, and Democratic to cultural values, language, and therapeutic adaptations. Research towards the different aspects of WEIRD may be helpful, given that psychologists' training and location of practice can occur in other places (i.e., training in Western society but practices in an Eastern). In addition, future studies should look to understand the adaptations of specific techniques within approaches. The current studies qualitative reports revealed some preliminary understandings of the types and rationale for adaptations. Further research may gather more specific examples to provide greater insight into how and why adaptations occur. A greater understanding of adaptations can allow practitioners to empirically evaluate treatments and develop procedures that are most effective for treating mental health needs of diverse groups.

Further, this study specifically focused on cognitive-behavioral therapies. Although cognitive-behavioral approaches are the most widely practiced, other treatment modalities are utilized. As such, future research could expand to other treatment modalities such as Acceptance and Commitment Therapy (ACT), Dialectical Behavioral Therapy (DBT), and psychodynamic approaches to gather a more inclusive view of therapy internationally. Lastly, future research should occur in languages other than

English so non-English speaking practitioners can be included, reducing the bias of English terms.

Limitations

This study had several limitations. One important factor to address is that while researching international practices and the impact of languages difference from English, the current survey was only offered in English. This therefore prohibited non-English speaking practitioners from completing the survey. It is possible that the use and adaptations would differ in non-English speaking practitioners. In addition, the study's conclusions are limited by the number of participants and attrition to complete the survey. The response rate of organizations that responded to the email request to distribute the survey was minimal (6%). Further, of the 235 participants who began the survey, there was a 54.9% attrition rate due to 45.1% of participants failing to complete the survey. Response patterns indicate that participants generally discontinued after completing initial consent or demographic items. One factor that influenced individuals to conclude the survey after initial consent is that their primary theoretical orientation must be CT, CBT, or REBT. If a patient does not practice one of these approaches, they could not complete the survey. Gathering data on all types of treatment (i.e., psychodynamic, DBT) internationally is helpful but outside the scope of the present study. Also, it is possible the amount and complexity of the English language caused some participants to discontinue completing the survey, too, given that once participants began completing the adaptation questionnaire portion of the survey, nearly all completed the survey. In general, a larger final *n* would have helped be more representative of the population of clinicians

providing mental health services, as the intended goal of this current research. In addition, a larger sample size would allow for power and more substantial analyses.

CHAPTER 7

Implications for the Profession of School Psychology

The present study has important implications for school psychologists. School psychologists have various duties; however, one that is becoming increasingly important is addressing mental health needs within schools (World Health Organization, 2017). Recently, there has been a shift towards social-emotional learning being a part of the curriculum in schools both within the USA and internationally, with some locations going as far as to mandate these services be provided (Barlas et al., 2021). School psychologists are at the forefront of implementing these standards and educating students on social-emotional topics. Further, there are increased rates of anxiety and depression in youth, partly exacerbated due to stressors from COVID-19 (Gerhart & Omar, 2021). Research shows that in-school counseling, including cognitive behavioral therapy, is an effective treatment for mental health needs (Barlas et al., 2021; Matsumoto & Shimizu, 2016). Therefore, there is a growing need for school psychologists to be providing mental health services, either through classroom instruction, group counseling, or individual counseling services in schools.

In line with this growing need for mental health services, diversity within schools has also been increasing (Hoody et al., 2019). With the migration of families worldwide, heterogeneity rather than homogeneity of populations with communities are becoming the norm. Approximately 3% of the global population are international migrants or those living in countries other than their home countries (Vega et al., 2015). In addition, migration trends, which were once the norm, are no longer so simple. For example, data from the USA's 2020 Census reveals a 276% increase in multiracial populations since

2010, emphasizing that "in combination" groups grew more than single races (Jones et al., 2021).

With migrations, a student's experience in schools is impacted in a number of ways. For example, migrant children and their families may not be fluent in the language of schooling, revealing that language patterns and needs within schools are varied and growing (Encarnacion, 2020). Approximately five million bilingual students are learning the school's language within the USA alone (Harris et al., 2020). Efforts to translate school materials to varying languages are growing as automated translation services or private translation companies are becoming more readily available. However, these methods can result in translation errors (van Ness et al., 2010). As such, bilingual school psychologists can serve as a connection between linguistically diverse families and schools; however, there is currently a shortage of bilingual school psychologists who can provide assessment, consultation, and interventions (Harris et al., 2020). Further, despite bilingual school psychologists' efforts to offset the confounds of language, the new patterns in migration emphasize that *all* school psychologists need to be aware of diversity issues, evidence-based interventions, and the relationship between both factors has never been more critical (NASP, 2020). Further, children who migrate from their home countries experience unique social, emotional, and academic needs, which often results in increased levels of mental illness or lower rates of academic achievement (Vega et al., 2015).

Therefore, consideration of ways to support culturally diverse children's mental health needs is needed. Cognitive behavioral approaches with children and adolescents are well-cited and proven effective for a myriad of disorders, including depression,

anxiety, and autism (Haupt, 2021; Olsson et al., 2021; Reinecke et al., 1998). At first, cognitive behavioral interventions for adults were extended towards adolescents and kids. However, this operated on the assumption that clinical diagnoses are homogenous from childhood through adulthood, and as such, the interventions will remain effective (Garber et al., 2016). Given this has been disproven, there are adaptions to traditional treatments or new treatments. In general, to adapt CBT for children and adolescents, a clinician may use age-appropriate activities, such as simplified language or child-friendly materials (i.e., incorporating monsters, superheroes, etc.). Next, beyond age, the developmental level of the child must be considered. For example, while the theory of mind develops early in childhood (around age 4 or 5) (Wellman et al., 2001), metacognition abilities begin developing around age 8 and are fully developed by age 13 (Flavell, 1999). These abilities, such as the theory of mind and metacognition, are necessary to engage in the core skills of CBT. As such, tailoring interventions to a child's cognitive, social, or emotional level is essential when providing interventions (Garber et al., 2016). Specific to CBT, cognitive restructuring techniques are often simplified. For example, children are taught how to replace negative thoughts with more positive ones because they do not have the reasoning capacity to participate in more complex techniques, including identifying cognitive distortions, examining beliefs, or Socratic questioning (Garber et al., 2016).

As the research base is growing for adaptations for cognitive behavioral therapy with children, there is a growing need for diversity to increase in these studies. Therefore, within a school psychologists' delivery of mental health services to diverse groups, they will want to consider various factors. For example, school psychologists can appeal to

one's cultural values that may make them likely to accept techniques used in therapy, such as a value for indulgence discussed above. Further, they may want to consider traditions that are important to the student and incorporate these techniques within counseling sessions. However, school psychologists also have some unique factors that may warrant unique adaptations. First, school psychologists work with school-aged children, so therapy already needs to be adapted to be developmentally appropriate (Holmbeck et al., 2006). Next, school psychologists often provide mental health services in a group format, so they need to consider the group dynamic, cultural values of individuals and groups, and languages when planning for adaptations (Kehle et al., 2009). Therefore, a school psychologist will likely have more adaptations in therapy with diverse clients than traditional private practices.

