Guidelines for the implementation of culturally sensitive CBT among refugees and in global contexts
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Guidelines for the implementation of culturally sensitive cognitive behavioural therapy among refugees and in global contexts

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In this article, we suggest guidelines that should be followed in order to create a culturally sensitive cognitive behavioural therapy among refugees and in global contexts more generally, so as to maximise efficacy and effectiveness. These guidelines can be followed to design culturally sensitive cognitive behavioural therapy studies, or what might be called 'contextually sensitive cognitive behavioural therapy', among refugees or other cultural groups in a given global location, and the guidelines can be used to evaluate such studies. Some examples of these guidelines are culturally appropriate framing of cognitive behavioural therapy techniques, assessing and addressing key local complaints (e.g. somatic symptoms, spirit possession and syndromes such as 'thinking a lot') and catastrophic cognitions about those complaints, and incorporating into treatment key local sources of recovery and resilience.

Keywords: cognitive behavioural therapy, global health, refugees

Introduction

Studies indicate the potential efficacy of cognitive behavioural therapy (CBT) among refugees and in global contexts (e.g. Bass et al., 2013; Drozdek, Kamperman, Tol, Knipscheer, & Kleber, 2014; Murray et al., 2014). This article suggests ways to make the next wave of CBT treatments among refugees and within global locations more sensitive to cultural context. A recent article advocated that a checklist be used for all studies published in journals to assure their cultural sensitivity (Lewis-Fernández et al., 2013). Here we suggest a kind of checklist that can be used to evaluate the cultural sensitivity (or what might also be called 'contextual sensitivity') of a CBT intervention among refugees or other cultural groups in a given global location. Many of these parameters have guided our treatment development and the global health research agenda more generally (Hinton, Chhean, Pich, Safren, Hofmann, & Pollack 2005; Hinton, Hofmann, Pollack, & Otto, 2009; Hinton, Hofmann, Rivera, Otto, & Pollack, 2011a; Hinton, Pham, Tran, Safren, Otto, & Pollack, 2004; Hinton, Rivera, Hofmann, Barlow, & Otto, 2012b; Patel, 2012; van Ginneken et al., 2013).

Guidelines for the implementation of culturally sensitive CBT

In Figure 1, we give an overview of the parameters and a subgrouping of those parameters that should be assessed in determining the cultural sensitivity of a treatment.

Background information

Identify the cultural group Identifying the exact cultural group is important because it will influence many of the parameters below, such as a group's history of trauma, stigma in the group about mental illness, catastrophic cognitions about symptoms and religious based techniques that may be included in treatment. Moreover, determining the exact cultural group that a study involves gives insights into generalisability. Moreover, in

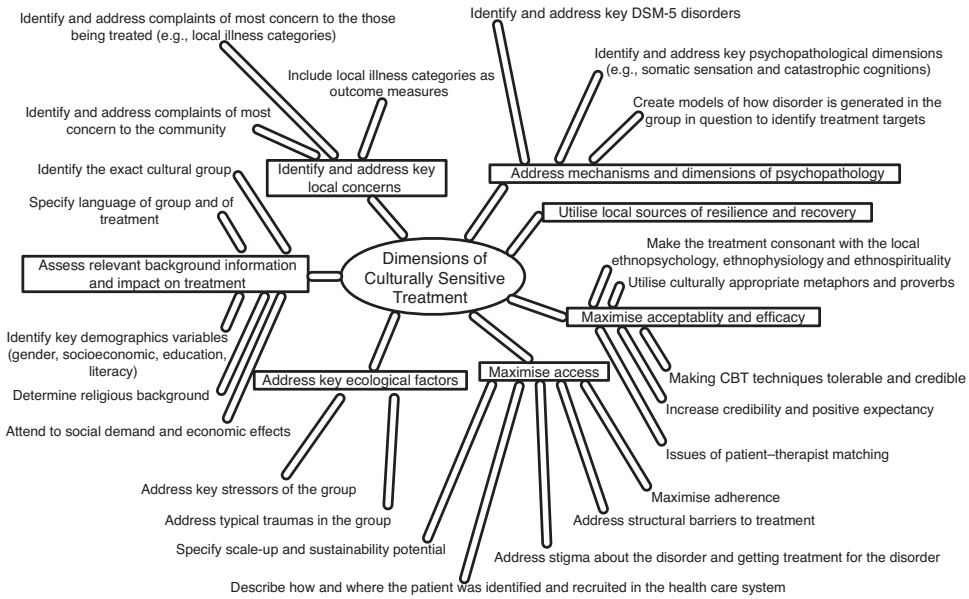

Figure 1: Key parameters for evaluating the degree of culturally sensitivity of a treatment. DSM-5, Diagnostic and Statistical Manual of Mental Disorders, 5th Edition.

