Culturally Adapting Cognitive Behavioural Therapy for Psychosis for Treatment in Cultures with Different Causal Attributions

By

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Dedication

This paper is dedicated to my wife, Kristen, and my son, Frederik. Completing this paper allows me to continue working to try and make the world a better place for us to grow as a family together. I love you.

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First and foremost, I would like to thank my wife, Kristen, for being the unconditional love and support I have needed to get through this process. You have supported us both through my grad school journey and sacrificed your time, energy, and sleep to take care of our son for the last few months of this process. I will be eternally grateful for all that you do to enable me to achieve my dreams.

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Abstract

This review seeks to gain an understanding on the applicability of culturally adapting cognitive behavioural therapy for psychosis (CBTp) for use in non-Westernized cultures where psychosis is not recognized as a mental illness. The author conducted a methodological analysis, review of the current literature, and discusses ethical considerations of the literature included in this review. Some non-Westernized cultures use causal explanations for psychosis, attributing the symptoms to religious or supernatural causes rather than biological or social ones. This makes the targeting of positive psychotic symptoms, such as delusions and hallucinations, less desirable for these individuals as the positive symptoms have a larger impact on the individual's identity and self-esteem. Reducing symptoms of distress and comorbid symptoms can have a significant impact on the affected individual's quality of life and ability to function. Non-Western cultures generally put more value into social relationships compared to Western cultures. Diagnosed individuals are likely to isolate themselves away from family and social relationships for fear of judgement. Findings from studies done in non-Westernized countries as well as Western countries find that individuals from non-Western cultural backgrounds face stronger stigmatization when compared to individuals with Western cultural backgrounds. Due to stigmatization, individuals from non-Western cultures are more likely to seek mental health treatment from religious and faith healers rather than from mental health professionals. The studies included in this review offer an initial look into the adaptations that can be made to CBTp to make it more acceptable and effective in non-Western cultures. Recommendations include individualizing CBTp interventions, offering family therapy to individuals of non-Western cultural backgrounds, and gaining knowledge of traditional cultural healing practices.

Keywords: *cultural adaptation, psychosis, cognitive behavioural therapy for psychosis, stigmatization, non-western culture, causal explanation, comorbid symptoms of psychosis*

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Culturally Adapting Cognitive Behavioural Therapy for Psychosis for Treatment in Cultures with Different Causal Attributions.

Chapter 1

Background

Mental illness is ubiquitous across cultures but is viewed and interpreted in different ways (Makanjuola et al., 2016). Culture has been defined as 'the set of distinctive spiritual, material, intellectual, and emotional features of society or a social group encompassing art and literature, lifestyles, ways of living together, value systems, traditions and beliefs' (United Nations Educational, Scientific and Cultural Organization [UNESCO] 2002, as cited in Naeem et al., 2019). Culture can influence how mental illness is explained, what impact it can have on the affected individual, and how people perceive and behave towards individuals with mental illness (Mirza et al., 2019). Perceptions about mental health cannot be studied in isolation from their sociocultural context. By examining cross-cultural differences in how mental health is understood, a greater understanding of mental disorders that is culturally sensitive can be developed (Mirza et al., 2019).

Psychosis is a mental illness that is characterized by two main symptoms, hallucinations and delusional beliefs (Mirza et al., 2019). In Western cultures, symptoms such as hallucinations and delusions mark psychosis as a mental illness. In non-Western cultures, these same symptoms are sometimes viewed as caused by supernatural or religious phenomena. For example, in sub-Saharan African cultures it is believed that the root cause of psychosis is supernatural and individuals who exhibit those symptoms are possessed by evil spirits (Makanjuola et al., 2016). South Asians who experience psychosis also use supernatural or spiritual understandings as explanations for their symptoms and combine their treatment with religious rituals such as

visiting faith healers or religious sites (Mirza et al., 2019). These causal beliefs about the nature of psychosis influence an individual's help-seeking behaviours, treatment outcomes, and contribute to the experience of stigma (Mirza et al., 2019).

Stigma

Stigma is a social construct that changes the view of an individual from being 'normal' to discreditable (Makanjuola et al., 2016). Factors that generally occur when an individual is being stigmatized include labeling, stereotyping, separation, status loss, and discrimination (Makanjuola et al., 2016). Individuals with mental health problems, including psychosis, often experience stigma and discrimination from the public (Mirza et al., 2019). Stigma is a barrier to recovery from mental illness and impacts the help-seeking behaviours of those individuals who live with mental illness. Self-stigma occurs when an individual's beliefs about their own identity are replaced by a negative view of themselves influenced by stigmatization (Makanjuola et al., 2016). Self-stigma is also generally associated with low self-esteem, poor coping skills, and for individuals who suffer from psychosis, poor recovery (Makanjuola et al., 2016).

Individuals who are part of cultures that view the symptoms of psychosis as religious gifts from their deities may feel shame or guilt over experiencing negative emotions and outcomes from these symptoms (Makanjuola et al., 2016). These negative emotions are empowered by societal stigma and there can be stigma centered around seeking mental health support for these feelings as well (Lannin et al., 2016). Many non-Western cultures place greater importance on family and relationships when compared to Western cultures, and this means that stigma surrounding mental health concerns can affect individuals to a greater extent (Ahmed et al., 2020).

Cognitive Behavioural Therapy for Psychosis

Cognitive behavioural therapy (CBT) explains that cognitions are central to behavioural, emotional, and physical responses, and that each of these elements are constantly interacting and influencing one another (Jenkinson et al., 2022). CBT involves exploration of core beliefs and unhelpful patterns of thinking and attempts to modify them. Individuals with depressive illness and anxiety usually have beliefs about self, others, and the world that are unhelpful, and these core beliefs, underlying assumptions, and contents of automatic thoughts can vary with culture (Naeem et al., 2019). CBT is an established psychotherapeutic intervention recommended by several national organization such as the National Institute fore Health and Care Excellence [NICE] in the United Kingdom (UK) and the American Psychiatric Association [APA] in the United States (USA) (Naeem et al., 2019). Cognitive behavioural therapy for psychosis (CBTp) is an adaptation of CBT that is tailored for the specific needs of individuals with psychosis (Peters et al., 2015). CBTp is a structured, time-limited psychotherapy designed to treat people with psychotic symptoms and disorders that uses both cognitive and behavioural strategies to address unhelpful thought patterns (Todorovic et al., 2023). Approaches that CBTp takes can vary due to the diverse presentations of psychosis in each individual. The aims of CBTp are to work with the individual to help them understand their psychotic experiences and the possible contributing factors, enhance coping and functioning, learn adaptive strategies for managing emotional distress, identify cognitive processes and behaviours that are maintaining the problem, and consider alternative ways of appraising their experiences that are less distressing (Peters et al., 2015). There is a large body of evidence that demonstrates that CBTp improves a variety of outcomes in individuals with psychotic symptoms and emotional difficulties, leading to it being the recommended treatment within the UK National Institute for Health and Clinical Excellence (NICE), American Patient Outcomes Research Team (PORT), and international guidelines for

psychosis and schizophrenia (Peters et al., 2015). This body of evidence is focused on CBTp trials that have occurred in Westernized countries around the world, while non-Westernized countries have had no CBTp trials as of the writing of this review.

There is evidence to show that CBTp alleviates symptoms of depression that are often comorbid with a psychotic diagnosis and can improve the quality of life of individuals who experience psychosis (Mason et al., 2022). CBT when compared to treatment as usual (TAU) resulted in a small to medium between-group effect size post-treatment and at 24-month follow-up regarding negative symptoms, depression, global functioning, and quality of life in a study done by Muller et al. (2020). Muller et al. (2020) also found that CBT when adapted for early-onset psychosis (EOP) in adolescents had high levels of acceptance, tolerability, feasibility, and safety within the sample. The study concluded that CBT adapted to the needs of the patient presented with an excellent benefit-risk ratio and could be a promising part of treatment for individuals with EOP (Muller et al., 2020).

While CBTp has been shown to be helpful for individuals with a psychotic diagnosis, it is important to note that most of the studies conducted so far have been done in Westernized countries and has not been tested for different cultural backgrounds. When being used for non-Westernized cultures, or cultures with different explanatory models of symptoms of psychosis, adaptation of CBTp interventions would be beneficial. Adapting techniques to suit specific cultures creates culturally based interventions. These interventions are more likely to be acceptable to individuals from the chosen population as they are adapted to use the cultural background of the population to support treatment goals and processes (Fendt-Newlin, Jagannathan, & Webber, 2020). Culturally based interventions require cultural competence to be used appropriately. Areas of cultural competence are outlined by Naeem et al. (2019). These

areas include awareness of cultural issues such as matters related to religion and spirituality, consideration of the capacity and characteristics of the healthcare system, the cultural context of cognitions and (dysfunctional) beliefs, assessment and engagement, and adjustments in therapy techniques. Naeem et al. (2019) defines cultural adaptation of CBT as making adjustments in how therapy is delivered, through the acquisition of awareness, knowledge, and skills related to a given culture, without compromising on the theoretical underpinning of CBT.