Beyond the scope of providing mental health services within schools, this knowledge can be helpful within the other roles of school psychologists, such as managing special educations services and consultation. School psychologists are often the gatekeeps to special education services in school (Reiser et al., 2010). Special education services vary across the globe, as governments regulate special education laws and services. Within the USA, delivery of special education services within schools has been occurring since 1975, when the Education for All Handicapped Children Act was passed. However, internationally, research, adaptation, and acceptance of special education services are more recent (Ritter et al., 2019). One reason for the delay in delivery of special education services internationally was the conceptualization of disabilities. In some locations such as Vietnam, disabilities were viewed as karma for sins in a previous life. So, individuals with disabilities remained cared for in the home, rather

than in schools, to maintain privacy (Shin et al., 2009). This was a rather traditional view, closely related to religion and more commonly held in Eastern societies. Although this belief is now being challenged, awareness of a student's cultural values and language is important as it may impact the family's attitude towards special education services and interventions. Language and cultural factors can clearly contribute to the misidentification of special education students, delayed identification of special education needs, and a reduced home-school collaboration (Harris et al., 2020). Therefore, a culturally responsive school psychologist will spend time building rapport with students, families, and colleagues to learn about their values and how best to support their students within the realms of special education.

As such, considering the increased diversity and mental health needs in children and adolescents, awareness of student's cultural values and language, and subsequently adapting interventions is a vital tool in a school psychologist's treatment toolbox. In addition, cultural competence can help establish rapport with students, develop meaningful therapeutic alliances, and increase collaboration with families (Vega et al., 2015). With the current patterns of migration and growing need for mental health services, research should continue to address ways to specifically develop cultural competence amongst school psychologists, as they provide critical social, emotional, academic, and behavioral interventions towards students at school.

APPENDIX A

Informed Consent

My name is Rebecca Wade and I am a doctoral student from St. John's University School Psychology program. I am currently conducting a study about how therapeutic techniques are clinically applied across a variety of cultural populations. The study is designed to identify any modifications made to specific CBT techniques based on cultural or linguistic considerations. Your cooperation and honest responses in completing the questionnaires are earnestly appreciated. The responses you make will be held in strictest confidence; only the researchers will see your responses. No St. John's students or faculty outside of those involved in the study will be told your answers, and your individual answers will not be shared. Once the questionnaires are completed, this consent form will be kept separately from the questionnaires in order to protect your identity. Your participation in this study is completely voluntary. You may refuse to participate or to terminate your participation at any time during the study. The questionnaire used in this study will be distributed to clinicians in multiple countries. After the study has been completed, a general profile of the results will be shared. The results of the study will indicate the ways in which various CBT techniques are modified based upon cultural or linguistic considerations and what reasons underlie these modifications. This will help clinicians and educators identify ways in which CBT techniques can be made more appropriate to a wide range of cultural populations. There are no perceived risks to this study.

You will be asked to rate the frequency in which you utilize of a number of techniques that are core to the practice of CBT. You will also be asked to rate the degree to which you modify each of these techniques as a function of cultural considerations. The entire process should take approximately 20-30 minutes. Please respond to every item. Mark your first impression, and don't spend a lot of time on any one item. Please contact the researchers Rebecca Wade or Mark D. Terjesen, Ph.D. at (718)990-5926 or Dr. Raymond DiGuiseppe, the chair of the St. John's University Institutional Review Board at (718)990-1955 if you have any questions or concerns. Thank you for your time and consideration.

Complete the email address section below if you would like to receive a description of the results when they are available.

_____

Date

_____

I have the read above information and consent to participation in this research.

○ Agree

○ Disagree

APPENDIX B

Demographic Questionnaire

We are asking you a number of background/demographic questions followed by asking you the frequency with which you use and adapt as a function of culture a number of core clinical interventions.

What country do you currently work in?

_____

What language(s) do you provide therapy in? Please list all that apply.

_____

Which of the following best describes your current education level?

○ Bachelors degree with less than 30 additional graduate credits

○ Bachelors degree plus 30 or more additional graduate credits

○ Masters degree with less than 30 additional graduate credits

○ Masters degree plus 30 or more graduate credits

○ Doctorate

○ Other _____

In what country did you receive the majority of your training?

_____

In what other countries did you receive training?

_____

What professional title best describes you?

☐ Clinical Psychologist

☐ School Psychologist

☐ Social Worker

☐ Mental Health Counselor

☐ Psychiatrist

☐ Professor

☐ Other _____

What settings do you provide services in? (Select all that apply)

☐ Inpatient hospital

☐ Inpatient clinic (non medical facility)

☐ Outpatient hospital

☐ Outpatient clinic (non medical facility)

☐ University

☐ School

☐ Private Practice

☐ Other _____

What population(s) do you primarily work with?

☐ 0-5 years

☐ 5-12 years

☐ 13-18 years

☐ 18-25 years

☐ 25-65 years

☐ 65+

What disorders do you commonly treat?

☐ Anxiety, dissociative, stress-related, somatoform and other non psychotic mental disorders (F40-F48)

☐ Disorders of adult personality and behavior (F60-F69)

☐ Behavioral Syndromes associated with physiological disturbances and physical factors (F50-F59)

☐ Pervasive and specific developmental disorders (F80-F89)

☐ Mood [affective disorders] (F30-F39)

☐ Schizophrenia, Schizotypal, Delusional, and other non-mood psychotic disorders (F20-F29)

☐ Behavioral and emotional disorders with onset usually occurring in childhood and adolescence (F90-F98)

☐ Mental and behavioral disorders due to psychoactive substance use (F10-F19)

☐ Mental disorders due to known physiological conditions (F01-F09)

☐ Other _____

For the questions below, we recognize beliefs will very often vary for individual clients. Overall, we are asking to what positions your current clients as a whole.

Please select the statement that is most descriptive of your clients' beliefs:

○ Hierarchy is needed in society; acceptance that power is distributed unequally within society

○ Equal rights among everyone in society are more important than privileges given to the powerful

Please select the statement that is most descriptive of your clients' beliefs:

- ○ One's personal identity is distinct from others
- ○ One's personal identity is dependent upon others

Please select the statement that is most descriptive of your clients' beliefs:

- ○ I am focused on personal achievement, material success, and the importance of status
- ○ I am focused on quality of life, taking care of those less fortunate, and ensuring leisure time

Please select the statement that is most descriptive of your clients' beliefs:

- ○ I need predictability and structure, in the form of written and unwritten rules
- ○ I accept uncertainty is normal and each day is taken as it comes

Please select the statement that is most descriptive of your clients' beliefs:

- ○ I and society focus on perseverance as the world is always changing.
- ○ I and society focus on tradition and fulfilling social obligations.

Please select the statement that is most descriptive of your clients' beliefs:

- ○ I have a positive attitude; I can act as I please.
- ○ My gratification is dependent on social norms; leisure time is of lesser importance.

What year did you **begin** your professional training in CBT?

_____

What year did you **complete** your professional training in CBT?