outcome studies, it allows a determination of the cultural heterogeneity of a sample and makes possible some balancing of treatment arms. However, often treatment studies simply state that the participants are from a certain country without discussing the cultural group or whether all or some of the participants are from a minority or an ethnic group. As an example, Latinos may be Caribbean Latino (e.g. from Puerto Rico or the Dominican Republic), Central American, Peruvian, or Mexican, among other localities, with each of these groups having different social and cultural histories, further, within those countries there are large minority groups (e.g. Quechua in Peru). Or, for another example, many Burmese are members of Karen or other hill tribe groups, groups that are culturally distinct from the majority of Burmese. Likewise, a person identified as Iraqi could belong to an Arabic, Kurdish, Turkmenian or Assyrian cultural group, and could be Muslim (Sunni, Shia, Alevi), Yezidi, Zoroastrian, Christian or Jewish, with each of these groups falling under the general category of Iraqi, and in some cases belonging to the same religious denomination (e.g. Sunni Islam), and may have very different cultural customs. For example, although Arabs and Kurds are both Iraqis and Sunni Muslims, their cultural customs differ.

Specify the language of the group and language of treatment The languages that the participants speak should be specified and whether the treatment was conducted in the preferred or a secondary language, and whether a translator was used. Degree of fluency of the client in the language in which therapy was conducted needs to be described. For example, in many countries, there are multiple languages spoken but a single national language, with variable fluency in the national language. For example, in Iraq, while Arabic is the national language, in major parts of Northern Iraq Arabic is not spoken, but rather Kurdish and Turkman.

Identify key demographic variables In addition to gender, the treatment population should be characterised in terms of key demographic variables such as socio-economic

status (SES), education and literacy level. It is important to know these variables so as to evaluate the generalisability of a particular intervention. For example, the level of education and literacy will determine whether written handouts can be used. Similarly, DVDs may not be well accepted among some members of lower SES who do not commonly use them. As an alternative to written handouts and DVDs, it may be necessary to draw easy-to-understand diagrams and figures. SES may indicate adherence to traditional culture and religion, a measure of acculturation. In addition, variables such as SES may indicate current levels of stress, which may influence the ability to tolerate and benefit from therapy: exposure may be contraindicated (Lester, Resick, Young-Xu, & Artz, 2010; see also the section below, 'Identify and address key stressors').

Detail the religious background of the group and its impact on treatment One should characterise the group in question in respect to religious background. Is the group mainly Buddhist, Christian, Muslim or another religion, and what is the distribution in the group? Which type of Buddhism (e.g. Theravandan or Zen), Christianity (e.g. Pentecostal or Catholic) or Islam (e.g. Sunni or Shia)? Furthermore, the way religion is practised and the level of religiosity may differ, even within the same subbranch of a religion. The way Sunni Islam is practiced in Saudi Arabia (where adherents often have a *salafi* orientation of Islam) may differ in some respects from the way Sunni Islam is practiced in, say, Egypt or Morocco; for instance, gender interactions outside marriage and one's immediate family may be more restricted in the former population. Religious hybridity should also be taken into account: Christianity among the Sepedi tribe of South Africa is an amalgamation of traditional Christianity and local beliefs in ancestral spirits, evil curses and black magic.

As is discussed in a section below, ideally local religious leaders should first be consulted to determine their understanding of the types of distress in the population, what religious and other treatments they think should occur and how they think western type interventions might be successfully conducted. Religious or spiritual beliefs may provide sources of resilience or constitute obstacles to care. In some Islamic cultures, it may be necessary to match therapist and client in respect to gender as a way of adapting treatment to religious beliefs (Murray et al., 2014). The local religion may provide ways to frame treatment to make it more acceptable. In our treatment, we incorporate local healing traditions to increase efficacy and treatment acceptability and positive expectancy; see the section 'Utilise local sources of resilience and recovery'.

Attend to social demand characteristics, economic incentives and economic effects In a given context, social demand and financial aspects of the study may affect the results both at the level of the therapist and patient: participants may feel pressure to report positive outcome. Identifying SES is important in terms of determining the effect of compensation for participation in treatments. In lower SES groups, if compensation is provided, this may serve as a primary motivator for the patient to complete the study. Consequently, it is difficult to determine the level of acceptability of the given treatment in the culture at hand. Likewise, general well-being may be enhanced by receiving compensation, which in effect would make the outcome data difficult to interpret. It is also a model that cannot be used at the scale-up stage owing to economic limitations.