Research Problem

Some non-westernized cultures believe that symptoms of psychosis are gifts from religious deities rather than symptoms of a mental illness (Makanjuola et al., 2016). While the affected individual may also view symptoms of psychosis as a gift, the symptoms can still have a profound impact on the individual's quality of life. In this instance, treating the comorbid symptoms of psychosis, such as low self-esteem, depression, and anxiety, could be beneficial for the individual and will help improve their quality of life. By treating the comorbid symptoms that are causing the individual distress rather than attempting to treat the hallucination symptoms directly, buy-in from individuals who view these hallucinations as gifts, could be easier to obtain. While CBTp in its current form does treat comorbid symptoms during treatment, it does so while actively working to treat the positive psychosis symptoms (hallucinations and delusions) at the same time. Adaptation would be necessary to ensure that techniques are not as focused on the positive symptoms and that the main focus is shifted to the comorbid symptoms that are present.

A number of systematic reviews and meta-analyses have concluded that CBT is effective in treating individuals with a psychotic diagnosis (Habib et al., 2015; Muller et al., 2020). The main instrument of change in CBTp is to make changes in the appraisals and behaviour of the affected individual to reduce stress and must be done within the context of a good therapeutic

relationship (Peters et al., 2015). However, most current studies on the efficacy of CBTp have been done by researchers from a Westernized culture on individuals living in a Westernized culture (Habib et al., 2015). There are few studies that examine the efficacy of CBTp on individuals living in a non-Westernized culture, and what adaptations would need to be made for it to be effective. CBT does not always meet the needs of non-Western groups due to pre-existing differences in cultural values, and these differing cultural values between Westernized and non-Westernized cultures could create rifts within any therapeutic relationship attempting to be built and affect the overall outcomes for the affected individual (Naeem et al., 2024). Cultural values need to be considered and adapted for in CBTp treatment for psychosis, and this presents a gap in the current knowledge.

This review seeks to answer the question: Can cognitive behavioural therapy for psychosis be culturally adapted for treatment in cultures with different causal attributions? Adapting treatment options to the culture they will be used in could reduce the stigma that may be associated with receiving treatment and ultimately improve the overall quality of life of many individuals who suffer in those cultures.

Rationale and Justification

CBT is short-term, focused, cost-effective, and evidence based (Naeem et al., 2019). There are more than sixty randomized controlled trials (RCTs) that have examined the efficacy of CBT for patients with schizophrenia and other psychotic disorders. There is also literature describing its use with individuals from other cultural backgrounds (Naeem et al., 2019). As stated, CBT is recommended by national organizations in most high-income countries for a variety of emotional and mental health problems such as NICE in the UK and APA in the USA (Naeem et al., 2019). CBT is currently the most culturally adapted therapy (Naeem et al., 2019).

CBTp is an adaptation of CBT that shares many of the same central tenants but tailored specifically to treating the needs of individuals with a psychotic diagnosis. A collaborative approach such as CBTp can help therapists understand and adapt to the culture of the patient. Change occurs with CBTp by changing appraisals and behaviours to reduce distress within the context of a trusting therapeutic relationship (Peters et al., 2015). Peters et al. (2015) also note that CBTp has received criticism for not targeting symptom reduction of delusions (Peters et al., 2015). While CBTp does treat positive symptoms of psychosis, its focus when used is to reduce symptoms of distress within individuals experiencing symptoms of psychosis. This focus on symptoms of distress would make CBTp a more acceptable treatment option for non-Western cultures that may not view positive psychosis symptoms as mental illness. While CBTp was developed in the West, its application to non-Western cultures has been recommended (Li et al., 2017). The need for CBTp to be adapted lies in the difference between Western and non-Western cultures and the different views that these cultures have towards mental health. Individuals in non-Western cultures attribute the delusions and hallucination symptoms of psychosis to supernatural, magical, or religious phenomenon. These specific symptoms can carry important cultural significance, such as in Bali where becoming a traditional healer requires experiencing an episode of psychosis that resolves without active treatment (Makanjuola et al., 2016). For some in sub-Saharan Africa, the view is that the cause of symptoms of psychosis is supernatural in origin (Makanjuola et al., 2016). In some Asian cultures, physical and mental health problems are grouped together with a tendency to experience psychological symptoms as somatic symptoms (Ahmed et al., 2020). This tendency focuses any healthcare treatment on medicalized help rather than psychological help, with psychological help more often being sought from faith institutions rather than mental health professionals. This leads to delaying psychological

treatment, such as CBTp, and potentially increasing symptom severity (Ahmed et al., 2020). Adapting CBTp by using traditional practices of the target culture to inform interventions could 'de-westernize' treatment and it may be viewed in a different light than the current Westernized medical model. Even when examining different cultures within Westernized nations, those differences in seeking out treatment for mental illness are still present. For example, South Asians in the UK were found to be less likely to engage with mental health services and less likely to complete treatment they do seek out when compared to White British individuals (Ahmed et al., 2020). In researching why these individuals do not engage with mental health services and adapting CBTp practices to acknowledge these cultural barriers, treatment becomes more acceptable to the South Asian population.

Li et al. (2017) lists three key reasons that CBT interventions should be considered for cultural adaptation. One is that the CBT model, framework, and skills can be flexibly applied to a broad range of pre-existing and emerging diagnoses and concerns. Specifically, high-yield cognitive behavioural techniques for psychosis are easily learned and deliver significant symptomatic improvement without a formal course of therapy. Second, these high yield cognitive behavioural techniques can be easily learned by a range of behavioural health professionals, paraprofessionals, and non-professionals, allowing for natural supports to learn CBTp skills and have them be effective. Finally, cognitive behavioural interventions such as CBTp are highly adaptable to different cultural values and circumstances. CBT itself has had its philosophy compared to collectivist cultures such as China, which makes it ideal for adaptation for these cultures (Li et al., 2017).

Psychosis is one of the most negatively viewed mental health problems by the public (Ahmed et al., 2020). These negative perceptions can inhibit help-seeking and recovery by the

affected individuals (Mirza et al., 2019). When examining what treatment options are available to a population, access and availability to treatment, care, and support are mediated by the pre-existing cultural practices and traditions of the population (Fendt-Newlin, Jagannathan, & Webber, 2020). More Westernized sources of mental health knowledge can be embedded with stigma and discrimination in non-Western cultures which prevent individuals from accessing Westernized treatment options. Individuals from these non-Western cultures are more likely to turn to traditional practices that are more culturally acceptable (Fendt-Newlin, Jagannathan, & Webber, 2020). Understanding the cultural values of a population and adapting treatment techniques to better align with those values has been shown to improve engagement with patients from these populations (Li et al., 2017). Treatments that are not culturally sensitive can lead to higher drop-out rates and poorer outcomes (Rathod et al., 2023).

Globalization is leading to a greater number of countries becoming culturally diverse (Naeem et al., 2019). The importance of studying ethnic differences in causal explanations and how they impact access to mental health services is crucial in determining how treatments such as CBTp can be adapted to be more effective and accessible to the individuals who endorse those explanations (Mirza et al., 2019). Westernized countries are becoming home to individuals moving from non-Westernized countries and bringing their cultural values with them. This places a large responsibility on healthcare systems of these countries to provide equitable, culturally responsive, appropriate, and effective treatment to these now diverse populations (Naeem et al., 2019). To provide this level of care, practitioners must work to understand and adapt their services to best serve their patients. Mental health services are especially affected by social, cultural, political, and religious values (Naeem et al., 2019). Therefore, researching and identifying techniques that can be effectively and efficiently adapted to varying cultural values is

crucial to providing a level of care that improves the equity and equality in the healthcare system (Naeem et al., 2019). Adapting CBTp to better provide psychological services to non-Westernized cultures would help to bridge this gap in service and improve the lives of affected individuals in these cultures.

Significance

Adapting CBTp for non-Western cultures would be significant as it would provide a reduction in symptoms of distress to individuals with a psychosis diagnosis that could be seen as acceptable to more traditional members of the culture. The stigmatization of the diagnosed individual could be lessened as interventions would be tailored to reflect and use the cultural values of the population. By making the priority coping strategies, managing emotional distress, and identifying cognitive processes and behaviours that are maintaining the problem, CBTp can help individuals diagnosed with psychosis without specifically targeting hallucinations or delusions that could be viewed as sacred in the individual's culture. These processes of CBTp can be culturally adapted to incorporate traditional practices from the individual's culture, making them more acceptable to the population and increasing acceptability and efficacy. This review helps identify what the literature has found in terms of current adaptations and barriers that have been encountered and gathers them to inform future research.

Theoretical Framework

A primary challenge of implementing effective strategies to minimize the mental health treatment gap for non-Western cultures is creating and adapting interventions that incorporate the social, economic, and cultural environments that they will be used in (Fendt-Newlin, Jagannathan, & Webber, 2020). Access to treatment, care, and support is mediated by pre-existing cultural practices and traditions which can prevent people from accessing treatment due

to embedded stigma and discrimination (Fendt-Newlin, Jagannathan, & Webber, 2020). Promoting traditional practices that improve mental health and well-being when adapting interventions may be seen as more culturally acceptable and enhance the efficacy of the treatment within the target culture.