What training certification have you achieved in CBT? (Select all that apply)

- ☐ Primary (1)
- ☐ Advanced (2)
- ☐ Associate (3)
- ☐ Supervisory (4)
- ☐ Children, Adolescents, and Family (5)
- ☐ Addictions (6)

Please indicate how you were trained in each of the following theoretical orientations. (Select all that apply)

	Primary orientation of university training program (1)	Taught in university training program (not primary orientation) (2)	< 7 workshop hours (3)	7-35 workshop hours (4)	> 35 workshop hours (5)	Planned university-based internship supervision (6)	Planned post-graduate training/supervision (7)
Cognitive (1)	☐	☐	☐	☐	☐	☐	☐
Cognitive-behavioral (2)	☐	☐	☐	☐	☐	☐	☐
REBT (3)	☐	☐	☐	☐	☐	☐	☐
Behavioral (4)	☐	☐	☐	☐	☐	☐	☐
Psychodynamic (5)	☐	☐	☐	☐	☐	☐	☐
Humanistic (6)	☐	☐	☐	☐	☐	☐	☐

Gestalt (7)	☐	☐	☐	☐	☐	☐	☐
Existential (8)	☐	☐	☐	☐	☐	☐	☐
Systemic (9)	☐	☐	☐	☐	☐	☐	☐
Interpersonal (10)	☐	☐	☐	☐	☐	☐	☐
Dialectical-behavioral (11)	☐	☐	☐	☐	☐	☐	☐
Acceptance and Commitment (12)	☐	☐	☐	☐	☐	☐	☐
Mindfulness (13)	☐	☐	☐	☐	☐	☐	☐
Other (please specify) (14)	☐	☐	☐	☐	☐	☐	☐

Age

_____

Gender

○ Male (1)

○ Female (2)

APPENDIX C

CT Adaptation Questionnaire

Below we have listed a number of techniques that are core to the practice of Cognitive Therapy. We would like you to rate the frequency with which you engage in the following Cognitive Therapy techniques, and the degree to which you have had to modify each of these techniques as a function of culture. We recognize the fact that very often we will modify techniques for individual clients. Rather, we are asking to what degree as a whole have you found you need to do this.

1. Domain: Set an Agenda with Adherence. For the purposes of this survey, setting an agenda is defined as the therapist and patient jointly establishing the patient's presenting issues, and involves the setting of discrete and realistic targets collaboratively.

Use: Rate the frequency with which you engage in this Cognitive Therapy technique.

- Never
- Rarely
- Occasionally
- Often
- Always

Adaptation: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

2. Domain: Provide Client with Feedback. For the purposes of this survey, providing a client with feedback is defined as helping to focus the patient on the main therapeutic issues, and assist in reducing vague issues to manageable units to ensure the therapist and patient have a shared understanding of the problems and concerns, and is usually done in the form of general summary or chunking of important units of information.

Use: Rate the frequency with which you engage in this Cognitive Therapy technique.

- Never
- Rarely
- Occasionally
- Often
- Always

Adaptation: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable

- I do not modify
- I slightly modify
- I considerably modify

3. Domain: Work Collaboratively with the Client. For the purposes of this survey, collaboration with the client is defined as having clear evidence of productive teamwork, with the therapist skillfully encouraging the patient to participate fully and take responsibility.

Use: Rate the frequency with which you engage in this Cognitive Therapy technique.

- Never
- Rarely
- Occasionally
- Often
- Always

Adaptation: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

4. Domain: Efficient Pacing and Use of Time. For the purposes of this survey, pacing and efficient use of time are defined as the therapist making optimal use of the time in relation to the agenda, and maintaining sufficient control to limit the discussion of peripheral issues, interrupt unproductive discussion, and to pace the session appropriately to the patient's needs.

Use: Rate the frequency with which you engage in this Cognitive Therapy technique.

- Never
- Rarely
- Occasionally
- Often
- Always

Adaptation: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

5. Domain: Interpersonal Effectiveness. For the purposes of this survey, interpersonal effectiveness is defined as the patient being put at ease by the therapist's verbal and non-

verbal behavior, such that the therapist should communicate that they are genuine, sincere, and open, and act in a manner that is not patronizing or condescending. The patient should feel that the core conditions such as warmth, genuineness, empathy, and understanding are present.

Use: Rate the frequency with which you engage in this Cognitive Therapy technique.

- Never
- Rarely
- Occasionally
- Often
- Always

Adaptation: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

6. Domain: Elicit the Appropriate Emotional Expression. For the purposes of this survey, eliciting appropriate emotional expression is defined as the ability of the therapist to deal effectively with the emotional content of the therapy session, such as the ability to increase or decrease the emotional atmosphere of a session through both their verbal and non-verbal behavior, and use the patient's emotions to promote therapeutic change.

Use: Rate the frequency with which you engage in this Cognitive Therapy technique.

- Never
- Rarely
- Occasionally
- Often
- Always

Adaptation: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

7. Domain: Elicit Key Cognitions. For the purposes of this survey, eliciting key cognitions is defined as helping the patient to gain access to their cognitions and to understand the relationship between their cognitions and their distressing thoughts through various methods of thought monitoring such as thought eliciting diaries, and downward narrowing techniques.

Use: Rate the frequency with which you engage in this Cognitive Therapy technique.

- Never
- Rarely
- Occasionally
- Often
- Always

Adaptation: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

8. Domain: Elicit Behaviors. For the purposes of this survey, eliciting behaviors is defined as helping the patient to gain insight into the effect of their behaviors such as withdrawal, avoidance, compulsions and various types of safety seeking behaviors, with respect to the problem which can be done through the use of questioning, diaries, and monitoring procedures.

Use: Rate the frequency with which you engage in this Cognitive Therapy technique.

- Never
- Rarely
- Occasionally
- Often
- Always

Adaptation: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

9. Domain: Use of Guided Discovery. For the purposes of this survey, guided discovery is defined as a form of presentation and questioning which assists the patient in gaining new perspectives for themselves without the use of debate or lecturing to increase their understanding through a questioning style that promotes discovery, exploration of concepts, synthesizing ideas, and developing hypotheses regarding the patient's problems and experiences.

Use: Rate the frequency with which you engage in this Cognitive Therapy technique.

- Never
- Rarely
- Occasionally

- Often
- Always

Adaptation: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

10. Domain: Conceptual Integration. For the purposes of this survey, conceptual integration is defined as helping the patient to gain an understanding of the cognitive rationale of their disorder, its underlying and maintaining features, and relevant triggers. The conceptualization process involves initially socializing the patient to the therapeutic rational, and establishing links between thoughts, feeling, and behavior. The patient needs to develop an appropriate understanding of the problem, and acknowledge what needs to be changed and the most appropriate strategies for change.

Use: Rate the frequency with which you engage in this Cognitive Therapy technique.

- Never
- Rarely
- Occasionally
- Often
- Always

Adaptation: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

11. Domain: Application of Change Methods. For the purposes of this survey, application of change methods is defined as the therapist helping the patient devise appropriate cognitive methods to evaluate the key cognitions associated with distressing emotions, leading to major new perspectives and shifts in emotion. The therapist helps the patient to identify potential difficulties and think through the cognitive rationale for performing the tasks.

Use: Rate the frequency with which you engage in this Cognitive Therapy technique.

- Never
- Rarely
- Occasionally
- Often
- Always

Adaptation: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

12. Domain: Homework Setting. For the purposes of this survey, homework setting is defined as negotiating an appropriate task for the stage of therapy in line with the conceptualization to ensure the patient understands the rationale for undertaking the task, to test out ideas, try new experiences, predict and deal with potential obstacles, and experiment with new ways of responding. Homework setting ensures that the content of the therapy session is both relevant to, and integrated with the patient's environment.

Use: Rate the frequency with which you engage in this Cognitive Therapy technique

- Never
- Rarely
- Occasionally
- Often
- Always

Adaptation: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

13. Briefly describe the areas in your practice of Cognitive Therapy that you had to modify in consideration of language and culture and how you modified it.