Key ecological factors to address

identify and address key stressors It has been shown that worry may be a key generator of distress in traumatised populations and other populations (Hinton & Lewis-Fernández, 2011; Hinton, Nickerson, & Bryant, 2011b). From a public health standpoint, when applying CBT in global contexts, it is

important to be aware of local problems that may be addressed for the entire group: security concerns, refugee status, and access to water (Bolton, Michalopoulos, Ahmed, Murray, & Bass, 2013; Hinton & Hinton, in press). Ideally, this may be addressed at the community level as a public health intervention. Also, one should specify whether the participant has an advocate who can help address key practical problems such as the equivalent of a social worker. The CBT may need to address practical problems as part of treatment, a kind of behavioural activation and didactics in coping (Nezu, Nezu, & Lombardo, 2004).

Identify and address typical traumas in the group The traumas that a group being treated has experienced and is experiencing should be identified and addressed. The group in question may have endured mass violence of some kind, may be fleeing from a genocide or civil war or may be experiencing high rates of sexual violence. When providing education about CBT, these traumas can be specifically described and addressed. Identifying traumas is also crucially important from a public health standpoint: it may be found that sexual violence or domestic violence is endemic in a certain context. This has important implications in respect to treatment and public health interventions: the therapist should be careful to query specifically about a history of the trauma such as domestic violence, should be sensitive to its possible presence and should be aware of what local resources are available for someone so impacted.

Identify and address key local concerns

Identify and address complaints of most concern to those being treated In a cultural context, certain symptoms will be of great concern; for example, among many Cambodian refugees, these may include sleep paralysis, dizziness, poor sleep and panic attacks (Hinton, Kredlow, Pich, Bui, & Hofmann, 2013a). The key local complaints may be cultural syndromes. For example, Cambodians frequently attribute anxiety symptoms to 'heart weakness' and 'wind attacks' (*khyâl* attacks), and these attributions produce multiple catastrophic cognitions. Especially in some African contexts, possession fears are prevalent in traumatised populations, with posttraumatic stress disorder (PTSD) and arousal symptoms sometimes being attributed to possession, and so a particular social and cultural course created (de Jong & Reis, 2010, 2013). As described below, framing treatment as addressing these key complaints greatly increases CBT acceptability and adherence. Also, as described above, failure to assess and treat key concerns such as somatic symptoms, possession and cultural syndromes would be a case of *category truncation*. See the following section for further discussion of the assessment issue.

Include local illness categories as outcome measures More generally, we have suggested that all outcome studies in cross-cultural settings should include a list of locally salient, somatic complaints, catastrophic cognitions and cultural syndromes, which we have called 'Symptom and Syndrome Inventories', for example, a 'Cambodian Symptom and Syndrome Inventory', or C-SSI (Hinton, Hinton, Eng, & Choung, 2012a; Hinton et al., 2013a). Or also, in a treatment of a Latino group, we showed that *ataques de nervios* improved across treatment (Hinton et al., 2011a) and so too, in a Cambodian population, orthostatic dizziness (Hinton et al., 2009). Given that these local illness categories indicate the patient's explanatory model of the disorders in question, and given the importance of explanatory models in treatment, this makes the assessment all the more important (Benish, Quintana, & Wampold, 2011; Hinton, Lewis-Fernández, Kirmayer, & Weiss, in press). These are the experience-near categories and will be highly related to self-perceived wellbeing. In addition, as a therapeutic intervention, the patient can be told that all the items in the assessment battery, including

the culturally salient categories of distress, should improve in treatment. As indicated above, we have used culturally sensitive measures in our treatment and found them to improve across treatment (Hinton et al., 2011a; 2012a; 2013a). Asking the patients about these locally salient distress forms and whether they have improved across treatment is a key part of culturally sensitive treatment.

Identify and address complaints of most concern to the community One should ask local leaders about which behavioural and symptomatic issues are of key concern, asking specifically about violence, substance abuse and suicidality in the community. If the treatment is then framed as addressing these issues, it will reduce stigma about the ailment and mobilise the community. (Local leaders may include political, religious, and informal and formal health providers, as well as heads of local advocacy groups.) For example, once it is understood what social and psychological mechanisms generate the problem, then the focus is on resolution rather than on blaming the victim or using other forms of nonproductive labelling. It provides an alternative framing.

Address mechanism and dimensions of psychopathology

Identify and address key DSM[1] disorders In some groups such as traumatised refugees, certain disorders such as PTSD and panic disorder may be particularly elevated (Hinton & Lewis-Fernández, 2011); for example, among Cambodian refugees, other than PTSD, there are extremely high rates of panic attacks and panic disorder. Each group may have a unique profile of DSM disorders. The profile of disorders will inform treatment and the design and implementation of modules. For example, if panic attacks are common in a locality, then panic attacks should be assessed and also addressed in modules.

As indicated in several places in this article, the DSM has limitations as a diagnostic system, and so just addressing DSM disorders is not ideal, leaving out key treatment targets. For one, the DSM often does not assess key areas of concern, such as somatic complaints in the case of PTSD. Second, it is a categorical approach that minimises dimensional assessment. And third, the experience-near categories according to which disorder is locally understood are usually not DSM categories, but other local categories such as *khyâl* attacks among Cambodian populations and 'thinking a lot' among many cultural groups; see below. These non-DSM constructs should also be identified and addressed (see below).