The theoretical framework utilized in this review is a cultural adaptation framework. The model used by Fendt-Newlin, Jagannathan, & Webber (2020) provides a blueprint to effectively adapt mental health treatments to different cultures. This model requires three phases to determine the best way to create intervention strategies that will be effective for the chosen population. Phase one is to conduct a feasibility study to determine what type of interventions would be effective within the social context and what kinds of adaptations would be necessary to maximize efficacy. Phase two uses the findings from phase one to create a culturally relevant intervention model that meets the needs of the target population. The intervention created in this phase should be evidence based and culturally appropriate (Fendt-Newlin, Jagannathan, & Webber, 2020). Phase three involves running a pilot study of the created intervention with the individuals who will be trained to provide the treatment to the selected population. In their study of this framework, follow-ups were conducted at 3, 6, and 9 months to continue to make adaptations and gather information that could help the model be more easily adapted in other cultures. Movement between phase two and three is normal to improve the efficacy of the treatments being adapted (Fendt-Newlin, Jagannathan, & Webber, 2020).

There is a knowledge gap in applying psychosocial interventions in low-resource settings where the prevalence of mental health conditions is highest and the need for services is greatest (Fendt-Newlin, Jagannathan, & Webber, 2020). This also presents the biggest primary challenge to trying to adapt and develop interventions for these populations, as they must incorporate the

nature of the social, economic, and cultural environment while retaining the basis that made the intervention effective (Fendt-Newlin, Jagannathan, & Webber, 2020). The framework created by Fendt-Newlin, Jagannathan, and Webber (2020) provides a systematic approach that will assist researchers to identify the most relevant intervention components for the targeted population and the capacity they have for service, while also documenting the adaptation process and evaluating the outcomes (Fendt-Newlin, Jagannathan, & Webber, 2020). The framework draws on the strengths of the target community and stakeholders' experience in the field by integrating feedback loops throughout the adaptation process to ensure efficacy.

Researcher's Position

At the time of this research project, I do not work with individuals who experience symptoms of psychosis. Most of my professional experience has been working with a rural North American population, consisting almost exclusively of one specific culture. This keeps me from relying on personal experience of how symptoms may have presented in clients and means that the only information I am bringing into the project is what I have gathered through research. This lack of first-hand information and experience also means that I do not have a practice basis for how effective CBT or CBTp is in working with psychosis and the degree to which it is necessary to adapt it for different cultures. While I do use CBT exercises for treating symptoms of anxiety and depression, the individuals I work with do not exhibit symptoms of psychosis.

In my personal life, I do not know anyone who has experienced symptoms of psychosis. I have seen different forms of media that involve individuals with symptoms of psychosis, such as movies and television. In these media forms, the individual who is showing the symptoms of psychosis is generally portrayed as someone committing acts of violence or cruelty. I have also played a game where the main character experiences symptoms of psychosis, such as hearing

voices and hallucinating. The developers of this game, called Hellblade, brought in psychiatrists to ensure that all of the portrayals of symptoms were authentic to what individuals in real life experience. These portrayals do impact how I view psychosis as a diagnosis as they provide vivid representation of the diagnosis. As they do not show how psychosis is treated from a clinical perspective, they will not impact how I view the clinical treatment of the diagnosis.

Overview of this Review

This review will examine how to provide culturally adapted CBTp to individuals of non-Westernized cultures who experience symptoms of psychosis. An explanation of how the research included in this study was found follows this chapter, elaborating on the search process and what criteria the studies met to be included in the current review. Common themes found throughout the research are explored to answer the research question and any future research done on the subject. How these themes impact practitioners and their ability to provide culturally adapted CBTp is examined. Finally, the writer's recommendations on what topics future research should explore based on the results of the literature review are provided.

Chapter 2: Methodology

This section describes the process used to find studies related to the research question and the process that was used to select the final set of studies**.** Included in this section are the search criteria to find the studies that were selected and the databases used to find these studies. All the studies selected help answer the question of how CBTp can be adapted for individuals of non-western cultures who experience psychosis.

Literature Search Process

Multiple databases were used to gather studies with relevant information to the research topic. These databases were accessed through the City University of Seattle Library and included the National Library of Medicine, ProQuest, and EBSCOhost. When using these databases, it was helpful to make use of the 'similar studies' and 'suggested sources' features. These features helped identify additional studies with similar keywords in addition to those that were already identified. Filters that were applied to all database searches included that the studies be peer-reviewed and having the full study available.

Gathering studies that had general information about CBTp was the first step in the research process. Initial keywords that were used included *CBTp* and *psychosis*. This initial search identified 195 results, with a range of publication dates. As the current review is aimed at using recent data as much as possible, refining this search to include studies only from the last five years reduced the results to 84. Once these initial studies were examined, the writer began to expand the search terms for additional studies. These search terms included: *stigma, medication, delusions, culture, cultural adaptation, and technology*. All these search terms were grouped with either CBTp, psychosis, or both CBTp and psychosis as key phrases to keep the results focused on those specific concepts. The combination of *psychosis* and *culture* were especially

helpful in finding studies that examined the non-western cultures that are included in the current review and their views of psychosis and how it impacts individuals within the culture. These search results had varied total results, and for the search term *culture* the publication timeframe was expanded from five years to ten years to gather enough information.

The inclusion criteria for the current review were that the studies had to reference either CBT, CBTp, or psychosis. All studies were published in 2015 or later, with most of the studies being published in 2020 or later. Studies that were included in this review consisted of original, peer-reviewed research. Studies that dealt with specific trials of treatment had to use CBT or CBTp as the treatment modality. Trials had to be conducted on individuals diagnosed with psychosis and experiencing symptoms of psychosis to be included in this review. Studies that focused on cultural differences in the perception of psychosis did not have to reference CBT as these studies were found specifically for examining the cultural differences and providing information on this topic. Multiple cultures were examined in this review to increase the breadth of research available. Limiting the review to only one culture of focus would narrow the topic too greatly, and examining different cultures where adaptations have been advantageous adds credibility to the reason for research to be done in the future.

Studies that treated psychosis with a treatment modality other than CBT or CBTp were excluded, except for studies that examined cultural adaptation specifically. Studies that were older than 2015 were initially excluded to focus on the most recent data and trials. However, the limited amount of research led to publishing date not being included as an inclusion or exclusion requirement. Studies that were non-peer reviewed or were review articles compiling other research were not included as original research is required in the capstone project.

Evaluation of Significant Studies

Ten studies were chosen to guide the current review. Table 1 is an overview of the ten studies that were chosen for methodological review. The table includes the authors, publication year, title, journal of publication, and research type.

Reference List of Significant Studies Reviewed (Table 1)

Author(s)	Year	Title	Journal	Type
Ahmed et al.	2020	Stigma towards psychosis: Cross-cultural differences in prejudice, stereotypes, and discrimination in white British and south Asians.	*Journal of the Community of Applied Social Psychology*	Quantitative
Habib et al.	2015	Preliminary evaluation of culturally adapted CBT for psychosis (CA-CBTp): Findings from developing culturally-sensitive CBT project.	*Behavioural and Cognitive Psychotherapy*	Qualitative
Li et al.	2017	A qualitative study to explore views of patients, carers, and mental health professionals to inform cultural adaptation of CBTp in China.	*BMC Psychiatry*	Qualitative
Makanjuola et al.	2016	Explanatory model of psychosis: Impact on perception of self-stigma by patients in three sub-saharan African cities.	*Social Psychiatry Psychiatry Epidemiology*	Mixed Method
Mason et al.	2022	Association between depressive symptoms and cognitive-behavioural therapy receipt within a psychosis sample: A cross-sectional study.	*BMJ*	Quantitative
Mirza et al.	2019	Cultural differences in psychosis: The role of causal beliefs and stigma in white British and south Asians.	*Journal of Cross-Cultural Psychology*	Quantitative
Naeem et al.	2024	Culturally adapted cognitive behavior therapy (CaCBT) to improve mental health services for Canadians of south Asian origin: A qualitative study.	*The Canadian Journal of Psychiatry*	Qualitative
Rathod et al.	2023	Results of a qualitative study of patient, carer, and clinician views on the experience of	*The Cognitive Behaviour Therapist*	Qualitative

		caring for individuals with psychosis in Pakistan.		
Sonmez et al.	2020	Cognitive behavior therapy in early psychosis with a focus on depression and low self-esteem: A randomized controlled trial	*Comprehensive Psychiatry*	Mixed Method
Vyas et al.	2021	A qualitative exploration of stigma experiences of second-generation British South-Asian people using an early intervention in psychosis service.	*Psychosis*	Qualitative

Challenges of the Search Process

One of the challenges in the search process was finding primary source studies related to CBTp that would be relevant to the current review. Many of the search results contained review studies that compiled the results of many different studies and were excluded from the current review as they were not original peer reviewed studies.