_____
_____
_____
_____
_____

APPENDIX D

CBT Adaptation Questionnaire

Below we have listed a number of techniques that are core to the practice of Cognitive Behavioral Therapy (CBT). We would like you to rate the frequency with which you engage in the following Cognitive Behavioral Therapy techniques, and the degree to which you have had to modify each of these techniques as a function of culture. We recognize the fact that very often we will modify techniques for individual clients. Rather, we are asking to what degree as a whole have you found you need to do this.

Domain 1: Agenda Setting: Agenda Setting refers to planning and setting an appropriate agenda, not adhering to it.
1. ITEM: Suitable Items. For the purposes of this survey, Suitable items are defined as helping the patient identify and prioritize specific, relevant, and appropriate agenda items.
USE: Rate the frequency with which you engage in this CBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

2. ITEM: Feasible Agenda. For the purposes of this survey, Feasible Agenda is defined as the ability to set an agenda which is realistic and feasible given the time available.
USE: Rate the frequency with which you engage in this CBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

Domain 2: FORMULATION: An initial formulation is typically developed as part of the assessment process. However, a formulation should not simply precede treatment, but should evolve throughout therapy as further clinical information arises and recurrent patterns and theme emerges.

3. ITEM: Coherent and Dynamic Formulation. For the purposes of this survey, Coherent and Dynamic Formulation is defined as the ability to develop a clear formulation which draws upon appropriate evidence-based theory to offer a concise, comprehensive, and personalized explanation of relevant history, triggers, and maintaining features of the patient's problems.

USE: Rate the frequency with which you engage in this CBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

Domain 3: **CBT INTERVENTIONS: The selection and application of cognitive and/or behavioral interventions designed to promote therapeutic change by targeting cognitions, behaviors or emotions likely to be maintaining the patient's problems. A range of CBT interventions can be used to promote change. These include, but are not limited to, cognitive restructuring, exposure/response prevention, addressing safety behaviors, imagery re-scripting, examining pros and cons, thought records, activity monitoring/scheduling, behavioral experiments, role play, graded task assignment, problem solving, assertiveness or other skills training, behavior modification.**

4. ITEM: Appropriate Intervention Targets. For the purposes of this survey, Appropriate Intervention Targets is defined as skillfully defining, clarifying and specifying intervention targets which both relevant evidence-based theory and the patient's idiosyncratic formulation suggests are likely to be maintaining problems.

USE: Rate the frequency with which you engage in this CBT technique:

- Never
- Rarely
- Occasionally
- Often

- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

5. ITEM: Choosing Suitable Interventions. For the purposes of this survey, Choosing Suitable Interventions is defined as selecting cognitive-behavioral interventions which form part of a logical, coherent, and unified treatment strategy which is likely to bring about therapeutic change in the treatment target(S) and is suited to the patient's therapeutic context. This selection is guided by appropriate theory-based practice of practice based on evidence when possible.

USE: Rate the frequency with which you engage in this CBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

6. ITEM: Rationale for Interventions. For the purposes of this survey, facilitating the patient's understanding of the importance and potential benefits of interventions.
USE: Rate the frequency with which you engage in this CBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

7. ITEM: Implementing Interventions. For the purposes of this survey, Implementing Interventions is defined as systematically implementing intervention(s) in a fluent and articular manner. To be sensitive and responsive to the therapeutic context and provide optimal levels of support, encourage and praise.
USE: Rate the frequency with which you engage in this CBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

8. ITEM: Reviewing Interventions. For the purposes of this survey, Reviewing Interventions is defined as conducting a comprehensive review of the results of interventions (whether positive or negative) in order to help the patient identify what they learned from experience.
USE: Rate the frequency with which you engage in this CBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

Domain 4: HOMEWORK:
9. ITEM: Reviewing Homework. For the purposes of this survey, Reviewing Homework is defined as conducting a comprehensive review of previous homework (whether completed or not) in order to help the patient identify what they learned from the experience.

USE: Rate the frequency with which you engage in this CBT technique:

- Never

- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

10. ITEM: Choosing Suitable Homework. For the purposes of this survey, Choosing Suitable Homework is defined as planning homework which is tailored to the therapeutic context and builds upon session material or previous homework.
USE: Rate the frequency with which you engage in this CBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

11. ITEM: Rationale for Homework. For the purposes of this survey, Rationale for Homework is defined as facilitating the patient's understanding of the importance and potential benefits of homework.
USE: Rate the frequency with which you engage in this CBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

12. ITEM: Planning Homework. For the purposes of this survey, Planning Homework is defined as working with the patient to ensure they have a clear and detailed understanding of the homework task(s).
USE: Rate the frequency with which you engage in this CBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

Domain 5: Assessing Change: A range of methods can usefully be employed to assess change, these include standardized questionnaires and/or informal idiosyncratic measures (e.g. diaries, frequency counts, ratings of duration of event or experience, self-ratings of emotions and cognitions etc.). These methods should be employed across treatment to measure change in symptoms and movement towards goals over the course of treatment as a whole as well as within treatment sessions to measure the impact of cognitive-behavioral interventions completed within session and for homework (e.g. belief ratings pre/post intervention).
13. ITEM: Choosing Suitable Measures. For the purposes of this survey, Choosing Suitable Measures is defined as selecting appropriate, clinically relevant standardized and/or idiosyncratic methods for change in symptoms and associated features (beliefs, behaviors, feelings) and movement towards goals.
USE: Rate the frequency with which you engage in this CBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

14. ITEM: Implementing Measures. For the purposes of this survey, Implementing Measures is defined as administering measures at suitable time points across and within session and to skillfully review, interpret and respond to the information gleaned.
USE: Rate the frequency with which you engage in this CBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

Domain 6: Effective Use of Time
15. ITEM: Pace. For the purposes of this survey, Pace is defined as pacing the session in a manner which is well suited to the therapeutic context and patient's capacity for learning.
USE: Rate the frequency with which you engage in this CBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

16. ITEM: Time Management. For the purposes of this survey, Time Management is defined as managing time within the session in a balanced and efficient manner.
USE: Rate the frequency with which you engage in this CBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

17. ITEM: Maintained Focus. For the purposes of this survey, Maintained Focus is defined as maintaining focus on important issues, while demonstrating appropriate flexibility in response to unanticipated issues.
USE: Rate the frequency with which you engage in this CBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

Domain 7: Fostering Therapeutic Relationship
18. ITEM: Interpersonal Style. For the purposes of this survey, Interpersonal Style is defined as embodying a positive therapeutic style (e.g sincerity, genuineness, honesty, optimism, professionalism, encouragement, etc.) which is congruent with the patient's current needs based upon presenting problems, history, stage of treatment, etc.
USE: Rate the frequency with which you engage in this CBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

19. ITEM: Empathetic Understanding. For the purposes of this survey, Empathetic Understanding is defined as accurately grasping the content and emotional tone of the

patient's viewpoint (i.e. their understanding of themselves and the world around them) and to sensitively and appropriately convey this understanding.
USE: Rate the frequency with which you engage in this CBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

20. ITEM: Collaboration. For the purposes of this survey, Collaboration is defined as encouraging the patient to take an active role in and to share responsibility for all aspects of the session in a manner suited to the stage of therapy and patient's presentation.
USE: Rate the frequency with which you engage in this CBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

Domain 8: Effective Two-way Communication
21. ITEM: Patient Feedback. For the purposes of this survey, Patient Feedback is defined as explicating, exploring, and responding to feedback about the patient's understanding of and reaction to all aspects of the session.
USE: Rate the frequency with which you engage in this CBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

22. ITEM: Reflective Summaries. For the purposes of this survey, Reflective Summaries is defined as working with the patient to reflect upon and summarize salient session content in order to facilitate joint understanding of crucial therapeutic material and consolidate key learning.
USE: Rate the frequency with which you engage in this CBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

23. Please briefly describe how you modify techniques of Cognitive Behavior Therapy as a function of culture.

_____
_____
_____
_____
_____

APPENDIX E

REBT Adaptation Questionnaire

Below we have listed a number of techniques that are core to the practice of REBT. We would like you to rate the frequency with which you engage in the following REBT techniques, and the degree to which you have had to modify each of these techniques as a function of culture. We recognize the fact that very often we will modify techniques for individual clients. Rather, we are asking to what degree as a whole have you found you need to do this.