Identify and address key psychopathological dimensions Other than DSM disorders, it is important to identify key psychopathological dimensions in a group, such as pathological worry (rather than a Generalized Anxiety Disorder), catastrophic cognitions, somatic symptoms, panic attacks, anger, substance abuse or suicidality (Hinton et al., 2011b; Morris & Cuthbert, 2012). This analytic approach is in keeping with the call to use dimensional analysis to identify treatment targets (Casey, Craddock, Cuthbert, Hyman, Lee, & Ressler, 2013). Let us further highlight the importance of identifying addressing somatic sensations and catastrophic cognitions among refugee and global populations in a culturally sensitive manner.

It has been found that somatic symptoms are prominent in many nonwestern populations (de Jong, Komproe, Spinazzola, van der Kolk, & van Ommeren, 2005; Hinton & Good, 2009; Hinton & Lewis-Fernández, 2011). Ideally, one should identify key somatic concerns in a population so that these may be addressed in CBT. This can be considered as the assessment of a psychopathological dimension, namely, somatic complaints, but with the aim of assessing key somatic complaints, in order to avoid an *abstraction error*, that is, the error of only considering

somatic symptoms in general without assessing key symptoms of concern; for example, Cambodians often present with somatic complaints, but with dizziness and headache being particularly important complaints. (An abstraction error is also not considering the local meaning of the complaint, such as the interpretation of a certain somatic symptoms in terms of the local ethnopsychology and ethnophysiology.) Not assessing key somatic symptoms is also an example of category truncation (Hinton & Good, in press) in respect to assessing local distress, as is not assessing other key concerns such as catastrophic cognitions. For example, among trauma survivors, not only '*PTSD*' but also these other complaints—somatic symptoms and catastrophic cognitions—may be a key part of the presentation.

A standard part of CBT is addressing catastrophic cognitions about symptoms such as those concerning PTSD and somatic symptoms (Hinton et al., 2012b). For example, many Cambodian refugees fear that neck soreness indicates that their neck vessels will burst, and they fear that dizziness on standing indicates the onset of a dangerous *khyâl* attack, or 'wind attack', a surge of *khyâl* and blood upward in the body that may cause various symptoms and disasters (Hinton & Good, in press; Hinton, Pich, Marques, Nickerson, & Pollack, 2010). Or many Cambodians are concerned that worry will overheat the brain and cause permanent forgetfulness. Our recent clinical experience in South Africa with members of the Sepedi tribe of Northern Sotho revealed that catastrophic cognitions about PTSD symptoms and somatic symptoms include belief in ancestral curses and spirits referred to as *amafufunyana* (for possession fears elsewhere in Africa, see de Jong & Reis, 2010, 2013). Among Egyptians, catastrophic cognitions may include concerns that anxiety and somatic symptoms are caused by heart problems (*alby beyrafraf*). Learning the local ethnopsychology, ethnophysiology and ethnospirituality as it applies to symptoms and processes such as 'worry' is a key way of identifying these catastrophic cognitions. In every culture, there will be local ideas about how symptoms of anxiety and depression are generated and treated. The clinician can address the catastrophic cognitions in several ways, such as giving an alternative framing in terms of the harmless biology of anxiety, by teaching to control the symptom by relaxation methods (breath-focused techniques or applied stretching and muscle relaxation) and by interoceptive exposure[2] that teaches the innocuousness of the symptoms.

Create 'etic' and 'emic' models of how disorder is generated in the population in question to identify treatment targets How particular complaints come to be generated should be identified, which have been called causal network models (McNally, 2012). We have described 'etic' and 'emic'[3] causal networks for key symptoms among Cambodian refugees. Cambodians refugees have high rates of somatic complaints and panic attacks. In respect to the 'etic' model, we have determined that panic attacks often began with a somatic symptom caused by a trigger, such as worry or standing up from the sitting or lying position; the somatic symptom often then gave rise to catastrophic cognitions, for example, dizziness resulting in fears of the onset of a dangerous *khyâl* attack, and the somatic symptom often triggered trauma associations, for example, dizziness giving rise to memories of doing slave labour while starving (Hinton & Good, 2009; Hinton, Hofmann, Pitman, Pollack, & Barlow, 2008; Hinton et al., 2010, 2011b). The model is also 'emic' in that it takes into account local ideas about the workings of the body and mind, and thus might be called an etic-emic model. Other than allowing the identification of treatment targets, determining these locally informed transcultural causal models promotes treatment in many ways. For example, data would suggest that eliciting these causal narratives, which will also be shared with patients and which incorporate the local conceptualisations of mind,

body and spirituality, improve positive expectancy, among other effects (Hinton & Lewis-Fernández, 2010); see below for further discussion.