Limitations of the Methodology

With the methodology of this review, some limitations became clear as sources were being found. One such limitation was that the same group of researchers have done multiple studies examining cultural adaptations of CBT. This effects the generalizability of any findings as the researchers would reference their own research within each study. Another limitation that was encountered was attempting to find relevant research within the last five years. When examining cultural adaptation of CBT and CBTp, there were few studies that have been published in the last five years. When removing a publishing date inclusion requirement, there were more studies that were relevant, but the amount of total research is still limited.

Chapter 3: Literature Review and Findings

This review explores research conducted to culturally adapt CBTp for individuals with a psychotic diagnosis whose culture does not recognize psychosis as a mental illness. The effect that stigma has on individuals with a psychotic diagnosis in non-Western cultures and their decision to explore Westernized treatment methods is examined. Differences in cultural values and knowledge of psychosis as a mental illness between Western and non-Western cultures affects help-seeking behaviours in the populations of each culture. These differences can create barriers to access and availability of treatments such as CBTp. Comorbidities associated with psychosis and how these could be treated using CBTp to help alleviate the distress level of individuals with a psychotic diagnosis will be examined. Ethical considerations for all the studies included in this review are examined. A methodological review of the included studies is also conducted, encompassing paradigms, sampling methods, and data collection strategies.

Stigma in non-Western Cultures

A diagnosis of psychosis in non-Western cultures is heavily stigmatized due to the causal explanations of psychosis as a religious or supernatural phenomenon (Makanjuola et al., 2016). Experiencing symptoms of psychosis can have a negative effect on the individual's social role within their family and society, leading to these cultures having a high prevalence of low self-esteem among individuals who suffer from psychosis (van der Stouwe et al., 2021). CBTp is shown to improve self-esteem and negative symptoms in individuals who experience psychosis (Sonmez et al., 2020). In non-Western cultures, social relationships play a larger role in an individual's values and have more influence over the decision to seek out mental health help (Li et al., 2017). Li et al. (2017) explored views of patients with a psychotic diagnosis, their carers, and mental health professionals living in China for the purpose of informing future cultural

adaptations of CBTp. This study noted that social relationships, specifically ones with family members, have a large impact on acceptance of therapy. Mental health professionals interviewed for this study commented that educating patients about illness was found to be the most useful part of treatment. The researchers noted that caregivers and mental health professionals interviewed in this study did not consider a spiritual or religious cause, but almost all patients shared that they had seen a faith/spiritual healer before attending a psychiatric facility and had spent time and money towards these healers (Li et al., 2017).

Non-Western cultures are more likely to have causal explanations of mental illness compared to Western cultures that focus mostly on the biopsychosocial explanation (Makanjuola et al., 2016). Causal explanations, such as religious or spiritual explanations, can have their own stigmas attached to them and are generally associated with higher stigma and lower help-seeking behaviours (Mirza et al., 2019). Stigma is identified as a major barrier to recovery from mental illness and can impact whether an individual will seek care and what their pathway to care will be (Makanjuola et al., 2016). Individuals with a psychotic diagnosis from a non-Western culture are more likely to avoid 'mainstream' services, with traditional practices more culturally acceptable (Rathod et al., 2023). Makanjuola et al. (2016) investigated explanatory models of psychosis in Africa and how these models impacted self-stigma by conducting interviews with individuals diagnosed with psychosis in three African nations. Self-stigma refers to the negative self-perceptions and demoralization that happen when societal stigma towards mental health and counselling is internalized by the individual and applied to their self-image (Lannin et al., 2016). The study identified the main explanatory models of these African nations to be supernatural and religiomagical, and the individuals that scored higher on the internalized stigma scale administered by the researchers were found to embrace these explanatory models. Individuals

interviewed who identified with the biopsychosocial explanatory model scored low on the internalized stigma scale. These individuals were able to identify biological and emotional causes for their psychosis symptoms, such as genetics, physical illness, and stress. This suggests that these individuals viewed their psychosis diagnosis as a product of their environment. Diagnosed individuals may attempt to hide their mental illness for fear of judgement from their family and community (Naeem et al., 2019). This can create internalized stigma, which can lead to low self-esteem. Low self-esteem in this way can also lead to the development of psychotic symptoms and depressive symptoms as well as higher risk of suicide and a lower overall quality of life (van der Stouwe et al., 2012).

The stigma that individuals of non-Western cultures experience exists when they live in a Westernized country as well. Multiple studies (Ahmed et al., 2019; Mirza et al., 2019; Vyas et al., 2021) examined the experiences of stigma in individuals of South Asian cultural origin living in Westernized countries, specifically Britian. Psychosis is considered one of the most stigmatized and negatively viewed mental health problems in the United Kingdom (UK) (Mirza et al., 2019; Vyas et al., 2021). South Asian populations in the UK are less likely to access mental health services compared to the general population (Mirza et al., 2019). Mirza et al. (2019) reported that South Asians interviewed in their study in the UK endorsed supernatural factors as causes for psychosis more than the interviewed White British individuals. Older generations of South Asians living in the UK are more likely to endorse religious strategies for treatment than younger generations of South Asians (Mirza et al., 2019). Second-generation South-Asians have an increased risk of psychosis developing compared to the majority population of the UK due to social factors including cultural identity, alienation, and racism (Vyas et al., 2021). When comparing South Asians and White British groups, the South Asian group disclosed fewer past or

current health problems, potentially due to fearing judgement by the interviewer or alienation from their community (Mirza et al., 2019). Second-generation South Asians were found to experience more pressure due to the challenge of having a cultural understanding of both their South-Asian and Western selves (Vyas et al., 2021).

Cultural Differences in the Understanding and Acceptance of Psychosis

While the experience of psychosis is universal, the interpretation of experience, notions of causation, treatment, preferred source of care, and the consequences and perceptions of associated stigma will vary from one culture to another (Makanjuola et al., 2016). In Western cultures, the biological (medical) explanation for symptoms of psychosis is most common while in non-western cultures these symptoms are more commonly attributed to supernatural or psychosocial causes (Makanjuola et al., 2016). Evidence to support CBTp and its effectiveness in low- and middle- income countries is emerging, but its availability in these countries is still limited (Li et al., 2017). A reason for this limited availability is the lack of adaptation that has happened to address local barriers, and the cultural adaptation of CBTp has been recommended for its application in non-Western cultures (Li et al., 2017). An example of a society that does not conceptualize psychosis from the Western, biological perspective is that of Sub-Saharan Africa. In this region, the cultural belief is that the root cause of psychosis is supernatural, with the affected individual being possessed or afflicted by evil spirits and witchcraft (Makanjuola et al., 2016). The content of this belief system could affect the level of stigma and self-stigma that individuals with psychosis in this culture face as myths are created about the conditions that the individuals are affected by (Naeem et al., 2019). In South Asian cultures, a strong belief in genetic predisposition to mental illness means that individuals avoid marrying into families with a history of mental illness (Naeem et al., 2019). Interventions adapted to the chosen local culture

could incorporate the specific beliefs of the population into treatment strategies that would improve acceptance and effectiveness (Fendt-Newlin, Jagannathan, & Webber, 2020).

The relationship between explanatory models of psychosis and self-stigma has been investigated in a recent study. Makanjuola et al. (2016) conducted in-depth interviews in complementary and alternative practitioner (CAPs) facilities in three major African cities to explore the relationship between explanatory models for psychosis and perceptions of self-stigma. Each of the participants were receiving care for severe mental disorder exhibited symptoms of a psychotic diagnosis with symptoms being identified by their caregivers (Makanjuola et al., 2016). Results from these interviews found that interviewees with low scores on the internalized stigma scale more commonly employed the biopsychosocial explanatory model. In contrast to this, most individuals with high scores on the internalized stigma scale held more supernatural beliefs about psychosis causes. Those who reported biopsychosocial views were able to attribute the onset of their symptoms to causes such as life stresses and health concerns. Individuals who reported supernatural views also reported these same causes, but that the onset of these causes was due to supernatural forces such as witchcraft, religious experiences, and 'spiritual attacks.' The biopsychosocial model gives the affected individual power over the diagnosis as it is in direct response to something that could be improved (i.e. life stresses). This implies that cultural values and traditions have a large impact on an individual's self-control and that providing psychoeducation to these cultures can improve their self-esteem and reduce their internalized stigma. When considering adapting CBTp, improving self-esteem is a core practice and one that can be adapted to include the cultural values to assist in treatment with individuals that would have scored high levels of internalized stigma.

When considering cultural adaptation of any intervention, the impact that the values and beliefs of the individuals being treated and the affect these values and beliefs have on their self-esteem and personal identity must be respected (Makanjuola et al., 2016). Western societies generally use the biopsychosocial model of explanation for psychosis, but health professionals who work with individuals who do not use this model must be respected. Educating against the supernatural or religious model the individual believes can have a negative effect on the self-esteem of the individual and lead to hopelessness or even suicide (Makanjuola et al., 2016). Most health professionals note the importance of cultural and spiritual values and norms when delivering therapeutic interventions (Li et al., 2017). Adapting therapy according to local needs and considering cultural and spiritual factors are important in influencing patient understanding of the illness, its causes, and treatment (Li et al., 2017).