1. Item: Ask for a Problem
For the purposes of this survey, asking for a target problem is defined as encouraging the client to disclose what problem he would like to work on first. Typically, choice of problem is deferred to the client. This might involve the client's most serious problem, or simply what they choose to address first.

USE: Rate the frequency with which you engage in this REBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

2. Item: Define and Agree Upon the Target Problem. For the purposes of this survey, defining and agreeing upon a target problem is defined as encouraging the client to disclose the problem they would like to discuss and work on first, and working with the client to distinguish between an emotional and practical problem, and convincing the client to focus on the emotional problem first.

USE: Rate the frequency with which you engage in this REBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

3. Item: Agree on a Goal with Respect to the Problem For the purposes of this survey, agreeing on a goal with respect to the problem is defined as the therapist and client working together to create an achievable, positively stated goal for the client to work on with respect to their problem. The goal could be broad but the therapist should ensure that it is within the client's power to achieve the goal and that it is designed to resolve the emotional and behavioral problem.

USE: Rate the frequency with which you engage in this REBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

4. Item: Ask for a specific example of the target problem.
For the purposes of this survey, asking for a specific example of the target problem is defined as assessing the problem in the ABC structure by being as specific as possible.

USE: Rate the frequency with which you engage in this REBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

5. Item: Work on Identifying a Specific A Each Session When Warranted For the purposes of this survey, identifying a specific A is defined as assessing the activating event which can be a thought, an inference, an image, a sensation, a behavior or an emotion as well as an actual event that triggered the client's irrational beliefs.

USE: Rate the frequency with which you engage in this REBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

6. Item: Assess the Activating Event (A)
For the purposes of this survey, assessing the activating event is defined as establishing with clarity and specificity an actual event and identifying the most relevant parts of the A. The therapist explains this process and why, ensuring the client understands these points and the techniques used to obtain the information.

USE: Rate the frequency with which you engage in this REBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

7. Item: Agree Upon A Goal with Respect to the Problem as Assessed
For the purposes of this study, agreeing upon a goal with respect to the problem as assessed is defined as re-negotiating with the client the goal of therapy, based upon the problem-as-assessed, rather than the problem-as-defined.

USE: Rate the frequency with which you engage in this REBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

8. Item: Help the Client to see the Link between the problem-as-defined goal and the problem-as-assessed goal.

For the purposes of this study, helping the client to see the link between the problem-as-defined goal and the problem-as-assessed goal is to encourage and support the client to see the link between the two goals, in order to assist client in understanding the aims of the therapeutic process.

USE: Rate the frequency with which you engage in this REBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

9. Item: Identify and Assess any Meta-Problems

For the purposes of this survey, identifying and assessing the presence of meta-problems is defined as assessing the client's problems about the original problem (i.e. a client feeling ashamed about feeling anxious, or feeling guilty about feeling depressed).

USE: Rate the frequency with which you engage in this REBT technique:

- Never
- Rarely
- Occasionally
- Often

- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

10. Item: Teach the Belief-Consequence (B-C) Connection

For the purposes of this survey, teaching the B-C connection is defined as helping the client understand that their emotional problem (C) is largely determined by their beliefs (B) rather than the activating event.

USE: Rate the frequency with which you engage in this REBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

11. Item: Assess the IB

For the purposes of the present study, assessing the iB is defined as distinguishing between inferences that will occur at A and the iBs, assess both the demand and the derivative form of the iB, and distinguish between absolute "should" and other "shoulds". Demands and derivates include awfulising, low frustration tolerance/frustration intolerance, and self/other/conditions that the client is holding about the problematic situation.

USE: Rate the frequency with which you engage in this REBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

12. Item: Connect the irrational belief and C
For the purposes of this survey, connecting the irrational belief and C is defined as ensuring the client understands the connection between the irrational beliefs and disturbed emotions at point C, before proceeding to disputing these beliefs.

USE: Rate the frequency with which you engage in this REBT technique:
- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.
- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

13. Item: Teach the Rational Beliefs
For the purposes of the present study, teaching the rational beliefs is defined as helping the client to establish a set of alternative, rational beliefs via collaboration with the client. This can be achieved in a Socratic manner, where the therapist guides the client to identify healthier ways to think about their adversity, or if this is not possible, didactic methods can be used where the therapist proposes alternative healthy beliefs to the client.

USE: Rate the frequency with which you engage in this REBT technique:
- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.
- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

14. Item: Question IB and RB
For the purposes of this survey, questioning both the IB and RB is defined as challenging the IB and RBs underlying the specific problem at hand, and eventually to a broader beliefs or philosophies held by the client philosophy. To do so, a therapist will use disputation strategies(questioning a belief based on logic, in terms of empirical support, and/or in terms of pragmatic outcomes) while utilizing questioning styles which include didactic or teaching style, socratic style, metaphorical style, and humorous style.

USE: Rate the frequency with which you engage in this REBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

15. Item: Use of Logical Disputation
For the purposes of this survey, logical disputation is defined as weakening the client's endorsement of irrational beliefs by pointing out their faulty logic, helping the client see why their irrational beliefs are illogical.

USE: Rate the frequency with which you engage in this REBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

16. Item: Use of Empirical Disputation
For the purposes of this survey, empirical disputation is defined as weakening the client's endorsement of an irrational belief by showing the client that their irrational belief is

inconsistent with empirical reality by questioning the validity and empirical evidence of the client's belief.

USE: Rate the frequency with which you engage in this REBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

17. Item: Use of Pragmatic Disputation

For the purposes of this survey, pragmatic disputation is defined as weakening a client's endorsement of an irrational belief by focusing on the pragmatic consequences of holding the belief in question, to show the client that as long as they hold onto the irrational belief, they are going to incur a number of negative emotional and behavioral consequences.

USE: Rate the frequency with which you engage in this REBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

18. Item: Logical, Empirical, and Pragmatic Questioning of the RB

For the purposes of this survey, Logical, Empirical, and Pragmatic Questioning of the RB is defined as utilizing the questioning strategies to evaluate the RB. In doing so, the client's endorsement of an iB becomes weaker as they have at alternative belief that is empirically valid, logically sound, and has fewer of the negative emotional and behavioral consequences.

USE: Rate the frequency with which you engage in this REBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

19. Item: Preparing the Client to Deepen Their Conviction in the Rational Belief (RB) For the purposes of this survey, preparing the client to deepen their conviction in the rational belief (RB) is defined as addressing the issues of intellectual and emotional insight. Through using a variety of cognitive, emotional, and behavioral techniques the therapist points out why a weak conviction in rational beliefs is insufficient to promote change, deals with the "head vs. gut" issue, and outlines for the client what may be realistically involved in achieving emotional and behavioral change.