A type of syndrome found in many cultures, 'thinking a lot', can be described by such causal network models (Hinton et al., 2008; Hinton, Reis, & de Jong, in press), providing an important entrée to local ethnopsychology and ethnophysiology. (On 'thinking a lot', see also Bolton, Surkan, Gray, & Desmousseaux, 2012; Kaiser et al., 2014; Patel, Simunyu, & Gwanzura, 1995.) Figure 2 shows how the syndrome of 'thinking too much' is conceptualised among Cambodian refugees. The local 'emic' model postulates distress episodes to involve certain pathological processes: the trigger of an episode, which may be various causes, particularly worry, thoughts about past traumas, rumination on past failures, or pained recall of someone who has died or lives far away; and then this 'thinking too much' may cause poor sleep and weakness, which in turns causes more 'thinking too much', and furthermore 'thinking too much' may cause elevated anger and various serious disturbances of mind and body, like permanent forgetfulness and '*khyâl* attacks'. Figure 2 also shows how Cambodians traditionally treat 'thinking a lot'. This 'emic' model can be conceptualised in terms of the 'etic' model described in the paragraph above. The 'etic' and 'emic' models reveal multiple possible treatment targets and how to discuss symptoms and interventions in a way that will be locally understood. Determining 'emic' models give a central place to local ideas of causation, culturally specific concerns and catastrophic cognitions, and local ideas of ideal treatment allows the researcher/clinician to ground the treatment in the local context and to bridge from current psychological theory to local explanatory models. Thus, for example, assessment of 'thinking a lot' in a locality where it occurs, and investigating the causal network, is an important part of treatment localisation, and we have proposed a questionnaire that can be used to do so (Hinton, Reis, & de Jong, in press).

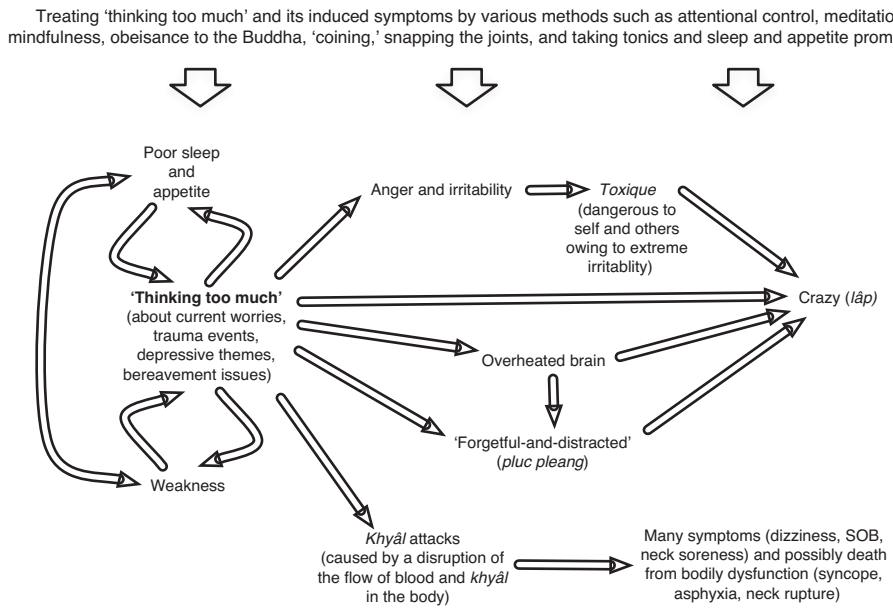

Figure 2: The Cambodian explanatory model of 'thinking a lot'.

Utilise local sources of resilience and recovery

In certain localities, there may be healing traditions such as Buddhist meditation or Islamic spirituality (e.g. *Tazkiyah-tul-nafs*, or 'purification of the soul') that are helpful to patients (Hinton & Kirmayer, 2013). Incorporating these practices into CBT also increases acceptability and positive expectancy. These techniques can inform the CBT treatment itself and its components, and participants may be encouraged to use such methods: for Buddhists, incorporating meditation into the treatment may be useful, and for some Islamic populations, incorporating a type of supplication known as *Dhikr* where God is repeatedly praised, often using various honorific names. In our treatment for traumatised Southeast Asian refugees, we utilise multiple mindfulness techniques (Hinton, Ojserkis, Jalal, Peou, & Hofmann, 2013b; Hinton, Pich, Hofmann, & Otto, 2013c). In our treatment for Islamic populations, we have incorporated traditional healing practices that involve attentional focus and centredness on a positive effect and that are compatible with CBT in those and other respects (Amer & Jalal, 2011). For one, there is *Dhikr*. Second, there numerous supplications recommended by the Islamic Prophet, Muhammad, for the person who is in distress, anxious or overcome by sadness or grief. And third, there are a wide variety of spiritual healing techniques, known as *Ruqyah*, that to a great extent are common to the major Islamic denominations and groups in the Islamic world (e.g. Sunnis and Shias). *Ruqyah* is the Arabic term for traditional Islamic healing practice, which includes recitation of the Quran, the holy book of Islam (often in a trance-like or meditative state), usually of certain Quranic verses thought to promote healing. Other practices of *Ruqyah* have traditionally been to recite Quranic verses over buckets of water that one may drink or bath in, and to apply olive oil (the olive is considered a blessed fruit in Islam) on the entire body, for example before sleep.