Comorbidities of Psychosis

CBTp can be adapted to meet the needs of individuals who do not see psychotic symptoms as mental illness by considering and targeting comorbidities. CBTp focuses on distress reduction by targeting negative beliefs and improving self-esteem more than reducing the positive symptoms such as delusions and hallucinations. These positive symptoms are generally what are the subject of religious and supernatural causal explanations for psychosis. Focusing instead on comorbid diagnoses and symptoms may reduce distress and be more culturally acceptable. Studies show that CBTp has strong evidence for improving depressive symptoms in the context of psychosis (Mason et al., 2022). By focusing on mood symptoms such as self-esteem and pessimism rather than the positive psychotic symptoms, depressive symptoms are targeted for treatment while leaving psychosis symptoms that may be viewed as gifts (Mason et al., 2022). Psychotic disorders increase the risk for affected individuals of having a comorbid

diagnosis, such as anxiety disorders, obsessive-compulsive disorder, post-traumatic stress disorder (PTSD), panic disorder, and depressive disorders (American Psychiatric Association [APA] 2022). For individuals who have a diagnosed psychotic disorder comorbid with a PTSD diagnosis, the trauma that these individuals experience can exacerbate their positive psychotic symptoms (Peters et al., 2022). For individuals diagnosed with psychotic disorders, depressive symptoms such as hopelessness, social avoidance, and problems forming relationships are often observed in addition to the classic symptoms of psychosis (Mason et al., 2022). Approximately fifty percent of individuals who experience first-episode psychosis have a depressive disorder at the start of treatment, and about eighty percent of individuals with schizophrenia experience a clinically significant depressive episode once or more in the early course of treatment (Sonmez et al., 2020). Comorbid depression increases the likelihood that individuals with a psychotic disorder experience lower quality of life, lower motivation, poorer social relationships, lower medication adherence, and psychotic relapse (Mason et al., 2022). Around fifty percent of patients with psychosis reported having suicidal ideation at least once and forty percent of individuals with schizophrenia reported clinical levels of depression and low self-esteem (Mason et al., 2022). These depressive symptoms and low self-esteem, along with the reduced likelihood of help-seeking, can contribute to the development of psychosis symptoms (Sonmez et al., 2020). Treatment should be focused on these comorbid symptoms and the distress they produce, building self-esteem, confidence, and a sense of self control (Mason et al., 2022).

Adapting CBTp for Non-Westernized Cultures

CBTp is recommended for cultural adaptation to better help individuals with a psychotic diagnosis in non-Western cultures, but how to culturally adapt this therapeutic system in an effective way is still being researched. In its current Westernized format, CBTp focuses on

distress reduction related to hallucinations and delusions by targeting negative beliefs held by the individual and improving their self-esteem (Mason et al., 2022). When an individual is receiving CBTp, sessions usually focus on goal setting and rebuilding positivity, and self-acceptance (Mason et al., 2022). Studies examining CBTp show strong evidence that it improves depressive symptoms in the context of psychosis, specifically with long-term reductions in suicidal behaviour (Mason et al, 2022).

Methods of adapting CBTp for non-Westernized cultures were identified by studies in the current review. Li et al. (2017) found that providing a more direct approach to treatment was most helpful with patients. Patients preferred a teacher-student dynamic with the mental health professional as opposed to a collaborative approach. This could indicate why mental health professionals included in this study found that educating patients on their illness was the most useful part of treatment. The participants in this study did not report problems with assigned homework, an important aspect of CBTp, during treatment as the therapist was seen as an authority figure (Li et al., 2017). Homework could be crucial in overcoming stigma and receiving psychological treatment as it provides ways for the patient to continue treatment while not actively attending sessions with a mental health professional. The mental health professionals interviewed by Li et al. (2017) reported that there was concern that others, specifically family members and relatives, would find out about the patient's psychotic diagnosis. Family members and relatives of patients were found to hinder both initial help-seeking behaviours and attendance at follow-up visits for therapy of those patients. Providing homework would minimize the amount of time actively spent with a mental health professional and encourage treatment adherence from patients. Li et al. (2017) also found that CBTp techniques focused on coping, behavioural techniques, social skills, family counselling, and dealing with family conflicts were

most helpful. Behavioural techniques were not specified by the study. Adjusting the techniques used in CBTp to align closer to specific cultural values of the population and focusing on these values may help increase the acceptability of CBTp as a treatment and the effectiveness it has on individuals from non-Western cultures. It is important to note that while almost all the patients interviewed by Li et al. (2017) had seen a spiritual or alternative healer for their psychotic symptoms in the past, they did not consider their illness to be caused by spiritual means at the time of the interview. It is possible that this was due to psychoeducation provided by mental health professionals in sessions prior to the interviews taking place. Li et al. (2017) identified several areas of adaptation that would benefit non-Western cultures. It was noted by one mental health professional that Socratic dialogue was not useful for patients with psychosis in this study, and that a more directive style was expected and more successful with patients.

Adapting language to the culture was identified as important rather than simply translating. Translation does not account for the local values and customs and may not be understood by the patient. By adapting the language used from Western cultures to the local culture, therapists make use of the local values and customs in treatment and makes treatment techniques easier to understand (Li et al., 2017). The therapist also requires an understanding of the local culture or the culture of the target population. This is important because it allows the therapist to identify and understand the patient's cultural and spiritual needs that influence who they are and underpin the patient's self-esteem and basic values (Makanjuola et al., 2016).

Increasing the Probability of Help-Seeking of Individuals in Non-Westernized Cultures

Finding ways that CBTp and other treatments can be adapted and accepted by non-Westernized cultures works to increase the probability that individuals will seek out psychological treatment and reduce the stigma surrounding these forms of treatment (Li et al.,

2017). Lannin et al. (2016) conducted a study investigating whether self-stigma and attitudes negatively impact decisions to seek out information about mental health concerns and counselling. This study found that greater distress in an individual with mental illness led to a greater probability of seeking mental health information and support. It also found that among individuals with greater distress, those with high self-stigma were half as likely to seek out mental health information and support when compared with those who have low levels of self-stigma (Lannin et al., 2016). Makanjuola et al. (2016) provides insight into how self-stigma in non-Westernized cultures impacts these help-seeking behaviours. They found that high levels of self-stigma were reported by between 21-44% of individuals interviewed, depending on which region the results were taken from. When combined with the information gathered by Lannin et al. (2016), it could be inferred that this large percentage of individuals would not seek out mental health information even under great distress.

Individualizing interventions to abide by the individual's personal explanation for their psychosis symptoms should reduce self-stigma within the individual and provide better care (Makanjuola et al., 2016). Makanjuola et al. (2016) explain that the complexity of the interaction between explanatory models of causation and perceptions of self-stigma among individuals with a psychotic diagnosis within the culture makes the use of universal interventions insufficient. Individualizing interventions by accounting for the aggravating and mitigating effects of explanatory models on self-stigma and the differences that each individual culture have in their explanations of psychosis symptoms. Considering these two factors along with the patient's cultural values could make treatment more acceptable to individuals who do not view their psychosis as a mental illness, as it uses their own personal values to inform treatment. Mason et al. (2022) state that treatment should focus on the broader distress that is produced by psychotic

symptoms and combat it by building self-esteem, confidence, and a sense of self-control and purpose. Building on the patient's knowledge of their mental illness could threaten their own personal beliefs and self-identity, therefore making it important to reinforce self-esteem and confidence to build resiliency to ensure that the patient is open to learning about their illness. By focusing on mood symptoms during treatment, the depressive symptoms the individual is experiencing can be specifically targeted rather than the positive psychotic symptoms that may have cultural value to the individual (Mason et al., 2022). Lannin et al. (2016) theorizes that using brief interventions (noted self-affirmation exercises) could highlight positive self-conceptions and protect self-worth from threats that individuals may encounter when seeking mental health information, and therefore increase the likelihood that they seek out support.