USE: Rate the frequency with which you engage in this REBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

20. Item: Check the Validity of A

For the purposes of this survey, checking the validity of A is defined as asking the client questions to determine their evaluation of the A for truth, and identifying what data needs to be gathered to check the validity of the inferences.

USE: Rate the frequency with which you engage in this REBT technique:

- Never
- Rarely
- Occasionally

- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

21. Item: Negotiate a Homework Assignment For the purposes of this survey, negotiating a homework assignment is defined as collaboratively developing tasks with the client to practice the new ways of thinking about a situation which may involve cognitive assignments, imagery assignments, or behavioral assignments, and in the later stages of therapy, should focus on challenging the irrational belief or strengthening the new rational belief.

USE: Rate the frequency with which you engage in this REBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

22. Item: Check the Homework Assignment
For the purposes of this survey, checking the homework assignment is defined as reviewing previous assigned homework in the next session, correcting any errors, and positively reinforcing the client for actively working on their problems.

USE: Rate the frequency with which you engage in this REBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

23. Item: Facilitate the Working Through Process:
For the purposes of this survey, facilitating the working through process is defined as prompting the client to question and change his irrational beliefs repeatedly and forcibly in relevant contexts at A, in order to strengthen conviction of rB and weaken conviction of iB.

USE: Rate the frequency with which you engage in this REBT technique:
- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.
- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

24. Item: Encourage the Client to Become His/Her own Therapist
For the purposes of this experiment, encouraging the client to become his/her own therapist is defined as helping the client to internalize the rational emotive behavioral problem-solving method. The client should learn to identify troublesome emotions and behaviors, to relate these to activating events, to identify core irrational beliefs, question these beliefs, and to develop plausible rational alternatives to these beliefs.

USE: Rate the frequency with which you engage in this REBT technique:
- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.
- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

25. Item: Establishing an Appropriate Bond with the Client
For the purposes of this study, establishing an appropriate bond with the client is defined as having an interpersonal connectedness between the therapist and the client in the service of therapeutic endeavor and maintaining this over time.

USE: Rate the frequency with which you engage in this REBT technique:

- Never
- Rarely
- Occasionally
- Often
- Always

ADAPTATION: Rate the degree to which you have had to modify this technique as a function of culture.

- I do not use this, culturally unacceptable
- I do not modify
- I slightly modify
- I considerably modify

Briefly describe the areas in your practice of REBT that you have had to modify in consideration of culture and language and how you modified it.

_____
_____
_____
_____
_____

APPENDIX F

Professional Psychological and Mental Health Organizations

Academia De Terapia Racional Emotivo Conductual De Grupo Creare Guatemala
Afghan Psychological Association
Afghanistan National Psychiatrists Association
Albert Ellis Institute
American Group Psychotherapy Association
American Psychological Association
American Psychological Association: International Psychology
Arab Union of Psychological Science
Arbeitsgemeinschaft für Verhaltensmodifikation e.v. (Germany)
Argentinean Association of Behavioral Science
ASEAN Regional Union of Psychological Societies (ARUPS)
Asian Cognitive Behavioral Therapy Association
Asian Psychological Association (APsyA)
Association des psychologues du Sénégal
Association for Behavioral and Cognitive Therapies
Association for Behaviour Modification in Austria (AVM)
Association for Cognitive and behavioral therapies
Association for Psychological Science
Association for Psychological Science
Association for the Advancement of Psychological Science
Association for the Study, Modification and Therapy of Behaviour in Belgium
Association of Child Psychiatrists & Psychologists
Association of German Professional Psychologists
Association of Greek Psychologists
Association of Psychologist in Nepal
Association of the Psychologists of French Guiana
Association of the Psychologists of Guadeloupe
Association of the Psychologists of Martinique
Australian Association for Cognitive and Behavioral Therapies
Australian Institute for RET: An Affiliated Training Center of Albert Ellis Institute
Austrian Association for Cognitive and Behaviour Therapy
Austrian Psychological Society
Azerbaijan Psychological Association
Bahamas Psychological Association
Beck Institute
Belgian Association for Psychological Sciences
Belgian Federation of Psychologists
Bermuda Psychological Association
Brazilian Society of Psychology
British Association for Behavioural and Cognitive Psychotherapy
British Psychoanalytic Association
Buddhist Based CBT

Bulgarian Psychological Society
Cambodian Psychology Society
Canadian Counselling and Psychotherapy Association
Canadian Psychological Association
Caribbean Alliance of National Psychological Associations (CANPA)
CBT and Mental Health Support Group
CBT California
CBT in Brussels
CBT-REBT therapists
Central Swedish Local Association
Centro de Psicología Cognitivo Conductual de Monterrey, (CPCCM)
Centro de Terapia Cognitivo Conductual
Centro de Terapia Cognitivo Conductual en Durango
Centro IPPC de Psicoterapia Cognitiva y TREC
CETREC
Chilean Society for Scientific Psychology
Chinese Psychological Society
Cognitive Behavioral Therapy (CBT)
Cognitive Behavioral Therapy (CBT)
Cognitive Therapy Special Interest Group
Cognitive Therapy Special Interest Group
College of Romanian Psychologists
Collegium of Chilean Psychologists
Colombian Association of Psychology
Colombian College of Psychologists
Colombian Society of Psychology
Council of International Schools
Counselling & Psychotherapy in Scotland
Croatian Association for Behavioral-Cognitive Therapies
Croatian Psychological Chamber
Croatian Psychological Society
Cuban Society of Health Psychology
Cuban Society of Psychology
Cyprus Psychologists Association
Czech Society for Cognitive Behavioral Therapy
Czech-Moravian Psychological Society
Danish Association of Behavioural and Cognitive Therapy
Danish Psychological Association
David Clark, Univeristy of New Brunswick (IACP leadership)
Deutsches Institut für Rational-Emotive & Kognitive Verhaltenstherapie (DIREKT e.V.)
Dipartimento REBT Studi Cognitivi – Cognitive Psychotherapy School
Dominica Psychological Society
Dominican College of Psychologists
Ecuadorian Association of Psychologists
Egyptian Association for Psychological Studies
El Salvador Psychological Association

Emirates Psychological Association
Estonian Association for Cognitive Behaviour Therapy
Ethiopian Psychologists' Association
European Association for Behavioural and Cognitive Therapies
European Community Psychology Association (ECPA)
European Federation of Psychologists Associations
European Network for Social and Emotional Competence
European Psychology Learning and Teaching
European Society for Cognitive Psychology (ESCoP)
Federation of French Psychologists
Federation of Psychologist of Argentine Republic (FePRA)
Federation of Psychologists of Argentina
Federation of Swiss Psychologists
Finish Association for Behavioral Analysis and Cognitive Behavioral Therapy
Finnish Association for Cognitive and Behavior Therapy
Finnish Psychological Association
Finnish Psychological Society
Flemish Association of Behaviour Therapy
French Association of Behaviour and Cognitive Therapy
French Psychological Society
Georgian Psychological Society
German Association for Behavior Therapy Modification
German Psychological Association
Grenadian Psychological Association
Guatemala College of Psychologists
Guatemalan Psychological Association
Guyana Psychological Association
Haitian Association of Psychology
Hellenic Behavior Research Society
Hellenic Psychological Society
Hellenic Society for Cognitive and Behavioral Psychotherapy (EEGSD)
Hong Kong Psychological Society
Hungarian Association for Behavioural and Cognitive Therapies
Hungarian Psychological Association
Icelandic Psychological Society
In Vivo – Mumbai Centre for RECBT
Indian Association of Clinical Psychologists
Indonesian Psychology Association
Institut fuer Kognitives Management, Stuttgart
Institut RET
Instituto Albert Ellis de Colombia
Instituto de Terapia Cognitivo Conductual en México
Instituto de Terapia Racional Emotiva, Lima, Peru
Instituut voor RET en CGT
International Association for Cognitive Psychotherapy
International Association for Counseling