Ideally, the treatment intervention can be framed in terms of these local traditions. In some cases, it is useful to end the CBT treatment with local rituals that indicate purification or healing in a general sense, which helps to change self-image and creates a sense of positive expectancy (Hinton et al., 2012b). As an example of this, for an Islamic population, there are *Wudhu* and *Ghusl* (ritualistic washing of face, arms and feet or the entire body), which are types of spiritual purification techniques signifying a transition from spiritual impurity to purity. Or among Southeast Asian populations, this takes the form of various types of steaming rituals. Such rituals help to change self-imagery, which is a key issue in traumatised and other populations, and increase the sense of being transformed, promoting positive expectancy (Agger, Igreja, Kiehle, & Polatin, 2012; Hinton et al., 2012b). (However, the clinician must also be aware that some local healing practices may have negative effects [Dyregrov, Gupta, Gjestad, & Raundalen, 2002; Kohrt, in press].)

Maximise acceptability and efficacy

Below we discuss ways to address treatment acceptability and to improve efficacy. These are closely related because whatever makes the treatment acceptable will usually make it more efficacious.

Make the treatment consonant with the local ethnopsychology, ethnophysiology and ethnospirituality As emphasised throughout this article, one should determine how the psychological distress is locally understood (e.g. in terms of local syndromes and certain key symptoms) and how it is locally thought that treatment should be conducted for the condition (Hinton et al., 2012b; Kohrt, Maharjan, Timsina, & Griffith, 2012; Ventevogel, Jordans, Reis, & de Jong, 2013). Investigating this local understanding of symptoms gives key insights for adaptation in respect to many of the parameters (Figure 1): locally emphasised complaints and sources of resilience and recovery. For

example, among the Cambodian culture, the complaint of 'thinking too much' is commonly described in terms of lack of mindfulness and attentional control, and so we have incorporated mindfulness (e.g. attending to sensorial input in the present moment) in our treatment for that group. A recent review indicated that cultural adaptation of treatment increased effect size and that the key aspect of cultural adaptation was eliciting the patient's explanatory model of disorder (Benish et al., 2011); the cultural adaptation should explain the intervention in a culturally consonant way, which might be called *explanatory model bridging*. Thus, the attempt at bridging, which requires eliciting the patient's explanatory model, is seemingly efficacious on its own for various reasons: the building of empathy and the patient's feeling that the therapist understands his/her concerns, with the therapist ideally addressing catastrophic cognitions about the disorder (Hinton, Lewis-Fernández, et al., in press).

Make CBT techniques tolerable and credible for the cultural group Exposure for trauma may be particularly problematic. It has been found that conducting exposure among ethnic populations presents challenges and may lead to drop-out and worsening (Hinton, 2012). With western populations, even when conducted by a doctoral level therapist, this approach has been found to be problematic (Hinton, 2012). But narrative exposure therapy uses traditional exposure—minimal preparation or modification—and has been shown to be effective in several countries (Morkved et al., 2014). Comparative studies of traditional exposure approaches compared to phase and modified approaches needs to be done with refugees having a range of severity of trauma, of level of current anxiety and of current stressors.

To increase exposure tolerability, a phase approach and other methods have been suggested. Metaphors used to frame treatment may promote acceptance (Hinton et al., 2012b; Hwang, 2006). For example, some researchers have employed analogies to make exposure more tolerable and to create positive expectancy: one group configured imaginal exposure as cleaning a wound and compared fear of exposure to the fear local women initially have of making bread on an open fire, a fear that diminishes over time (Murray et al., 2014). In our treatment, to increase tolerability and efficacy, we use the distress resulting from exposure as an opportunity to teach emotion-regulation techniques (Hinton et al., 2012b), with these emotion-regulation techniques informed by the local culture. To increase tolerability of interoceptive exposure, we frame the techniques as a 'game' and try to create positive associations to somatic sensations; for example, during head rolling, evoking the joy experienced by a child while rolling down a hill and also feeling dizziness.