A way to increase the availability, accessibility, and efficacy of CBTp in non-Westernized cultures is to provide it in a group therapy format. Currently, CBTp is most often provided by psychologists that have years of education and specialized training in the specific treatment protocol (van der Stouwe et al., 2021). CBTp interventions are generally done in an individualized manner, limiting the availability of these treatment protocols. Only about one-third of individuals with psychosis receive psychological treatment due to these limitations (van der Stouwe et al., 2021). Along with this information, multiple studies have shown that individuals with a psychotic diagnosis from non-Western cultures isolate themselves and socially withdraw (Naeem et al., 2019; Rathod et al., 2023; Vyas et al., 2021). Given this information, studying the efficacy of group therapy may be one way to increase the availability of this treatment and provide social support for individuals in non-Westernized cultures who are having potentially similar experiences. Group therapy by therapists that have less specialized training would increase the availability of treatment (van der Stouwe et al., 2021). In the study by van der

Stouwe et al. (2021), group therapy for psychosis treatment was investigated with group treatments targeting self-esteem in individuals diagnosed with a psychotic disorder. The study was conducted in a university hospital psychosis department in the Netherlands and used a psychological treatment protocol focused on strengthening the pathways in the individual's brains toward positive self-beliefs and make them more easily accessible. The researchers predicted that this would have a positive effect on self-esteem and depression in those receiving treatment. Van der Stouwe et al. (2021) used a protocol designed to provide simple exercises that individuals could integrate into their daily lives and consisted of several subsequent steps. Individuals initially received psychoeducation about negative and positive self-beliefs to increase motivation for changing their negative beliefs. A positive self-belief was then created in direct contrast to the core negative belief that the individual had been holding. Positive events were connected to personal qualities which were gathered and put into a list for each individual. Based on this list and the positive self-belief, desired behaviours were decided upon and then practiced. Individuals also received information and training about receiving criticism and had discussions about how to prevent relapse (Van der Stouwe et al., 2021). The results of this study showed an improvement in self-esteem and decrease in depressive symptoms of the individuals who participated.

Based on the results of the study by van der Stouwe et al. (2021), easily accessible self-esteem treatment such as CBTp may be effective for individuals with a psychotic disorder, though more research would need to be done to test its efficacy for non-Westernized populations. The sample used by van der Stouwe (2021) was taken from a Westernized culture and more trials will need to be done to test if CBTp in group therapy is effective in non-Westernized cultures with causal explanatory models of psychosis. The study further outlines advantages to group

treatment: normalization of feelings, socialization and social support for individuals who may otherwise be lonely, and improvement of self-worth through helping others within the group (Van der Stouwe et al., 2021). As outlined in the studies examined in this review, individuals in non-Western cultures who are diagnosed with a psychotic disorder tend to isolate themselves and pull away from social relationships for fear of being judged (Ahmed et al., 2019; Mirza et al., 2019; Naeem et al., 2019). Providing them with a safe place to interact with others who share their experience could help break this barrier and improve acceptance and effectiveness of treatment. This aspect of group therapy also allows more individuals to receive treatment and improves cost effectiveness.

Identified Barriers to Individuals Receiving CBTp in Non-Western Cultures

When examining how to culturally adapt CBTp to benefit individuals with a psychotic diagnosis from non-Western cultures, it is important to gather knowledge from those cultures on what barriers currently stop individuals from those cultures from seeking out treatment. Adapting CBTp to better address the barriers faced by individuals seeking treatment in non-Western cultures allows it to be more accessible. Investigating the culture and those who live within it provides first-hand knowledge from those who would be accessing the adapted services. Through multiple studies that are included in this current review, adaptations to overcome the identified barriers emerge and are expanded on in this section.

Role of Social Relationships

In non-Western cultures, a higher emphasis is placed on family and relationships when compared to Western cultures (Mirza et al., 2019). Family members can be important support during treatment but can also be a hinderance due to the stigma of seeking treatment within the culture (Li et al., 2017). According to Rathod et al. (2023), individuals with a psychotic diagnosis

fear that their diagnosis might affect their loved ones and how these loved ones will react to their diagnosis. Vyas et al. (2021) found that individuals with symptoms of psychosis experience stigma from their families and communities. Participants in the study also described stigma as harmful to themselves and their family members. Stigma from family is reported to be larger and have more devastating consequences when compared to stigma from other sources (Ahmed et al., 2019). South Asians have a strong belief that there is a genetic predisposition to mental illness and may avoid marrying into families with a history of mental illness (Naeem et al., 2019).

While researching CBTp adaptation in China, Li et al. (2017) found that useful techniques included social skills work, family counselling, and dealing with family conflicts. Mental health professionals interviewed in this study insisted on involving families in decisions regarding the care of patients, and a family member generally accompanied patients to their appointments. By educating the family and the patient, mental health professionals expand the knowledge of mental illness of the entire family unit and work to reduce stigma and increase therapy adherence. This psychoeducation must be done in a way that is adapted to the local values system to increase acceptability of the information by both the patient and the family member. While this was not explored in detail by Li et al. (2017), the mental health professionals interviewed in the study did report that both patients and carers preferred the therapeutic relationship be more of a teacher-student dynamic, compared to the collaborative approach more common in Western cultures.

Non-Westernized Cultural Understanding of Psychosis and Treatment

Specific cultural beliefs influence a patient's understanding of illness, its causes, and its treatment (Li et al., 2017). More often in non-Western cultures, people believe that psychosis is

caused by supernatural or spiritual influences (Li et al., 2017; Makanjuola et al., 2016; Mirza et al., 2019; Rathod et al., 2023). These causal explanations can delay seeking out psychological treatment, as these individuals are more likely to seek out treatment from a traditional healer or faith/spiritual leader before considering seeking out mental health treatment (Li et al., 2017). Younger generations from these cultures are less likely to endorse the explanations of supernatural or spiritual causation (Mirza et al., 2019).

Illness narratives are often closely linked to social adversity and trauma and can hold a specific meaning within the local cultural context (Fendt-Newlin, Jagannathan, & Webber, 2020). Accessibility of treatment and support is often mediated by pre-existing cultural practices and traditions which are often embedded with stigma and discrimination against individuals diagnosed with psychosis and can prevent individuals from accessing treatment that they need for fear of being judged or isolated (Fendt-Newlin, Jagannathan, & Webber, 2020). The availability of traditional healing practices that promote mental health and well-being can help shape culturally acceptable interventions by incorporating social, economic, and cultural aspects of the local population and therefore enhance the intervention's effectiveness (Fendt-Newlin, Jagannathan, & Webber, 2020). Language is also a factor when considering accessibility (Naeem et al., 2019). Language barriers can impact how concepts are understood and implemented across different cultures (Naeem et al., 2019). Language that is used to explain a concept must be changed to reflect the culture that it is being adapted to. This is done to ensure that concepts that may not exist within the culture of the population are not included and can be adapted (Li et al., 2017). Simply translating from one language to another may not have the same meaning across cultures (Li et al., 2017). Using the native language rather than a translated version can be more

easily understood by the patient and would assist in having that patient commit to treatment (Li et al., 2017).

Providing psychoeducation about psychosis itself and the biopsychosocial cause of the illness is an integral part of growing the cultural acceptability of psychological and psychiatric treatment methods (Naeem et al., 2019). Especially in non-Westernized countries, knowledge of psychotherapy is very limited (Li et al., 2017). Patients do not have the insight and knowledge into their illness to seek out a suitable treatment method, and more traditional treatment methods are chosen due to familiarity (Rathod et al., 2023). Professionals in these countries found that educating their patients about their illness was one of the most useful parts of treatment (Li et al., 2017). Care needs to be taken when discussing these explanations with individuals from non-Western cultures, as parts of their self-identity can be tied to their religious or spiritual beliefs (Naeem et al., 2019). This can lead to a form of resistance called mind-guarding, which occurs when the individual resists altering their beliefs because it will erode a vital psychological structure that the individual's identity, vitality, self-esteem, or emotional regulation ability depends on (Garrett et al., 2019). This also affects how successful some interventions are, as techniques are ineffective if they ask clients to go against their own cultural beliefs and values (Naeem et al., 2024).

Methodological Analysis

This section will critique the research paradigms, sampling and recruitment practices, data collection, and data analysis procedures of the ten highlighted studies. Qualitative, quantitative, and mixed methods studies will be critiqued separately. Of the ten selected studies, four are qualitative, four are quantitative, and two are mixed methods.

Qualitative Studies

Paradigms

Qualitative research makes up four of the studies included in this review (Li et al., 2017; Naeem et al., 2024; Rathod et al., 2023; Vyas et al., 2021). Qualitative studies took a constructivist approach to inform their research. The main goal of these studies was to gather information on what factors affect the participants' view of mental health and psychosis. This required relying on participants' worldviews and cultural environment that shaped these views throughout their lives. Non-Western cultures put more value on family and social relationships in comparison to Western cultures, and constructivist perspectives puts social interactions as a main generator of meaning (Cresswell & Cresswell, 2018).

Researchers' role in the constructivist paradigm is to use open-ended questions to gather as much information as they can from participants. Qualitative studies in this review used semi-structured interviews to gather information on specific areas of interest involving views on psychosis and factors that impact those views. Researchers' own experiences and background can shape the interpretation of the information that is gathered through these interviews (Cresswell & Cresswell, 2018).