International Association for Group Psychotherapy and Group Processes
International Association of Applied Psychology
International Association of Counselors & Therapists
International Association of Therapists
International Council of Psychologists
International Network of Integrative Mental Health, Inc. (INIMH)
International Positive Psychology Association (IPPA)
International Psychoanalytical Association (IPA)
International Psychotherapy Institute
International School Counselor Association
International School Psychology Association (ISPA)
International School Psychology Association (ISPA)
International Union of Psychological Science
Iranian Psychological Association
Irish Association for Counselling and Psychotherapy
Israel Psychological Association
Israeli Center for REBT
Isreal Association of CBT
Istituto A.T.Beck
Italian Association for Behavioural Analysis, Modification and Behavioural and Cognitive Therapies
Italian Association of Psychology
Italian Psychological Society
Japanese Psychological Association
Jordanian Psychological Association
Kenya Psychological Association
Korean Psychological Association
Kosovo Association of Psychology
Latin American Association of Analysis, Behavior Modification, and Cognitive Behavioral Therapy
Lebanese Psychological Association
Lebanon (Lebanese Society for Cognitive and Behaviour Therapy)
Lithuanian Psychological Association
Malaysian Society of Clinical Psychology
Malta Chamber of Psychologists
Malta Union of Professional Psychologists
Mexican Psychological Association
Mongolian Psychologists Association
Morphic Minds
National Academy of Psychology/ Indian Psychological Association
National Association for Research and Graduate Studies in Psychology
National Council of the Order of Psychologists
National Syndicate of Psychologists
Nepalese Psychological Association
Netherlands Institute of Psychologists
Network of Professional Social Workers

New York Association of School Psychologists
New Zealand Psychological Society
Northern Local Association; Sweden; Local Org of Swedish Association for Cognitive and Behavioral therapy
Norwegian Psychological Association
Order of Portuguese Psychologists
Organization of Psychologists of San Marino
Pakistan Psychological Society
Panamanian Association of Psychologists
Pancyprian Society of Psychologists
Paraguayan Society of Psychology
Polish Association for Cognitive and Behavioural Therapy
Polish Psychological Association
Portugese Association of Psychology
Portuguese Psychological Society
Professional Association of Austrian Psychologists
Professional Association of Liechtenstein Psychologists
Professional Association of Psychologists of Costa Rica
Psicotrec – Centro de Terapia Cognitiva y Terapia Racional Emotiva
Psycho-Pedagogical Association of Vietnam
Psychological Association of Barbados
Psychological Association of Namibia
Psychological Association of the Philippines
Psychological Society of Ireland
Psychological Society of South Africa
Psychologist and Clinical Psychology
Psychologists' Association of Peru
Psychology and Counseling Organization of I.R. Iran
Psychology Association of Zambia
Psychotherapy: Cognitive Behavioral Therapy within an Integrative approach
Psycologist CAPA Seville
Puerto Rico Psychological Association
Pyschology UK
Rasyonel Emotif Bilissel Davranissal Araştırma Danismanlik Merkezi Ltd.
REBT Affiliated Training Center of Albert Ellis Institute
Romanian Center for Cognitive & REBT
Russian Psychological Society
Said no psychologist ever
Saudi Educational and Psychological Association
School psych to school psych
School Psychology Interns
School Social Workers and Mental Health Providers
Self Align: An Affiliated Training Center of Albert Ellis Institute
Sensorium – Centro Especializado en Psicología
Serbian Psychological Society
Shangai International Mental Health Association

Sierra Leone Psychologist Association
Singapore Psychological Society
Slovakian Chamber of Psychologists
Slovenian Association of Behaviour and Cognitive Therapies
Slovenian Psychologists' Association
Social Workers Life
Sociedad Interamericana de Psicología
Société Suisse de Thérapie Comportementale et Cognitive (Switzerland)
South Swedish local association; Swiss Association for Cognitive Psychotherapy
Spanish Psychological Association
Surinamese Association of Psychologists and Special Educators
Swedish Association for Cognitive and Behavioural Therapies
Swedish Association of Behaviour Therapy
Swedish Psychological Association
Swiss Association for Cognitive Psychotherapy
Swiss Psychological Society
The American Academy of Cognitive and Behavioral Psychology
The Asian Association of Social Psychology (AASP)
The Australian Psychological Society LTD
The British Psychological Society
The Centre for REBT University of Birmingham
The International Society for the Psychological Treatments of the Schizophrenias and Other Psychoses
The Jamaica Psychological Society
The Norwegian Association for Cognitive Therapy
The Psychologists - an Association of Psychologists
The Slovak Psychological Society
Transcultural Psychosocial Organization
Trinidad and Tobago Association of Psychologists
Turkish Psychological Association
Ukrainian Psychological Society
Union of Estonian Psychologists
Union of International Associations
United Association of Italian Psychologists
Uruguay Psychological Society
Venezuelan Federation of Psychologists
West Swedish local association; Swiss Association for Cognitive Psychotherapy
Yemeni Psychological Association
Zanzibar Psychological Counseling Association
Zimbabwe Psychological Association

APPENDIX G

Universities Contacted for Recruitment

Aalborg University
Aarhus University
Akdeniz Üniversitesi
Alexandru Ioan Cuza University
American University of Central Asia
Amity University, Gwalior
Anglia Ruskin University
Ankara UNiv
Annamalai university
Ariel University
Aristotle University of Thessaloniki
Ashoka University
Auckland University of Technology
Australian College of Applied Psychology
Autonomous University of San Luis Potosí
Babeş-Bolyai University
Bahçeşehir University
Banaras Hindu University
Bangor University
Bar-Ilan University
Baskent University
Belarusian State Pedagogical University. Maxima Tanka
Belarusian State University
Ben-Gurion University of the Negev
Birkbeck Univeristy of London
Bishkek State University
Bjørknes College
Bogazici University
Bournemouth University
British Univ in Egypt
Brunel University
Burapha University
Canterbury Christ Church University
Carleton University
Catholic University of Mocambique
Catholic University of the Sacred Heart
Central China Normal University
Charles Sturt University
Christ University, Bengaluru.
Chulalongkorn University
CITY College, International Faculty of the University of Sheffield
Colorado State University Pueblo