Utilise culturally appropriate metaphors and proverbs This increases acceptability and positive expectation, and it helps in the retention of taught information. These metaphors may be taken from the religious tradition. For example, in Cambodian Buddhism, anger is compared to a dangerous fire, which one should not bring into the house, and there is the proverb, '*Not getting angry once results in a hundred days of happiness*' (Nickerson & Hinton, 2011). These sorts of analogies and proverbs can be used in treatment. Likewise, anger is highly discouraged in the Islamic tradition. For example, it is told that the Prophet of Islam, Muhammad, advised, '*The strong man is not the one who can throw another down. The strong man is the one who can keep hold of himself when he is angry*' and '*Anger is from Satan, and Satan was created from fire. Fire is extinguished by water, so if one of you gets angry, he/she should perform Wudhu*' (ritualistic washing of face, arms and feet; i.e. to cool down). We would consider these uses of metaphor and proverb as other examples of explanatory model bridging—of bridging between the clinician's and patient's view of disorder. This might be called metaphor- and proverb-type bridging.

Identify issues of therapist–client matching This is particularly important in respect to gender. For example, in some traditional cultures, such as in some Islamic cultures, the therapist should ideally be of the same gender as the patient, to reduce social uneasiness (Murray et al., 2014). If gender matching cannot be achieved, a third person should be present during treatment sessions (preferably of the same gender as the patient), to make the patient feel more at ease. In respect to cultural matching, one study (Benish et al., 2011) suggested that explanatory model matching was the key therapeutic element: the therapist's elicitation of the patient's explanatory model and the creation of an explanatory model of treatment acceptable to the patient, which we have referred to as explanatory model bridging.

Increase credibility and positive expectancy This will be achieved by various means such as stating that treatment will help with symptoms of greatest concern, like cultural syndromes and somatic complaints such as dizziness or poor appetite. Showing videos of those who have become better through the treatment may help improve credibility/expectancy; videos of local leaders who advocate treatment and attest to its efficacy may have the same effect. Credibility/expectancy may be enhanced by framing the treatment as incorporating local therapeutic techniques such as meditation in a Buddhist context and *Dhikr* and *Ruqyah* in an Islamic context. Credibility and positive expectancy will arise in large part from the credibility and positive expectancy of key CBT techniques, which can be maximised by appropriate framing. Credibility and expectancy can be built by certain descriptions of the entire treatment, and about specific elements. For example, in our treatment, we compare the treatment to the making of a special local dish that involves multiple culinary steps in order to promote positive expectancy and to teach patience about the time frame of improvement. Multiple studies indicate how positive expectancy increases efficacy (Rutherford & Roose, 2013; Tsai, Ogrodniczuk, Sochting, & Mirmiran, 2014).

Maximise access

Describe how and where the patient was identified and recruited in the health care system

It is important to specify how patients were recruited, such as in a mental health clinic, a primary care setting or other location. This gives insight into the nature of the health care system and gives information about the generalisability to other contexts (Jordans & Tol, 2013).

Address stigma about the disorder and getting treatment for the disorder

One should determine how various psychological disorders are viewed in the treatment locality. The order should be normalised as much as possible. This helps to reduce self-stigma and stigmatisation by others. It may be necessary to educate family members. Videos of patients and community leaders in which they talk about the disorder and the importance of treatment may help. It may be necessary to frame the treatment as addressing locally salient concerns that are not stigmatising, such as poor sleep, nightmares or somatic complaints. It may be that coming to the location of treatment is stigmatising. This may lead to the need to do the treatment in a primary care or other non-stigmatising locality. In this category, one would place various types of social blaming and self-blaming. In some localities, the victim may be blamed (e.g. in the case of rape) and stigmatised. Or also, in many Asian countries, the concept of *karma* (i.e. the idea that what happens to one is a result of past bad actions and so is deserved) can have this effect. So for example, in the case of the karma explanation, various techniques can be used. If the person thinks the current state is due to 'low merit' or past bad actions ('bad *karma*'), ideally cultural means used

to elevate spiritual status can be encouraged: in Buddhism, an act such as meditating or projecting loving kindness are considered merit-making. By doing these activities, the patient regains a sense of agency (there is a transformation of self-image), and the patient engages in a practice that is therapeutic by both local and 'scientific' standards. (Note that addressing stigma is often part of addressing catastrophic cognitions, because the perception of low spiritual power and great vulnerability leads to multiple types of catastrophic cognitions.) This is another example of explanatory model bridging: one uses local explanatory frames to convince the patient to engage in practices that, from the current state of psychological science, are considered to be effective. It should be noted that local models such as that of karma may be used as a justificatory frame for perpetration of violence and need to be addressed at the community level. More generally, stigmatisation of a victim may need to be addressed at such a level, such as through finding group consensus and finding local religious and transnational human rights frames.