Sampling

Qualitative studies examined in this review took place in Pakistan (Rathod et al., 2023), China (Li et al., 2017), and Westernized countries such as the United Kingdom (Vyas et al., 2021) and Canada (Naeem et al., 2024). Vyas et al. (2021) examined the experiences of individuals of South Asian cultural background living in the United Kingdom, while Naeem et al. (2024) examined the experiences of individuals of South Asian cultural background living in Canada. Convenience sampling was used to keep the sample attributes focused on what the researchers were specifically targeting. Researchers from all four qualitative studies gathered

their samples from outpatient programs. While one study had an inclusion requirement of speaking English (Vyas et al., 2021), others ensured that participants could speak their native language (Li et al., 2017; Rathod et al., 2023). Sample size for all four of these studies were kept small, with each study being under 50 total participants. Studies with multiple sample groups (Li et al., 2017; Naeem et al., 2024; Rathod et al., 2023) had each groups size below 20 participants.

Data Collection

Face-to-face individual interviews were used as the main source of information gathering. Some studies made use of videoconferencing software to conduct their interviews (Naeem et al., 2024). Semi-structured interviews were conducted using open-ended questions (Li et al., 2017; Rathod et al., 2023; Vyas et al., 2021). Interviews ranged from 30-90 minutes in duration. Interviews were generally conducted in the language native to the sample being interviewed (Li et al., 2017; Rathod et al., 2023). Interviews done in Western countries either allowed the participant to use the language they were most comfortable speaking (Naeem et al., 2024) or required English to be used (Vyas et al., 2021). Translating information across languages can impact how concepts are understood by the individual and the researchers, which can impact the validity of the findings. No information was given as to how validity was ensured during the study while using different languages in interviews. Audio recordings were sometimes utilized and later transcribed and translated to English where necessary (Li et al., 2017; Naeem et al., 2024; Rathod et al., 2023). Consent for phone contact in case of the need for clarification was obtained (Li et al., 2017). Interviews were typically conducted at a centralized location (Li et al., 2017; Makanjuola et al., 2016; Vyas et al., 2021), though Rathod et al. (2023) conducted interviews at places and times of convenience to the participants.

Data Analysis

Themes were identified in two ways: they were predetermined from previous work done by the researchers (Li et al., 2017) or by software such as NVivo 12, a computer assisted qualitative data analysis software (QSR International, 2018; Naeem et al., 2024; Vyas et al., 2021). Rathod et al. (2023) had both researchers and software identify themes for a validity check and to increase inter-rater reliability. Li et al. (2017) had two separate teams, one in Canada and one in China, coding data separately for the English and Chinese versions of the transcripts to improve reliability of the analysis and ensure any translations were accurate and working.

Quantitative Studies

Paradigm

The four reviewed quantitative studies (Ahmed et al., 2020; Habib et al., 2015; Mason et al., 2022; Mirza et al., 2019) used a positivist approach, relying on data and evidence gathered by verified data collection instruments to come to conclusions (Cresswall & Creswell, 2018). The quantitative studies included in this review required researchers to remain neutral and not impact the data that was being collected. This ensured that the data was accurate and non-biased as possible.

Sampling

Quantitative studies examined in this review took place in Pakistan (Habib et al., 2015) and the United Kingdom (Ahmed et al., 2020; Mirza et al., 2019). Ahmed et al. (2020) and Mirza et al. (2019) drew comparisons between two groups of people living in the United Kingdom: White British individuals and South Asian individuals. Convenience sampling was used, allowing researchers to focus specifically on individuals affected by psychosis and comorbid diagnoses from specific cultural backgrounds. Samples were gathered from an inpatient clinic

(Habib et al., 2015), an electronic health record (HER) database (Mason et al., 2022), and secondary schools and colleges (Ahmed et al., 2020; Mirza et al., 2019). Ahmed et al. (2020) and Mirza et al. (2019) sampled from the same general area, Northern England, but it is not clear if their sample bases were pulled from the same schools as each other.

An exclusion criterion across each of these studies was if individuals were deemed severely ill or had a serious substance misuse problem. Neither of these criteria had specific definitions given by the study. Habib et al. (2015) and Mason et al. (2022) samples are only from individuals who have received treatment for their psychosis symptoms, with individuals who have not received treatment after a psychotic episode being excluded as they would not be known to the local healthcare system.

Data Collection

Habib et al. (2015) measured psychopathology using the Positive and Negative Syndrome Scale of Schizophrenia (PANSS; Kay, Fiszbein & Opfer, 1987), Psychotic Symptom Rating Scales (PSYRATS; Haddock, McCarron, Tarrier, & Faragher, 1999), and the Schedule for Assessment of Insight (SAI; David, Buchanan, Reed, & Almeida, 1992). These scales were translated into Urdu, the native language for the population of the study. The PANSS is a widely used, well established, and comprehensive symptom rating scale (Habib et al., 2015). The PSYRATS has demonstrated good interrater reliability, test re-test reliability, concurrent validity, and sensitivity to change in patients diagnosed with schizophrenia (Habib et al., 2015)

Mail questionnaires were also used in some cases (Ahmed et al., 2019; Mirza et al., 2019). Participation in these studies required English to be understood as the questionnaires were provided in English. These made use of Likert-type scales to measure how participants identified

with pre-determined statements. Many of the measures were adapted for the study from previously used measures, though the adaptations were not identified explicitly.

Data Analysis

In the study conducted by Habib et al. (2015), analysis for errors in input was done using SPSS version 16.0 on an intention to treat basis. Researchers then compared two groups to determine baseline differences between the experimental and control group. Baseline differences were also analyzed to show the effect of each modality. Data from mail-in questionnaires were screened for outliers and normality (Mirza et al., 2019). Mirza et al. (2019) also assessed whether the effect of ethnic group on supernatural beliefs was moderated by previous psychotic experiences using the PROCESS macro provided by Hayes (2016, Model 1). Ahmed et al. (2020) created composite scores from the 9-point Likert scales used by using the mean score from each subscale, with scales measuring blame and coercion not being used due to a lack of internal consistency.

Mixed Methods Studies

Paradigm

The two reviewed mixed methods studies (Makanjuola et al., 2016; Sonmez et al., 2020) used a pragmatic paradigm to research, employing both quantitative and qualitative measures to gather data (Cresswell & Cresswell, 2018). Sonmez et al. (2020) emphasized the quantitative measures as they sought to compare data between two groups, while Makanjuola et al. (2016) used qualitative measures and interviews to gather data around causal explanations of psychosis in African cultures.

Sampling

Both studies recruited less than one hundred participants. Sonmez et al. (2020) noted that their study did not meet the minimum participant level to deem their findings statistically significant. Makanjuola et al. (2016) had their total sample pool split into three groups based on what region of Africa they were interviewed in. Convenience sampling methods were used for both mixed methods studies. Sonmez et al. (2020) recruited their sample from patients attending the Thematically Organized Psychosis (TOP) Study at the NORMENT KG Jebsen Centre for Psychosis Research. All participants had to have a primary diagnosis of psychosis spectrum disorder according to the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, (DSM-IV; APA, 2011) and must have had a diagnosable depressive episode within the past year or score a five or higher on the Calgary Depression Scale for Schizophrenia (CDSS: Addington, Addington, & Schissel, 1990). Makanjuola et al. (2016) required that their participants were receiving treatment from traditional healers.

Data Collection

Makanjuola et al. (2016) made use of semi-structured, private interviews guided by the specifications of the McGill Illness Narrative Interview (MINI; Ritsher, Otilingam, & Grajales, 2003), which is designed to elicit illness narratives. A stigma assessment was also done by Makanjuola et al. (2016) using the Internalized Stigma of Mental Illness (ISMI; Groleau, Young, & Kirmayer, 2006) scale. This scale has been validated in several languages and is shown to have good reliability and validity (Makanjuola et al., 2016). Both scales were translated into the local language of each sample by a panel of bilingual experts using the iterative back translation method (Makanjuola et al., 2016). Interviews were audio recorded and transcribed and translated to English for researchers to code appropriately.

Sonmez et al. (2020) made use of several scales to gather information from their participants. The initial diagnosis was set according to the Structural Clinical Interview for DSM-IV Axis I Disorders (SCID I; APA, 2011). Level of symptoms was measured by the Structured Clinical Interview for the Positive and Negative Syndrome Scale Score (SCI-PANSS; Kay, Fiszbein, & Opler, 1987). Depression was assessed with the CDSS with a cut-off score of five or higher, as well as the Beck Depression Inventory (BDI-II; Beck et al., 1961). Self-esteem was measured using the Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1989). Premorbid adjustment was assessed using the Premorbid Assessment Scale (PAS; Cannon-Spoor, Potkin, & Wyatt, 1982), with the premorbid phase being defined as the time from birth until six months before the onset of the psychotic disorder. Global functioning was measured by the clinician rated Global Assessment of Functioning (GAF; Pederson, Hagtvet, & Karterud, 2007) scale, split version. Duration of untreated psychosis was defined by number of weeks with symptoms qualifying four or more on PANSS items P1, Delusions, P3, Hallucinatory behaviour, P5, Grandiosity, P6, Suspiciousness, or G9, Unusual thought content, before adequate treatment for psychosis. Alcohol and drug use was self reported on the Alcohol Use Disorder Identification Test (AUDIT; Saunders et al., 1993) and the Drug Use Disorders Identification Test (DUDIT; Berman et al., 2005). Participants were randomly assigned to receive CBT plus treatment as usual (TAU) or TAU alone for a period of up to six months. Participants were invited to complete full assessments at baseline, six months after baseline, and fifteen months after baseline.