Comrat State University
Concordia University
Coventry University
Cyprus International Univ.
Dalhousie University
Deakin University
Devi Ahilya Vishwavidyalaya, Indore
Dresden University of Technology
Edge Hill University
Eduardo Mondlane University
Ege University
Erasmus University College Brussels
Erasmus University Rotterdam
Europe University Cyprus
Federal University of Rio Grande do Sul (UFRGS)
Ferdowsi University Mashhad
Flinders University
Frederick University
Free International University of Moldova
Freie Univ. in Berlin
Gazi University
Ghent Univ
Goldsmiths University of London
Great Zimbabwe University
Griffith University
Häme University of Applied Sciences HAMK
HELP University
Hosei University.
Hyperion University.
IBERO: Ibeoamerican University
IDC Herzliya
IESB:Centro Universitario
Imam Abdulrahman Bin Faisal University
Immanuel Kant BFU, FGOU
innsbruk University
International University of Health and Welfare
Iscte - University Institute of Lisbon
Istanbul Bilgi University
J. F. Oberlin University
Jackson State University.
Jamia Milia Islamia, New Delhi.
Jönköping University
Karel de Grote University College
Kazan Federal University
Keio University
King Abdulaziz University

Koç University
KU Leuven
Kuban State University
Kyoto Notre Dame University
Kyrgyz-Turkish Manas University
Kyunghee University
La Trobe University
Lancaster University
Leiden University
Linnaeus University
Liverpool John Moores University
LMU Munich
Lomonosov Moscow State University
London Met. University
Lunds university
Madras Christian College
Mahatma Gandhi Univ- Kerala
Mangalore University
Manipal College of Health Professions
Massey Univ
Mcgill University
McMaster University
Mediterranean College
Meiji Gakuin Univ
Memorial University of Newfoundland
Metanoia Institute
MF Norwegian School of Theology, Religion and Society
Michoacan University of San Nicolás de Hidalgo
Middle East Technical University
Midlands State University
Monash University
Moscow Pedagogical State University
MSH Medical School Hamburg
Murdoch University
Nanjing Normal University
National University of Entre Ríos
National University of Ireland Galway
Neapolis Univ. Pafos
NIMS University
Northumbria University
Oslo and Akershus University College
Østfold University College
Oxford Brookes University
Paris Descartes Univ
Patna University
Peoples' Friendship University of Russia

Princess Noura bint Abdulrahman University
PUC:Pontifical Catholic University of Rio de Janeiro
PXL University College
Queen Maud's College of Early Childhood Education
Queen's University Belfast
Queen’s University
Radboud University
Regents University -London
Reykjavík University
Rikkyo University
RMIT University
Royal Global University
Royal Holloway Uni of London
Ruhr University Bochum
Saint Petersburg State University
Sapienza University of Rome
School of Social Work, Odense – University College, Little Belt
Seoul National University
Shahid Beheshti University
Shiraz University
Slavonic Univ
SNDT Women's University
Sonora University
Sophia University
South Federal University
Southern Cross University
Srinivas University
St. Xavier’s College
State Pedagogical University ”Ion Creanga”
State Univ. Of Moldova
SWPS University of Social Sciences and Humanities
Taibah University
Tata Institute of Social Sciences
Teesside University
Tel Aviv University
Thammasat University
The American College of Greece
The American University in Cairo
The Cairnmillar Institute
The Chinese University of Hong Kong,
The Hebrew University of Jerusalem
The International University of Kyrgyzstan
The Technological Educational Institute of Crete
The University of Adelaide
The University of Applied Sciences Campus Vienna
The University of Edinburgh

The University of Melbourne
The University of Notre Dame Australia
The University of Syndey
The University of the West Indies-St. Augustine
The University of Tromsø
The Wright Institute
Tiraspol State University
Titu Maiorescu University
Tokai University
Tokyo Metropolitan University
Tomsk State University
Transilvania University
UCLouvain
UCSI University- Kuala Lumpur
UiT Norges Arctic university in Narvik
Ulm University
UNESP: São Paulo State University - International
Unisinos Brazilian Jesuit University
Univ of Bergen
Univ of Delhi
Univ of Iceland
Univ of Iowa
Univ of Nantes
Univ of Patras
Univ of social welfare and rehab.
Univ of Strasbourg
Univ. of Namibia
Univeridad Catolica de Salta
Univeristiy of Alberta
Universatario de Universato Rosario
Universidad Autonoma de Nuevo Leon
Universidad Autónoma de Yucatán UADY
Universidad de Buenos Ares
Universidad del Norte Santo Tomás de Aquino
Universidad Nacional de La Plata
Universidad Nacional de Rosario
Universidad Nacional de San Luis
Universidad Pontificia Bolivariana - Medellin
Universidade de Brasilia
Universidade Do Estado De Mina Gerais
Universitat Autònoma de Barcelona.
Universitat de Barcelona
Universität Duisburg, Federal Republic of Germany
Universiti Kebangsaan Malaysia
Universiti Sains Malaysia
University College Copenhagen

University College Cork
University of Lausanne
University of Aberdeen
University of Adam Mickiewicz in Poznań
University of Agder
University of Akron
University of Akureyri
University of Antwerp
University of Babylon
University of Basel
University of Bath
University of Bergamo
University of Birmingham
University of Bologna
University of Botswana
University of British Columbia
University of Buchares
University of Calcutta
University of Calgary
University of Calicut.
University of Cantebury
University of Catania
University of Central Arkansas
University of Chester
University of Coimbra
University of Constanța-Ovidius”
University of Cyprus
University of East Angelia
University of East London
University of Essex
University of Fernando Pessoa
University of Florence
University of Fribourg
University of Gävle
University of Gdańsk
University of Gothenburg
University of Granada
University of Groningen
University of Haifa
University of Hokkaido
University of Hull
University of Illinois at Urbana-Champaign
University of Kufa
University of L'Aquila
University of la sabana
University of Lille

University of Limerick
University of Lusofona
University of Madrid-Autonoma
University of Manitoba
University of Milan
University of Minho
University of Mosul
University of New Brunswick
University of Nicosia
University of Ottawa
University of Padua
University of Paris
University of Pavia
University of Pisa
University of Porto
University of Portsmouth
University of Queensland
University of Regina
University of Reims Champagne Ardenne
University of Rhode Island
University of Roehampton- London
University of Salzburg
University of Sao Paulo
University of Saskatchewan
University of Savoy Mont Blanc - Chambery
University of Southern Caribbean
University of Southern Queensland
University of Stavanger
University of Sterling
University of Stockholm
University of Suceava
University of Tasmania
University of Tehran
University of the Republic of San Marino
University of the Sunshine Coast Thompson Institute
University of the Virgin Islands
University of Toronto
University of Trieste
University of Tsukuba
University of Turin
University of Turku
University of Valencia
University of Warmia and Mazury in Olsztyn
University of West Attica
University of Western Australia
University of Windsor

University of Wollongong
University of Wrocław
University of Zimbabwe
University of Zurich
University of the West Indies: Mona Jamiaca
Uppsala University
Ural Federal University
Üsküdar University
Utrecht University
Veracruz Univ.
VIA university college
Victoria Univ of Wellington
Victoria University
Vitebsk State University
Vrije Universiteit Brussel
Webster University Leiden
Webster Vienna Private University
West University of Timisoara
Western Norway Univ of Applied Sciences
Western Sydney University
Wilfrid Laurier University
Yanka Kupala State University.
Yeditepe University
York University
Zurich University of Applied Sciences

APPENDIX H

Journals Contacted for Recruitment

Behavior Therapy
Child & Family Behavior Therapy
Cognitive and Behavioral Practice
Cognitive Behavioral Therapy
Cognitive Therapy and Research
International Journal of Cognitive Therapy
Journal of Behavioral and Cognitive Therapy
Journal of Cognitive Psychotherapy
Journal of Rational Emotive and Cognitive Behavioral Therapy

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