Address structural barriers to treatment These include transportation issues, payment issues and the ability to take time off to go to the clinic.

Maximise adherence Whatever increases credibility and expectancy will tend to increase adherence. Also, adherence, such as not dropping out or missing sessions, will relate to various other issues such as stigma about treatment and structural barriers, for example, lack of transportation or inability to take time off from a busy work schedule. A person may attend sessions but not actually do homework or other potentially helpful aspects of a treatment, which is another example of nonadherence. Metaphors that emphasise the need to complete all parts of the treatment, like those in which all elements of the treatment are analogised to all the steps needed to prepare a dish that is highly prized in the culture, may help to increase adherence, and adherence will be increased by anything that decreases stigma, helps to increase credibility/expectancy, or tolerability, or addresses structural barriers.

Specify scale-up and sustainability potential Scale-up and sustainability will be greatly influenced by the level of education required of the service provider, how much time is needed to be trained, whether the treatment can be taught to multiple providers, how many sessions the treatment entails, whether the treatment is based on a group or individual and whether it allows task shifting (Lancet Global Mental Health Group et al., 2007; Patel, 2012). In addition, the scale-up and sustainability potential will be influenced by public health system variables: by whether there is a place in the health care system to situate the treatment, whether the government is willing to incorporate the CBT into standard treatment and whether there is funding available for the programme (Jordans & Tol, 2013).

Conclusions

As reviewed above, recent studies show the potential of CBT among refugees and other groups in various global contexts. We have attempted to outline some key ways of implementing CBT among refugees and in global contexts more generally to make it culturally sensitive so as to maximise efficacy and effectiveness. In studies involving implementation of CBT among refugees and in global contexts, the guidelines outlined this article (see Figure 1) can be used as a sort of checklist of cultural sensitivity. (The parameters are also applicable to studies of ethnic minority populations.) Here we consider culture in a broad sense that includes context, that is, context-sensitive CBT. Elsewhere, we have referred to ignoring parameters such as outlined in this study (Figure 1) as *an error of decontextualisation* (Hinton & Good, in press; Hinton & Hinton, in press). So the current study might also be considered a delineation of parameters of contextually sensitive CBT.

The type of information specified in Figure 1 can be gathered in various ways. It may be through a review of the literature, discussion with community leaders, ethnographic surveys and pilot studies in a population. Also, the treatment itself may involve asking participants about these domains. For example, in our treatment (Hinton et al., 2012b), we specifically ask participants whether they are using any other means to cope with distress, such as local religiously informed techniques, and we use probes to elicit local catastrophic cognitions and key somatic complaints. As one approach to begin to elicit this information, the explanatory module from the cultural formulation could be used to assess the typical presenting complaint of the population in question (Hinton, Lewis-Fernández, et al., in press). As indicated above, we have developed a 'thinking a lot' questionnaire to assess that construct in various cultural contexts, and the questionnaire can also be adapted to assess any complaint (Hinton, Reis, et al., in press). In localities where 'thinking a lot' is common, using the questionnaire is a good way to learn about the local ethnopsychology, ethnophysiology, and current stressors. In summary, the treatment developer can review the parameters presented in this article to further refine treatment at each stage of the treatment's development and to try to address each of the indicated parameters of culturally sensitive treatment. The parameters can also be used to assess the cultural sensitivity of CBT treatments and treatment studies. As we have suggested, in designing a treatment, a good initial starting point is the determination of common presenting key complaints within a community; then the relationship of the complaint to DSM disorders and dimensions of pathology should be determined, and the complaint evaluated in respect to local understanding such as perceived cause, how it disturbs the psychological, physiological and spiritual state and how it is thought to be best treated. Then all the parameters shown in Figure 1 can be progressively assessed and designed.

Certain limitations of the current article, and future research directions, should be noted. The extent to which culturally sensitive CBT as operationalised in this publication improves efficacy needs to be determined. One meta-analytic review (Benish et al., 2011) gave support for increased efficacy with cultural adaptation of treatment elements, in particular, eliciting the patient's explanatory model of the disorder; however, more studies need to be done to see how and why the various parameters of culturally sensitive CBT improve treatment outcome. The current study is based on data mainly from studies in Asian populations (mainly, Southeast Asian), though we also refer to work with other cultural groups: Latinos and certain Middle Eastern groups. Applicability to other cultural groups needs further investigation.

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[1] DSM = *Diagnostic and Statistical Manual of Mental Disorders* Arlington, VA: American Psychiatric Association.

[2] Interoceptive exposure is a cognitive behavioural therapy technique used in the treatment of panic disorder in which the individual is exposed to interoceptive sensations like dizziness to decrease fear of them.

[3] Etic and emic refer to two kinds of viewpoints; etic is the universalistic model and the emic model is that from within the social group, that is, from the perspective of the subject.

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