Data Analysis

Makanjuola et al. (2016) transcribed interviews read several times by the first author and subjected the data to thematic analysis. Emerging themes were coded using MAXQDA software, with initial codes generated based on supernatural and biopsychosocial themes. Subcodes

included witchcraft, spiritual attacks, biological, stress, and drugs and alcohol. The process of coding was discussed, critiqued, and suggestions incorporated in meetings between the co-authors to ensure fidelity in assignment of codes and subcodes.

Sonmez et al. (2020) used SPSS for Windows (version 25.0) to perform statistical analyses. Completing participants and dropouts were compared on demographic and clinical variables at baseline and six months, while differences between completing participants of both the CBT and TAU groups in regards to primary (CDSS) and secondary (RSES) outcome measures were also assessed with independent sample t-tests at all available time points. Linear mixed model procedures in SPSS were used to analyze the longitudinal data of the primary outcome measures and used to analyze the longitudinal data of all five PANSS subscales and GAF subscales at all timepoints. Linear mixed model was used to account for missing data and confounding variables, and best fit was for the model with random intercept. To reduce the risk of type 1 errors, P-values were multiplied by number of comparisons.

Findings

Qualitative

The qualitative studies included in this review came to the same conclusion that shame and stigma influenced help-seeking behaviours of affected individuals (Li et al., 2017; Naeem et al., 2024; Rathod et al., 2023; Vyas et al., 2021). To varying degrees, all four qualitative studies found that patients and families of non-Western cultures are more likely to explain psychosis because of supernatural rather than biological causes. Individuals are more likely to see a religious or spiritual healer before seeing a mental health professional.

Li et al. (2017) used specific themes to guide the interviews they conducted, including the participants knowledge of illness, causes, and treatments; perception of effect of the illness on

their lives; presenting problems and care pathways; experience with methods of help both traditional and modern; and understanding of ideal treatment. These themes were investigated with both patients and carers, with mental health professionals being asked about their experiences in providing therapy to individuals experiencing symptoms of psychosis, barriers to providing therapy, and if adaptation is necessary. The findings indicated the need for adaptation of therapy according to cultural differences and local needs, such as adapting the language used in interventions. Li et al. (2017) also found that there was a lack of knowledge in patients on the cause of their illness and the existence of psychotherapy. Overall, Li et al. (2017) determined that a bio-psycho-social model of psychosis was used by the participants, but with an added emphasis on spiritual and religious causes. Mental health professionals interviewed in this study emphasized the need for adaptation of treatment and the need to be mindful of cultural, spiritual, and other related factors when providing therapy.

Rathod et al. (2023) found in Pakistan that there were multiple attributions for psychosis endorsed simultaneously, which included key themes such as supernatural beliefs and religious attributions to developing psychosis, which resonated with patients and family/carers. Their findings suggest that individuals in Pakistan could have better experiences and therapeutic engagement with mental health services if there could be an integration or consideration of patient's spiritual, supernatural, and religious beliefs in treatment. Researchers found that individuals in Pakistan also attributed multiple other causes to psychosis, including social factors, family related stress, relational stress, and academic stress and expectations.

Naeem et al. (2024) found that South Asian cultural values were not included in CBT interventions conducted in a Westernized country (Canada), which caused a lack of understanding between the participants and therapists and lead to less engagement with these

treatments. This shows a need to adapt CBT to the cultural values, language, and spiritual values of the patient for treatment to be accessible and effective, even when treatment is being conducted in Westernized countries. These results are consistent with findings from Vyas et al. (2021), where British South Asian people with a psychotic diagnosis felt that their experiences were not recognized and understood by their service providers, increasing the public and internalized stigma that they felt This was especially the case for second-generation British South Asians who have both South Asian and Western cultural understandings of themselves and their psychotic experiences. Moving between two different cultural identities creates stress on the individual and a perceived social unacceptance of their cultural identity.

Quantitative

Mirza et al. (2019) and Ahmed et al. (2020) both conducted comparison studies between White British individuals and South Asian individuals. Mirza et al. (2019) tested four hypotheses, including the hypothesis that White British individuals would report more previous contact with mental health services, would disclose more mental health problems, would report lower stigma towards psychosis, and would endorse more beliefs in biological or psychosocial causes of psychosis when compared to South Asians. Their findings indicated that all of their hypotheses were correct, showing that individuals with non-Westernized cultural backgrounds struggle with aspects of mental health even if they live in a Westernized country.

Ahmed et al. (2020) examined how stigmatization affected behaviours towards people with psychosis when comparing South Asian and White British populations in the United Kingdom. They hypothesized that South Asians would report greater affective prejudice, more negative stereotypes, and more discriminatory behaviour towards people with psychosis when compared to White British individuals. The study results found support for all of these

hypotheses, suggesting stigma towards people with mental health problems may be greater in Asian cultures. While this study appears to indicate that stigma is more severe in non-Western cultures compared to Westernized cultures, the researchers state that more research is necessary to test if this is true or not.

The trial conducted by Habib et al. (2015) showed that culturally adapted CBTp was found to be effective in reducing psychotic symptoms and improving insight. These researchers also found that participants still consulted traditional and faith/spiritual healers when consulting with medical doctors. The researchers emphasized that qualitative methods to explore local beliefs and barriers in therapy are necessary to adapt and further inform interventions for the local population.

Mixed Methods

Makanjuola et al. (2016) explored the relationship between explanatory models of psychosis and perceptions of self-stigma. The researchers found that most respondents in their study experienced stigma as a consequence of their psychotic diagnosis. Explanatory models of mental illness are shown to impact perceptions of stigma on people living with mental illness. Supernatural attributions of mental illness most often resulted in high perceptions of self-stigma. There were also individuals with low self-stigma who embraced a supernatural explanatory model, and therefore the researchers recommend individualizing interventions to minimize self-stigma.

Sonmez et al. (2020) found that CBTp led to improvement in negative symptoms and functioning when compared to treatment as usual. They noted that both treatment groups showed similar benefits in terms of depressive symptoms and self-esteem both during treatment and in

follow-up. The researchers recommend replicating the study as it was underpowered due to the small sample size.

Ethical considerations

This section examines the ethical considerations of the chosen studies using the Canadian Code of Ethics for Psychologists (Canadian Psychological Association [CPA] 2017) and the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (Canadian Institutes of Health Research [CHR] et al., 2022). The Canadian Code of Ethics for Psychologists (CoE; CPA, 2017) is made up of four ethical principles. These principles include respect for the dignity of people, responsible caring, integrity in relationships, and responsibility to society (CPA, 2017). The Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS; CIHR, 2022) has similar ethical considerations outlined in three core principles for researchers: respect for persons, concern for welfare, and justice (CIHR, 2022). While most of the studies examined in this review did not take place in Canada, they received approval from the relevant review boards responsible for assessing risk and benefits to minimize the harm to participants in each study.

Informed Consent

Principle one of the CoE (CPA, 2017) is respect for the dignity of persons and peoples. The principle aligns with first core principle of the TCPS (CIHR, 2022), respect for persons. This principle contains components of informed consent such as the ongoing nature of consent and the responsibility of the researcher to communicate the purpose of the research. Participants also have the option to withdraw at any time without the risk of negative consequence. Studies made it clear that informed consent was obtained from all research participants. Participants were asked to give consent before talking with researchers if they were in outpatient settings, with a

separate consent process being undergone for individuals to participate in the study. All studies made note that inclusion criteria included participants being able to consent for themselves to be a part of the research. Whenever a minor was to be part of a given study, a guardian's consent was received (Ahmed et al., 2020; Mirza et al., 2019; Muller et al., 2020). Minors who were included in these studies still had to supply their assent, as outlined by the TCPS (CIHR, 2022). Separate signed consent was received for additional information being gathered, such as audio recordings (Makanjuola et al., 2016; Rathod et al., 2023). Habib et al. (2015) noted that the informed consent was received verbally as the low literacy rate of the area being studied meant that written consent would not ensure that participants were fully informed of what they were participating in. One study was not reviewed by an ethical board before being conducted as it concerned the evaluation of regular care at the facility (Van der Stouwe et al., 2021).

Care for Participants

Principle two of the CoE (CPA, 2017) is responsible caring and aligns with principle two of the TCPS (CIHR, 2022). This principle emphasizes the researcher's role in protecting participants and ensuring that the benefits of any research outweigh the potential harms being done physically or psychologically. In studies where treatments were being actively applied to patients (Sonmez et al., 2020; Muller et al., 2020), participants in control groups received treatment as usual (TAU) to ensure that they received care during the study, with the experiment group receiving CBT. As noted, most of the studies were conducted in inpatient or outpatient settings, which allowed medical professionals to monitor all participants during the period of study and note any concerns that could be caused by the studies being conducted. Principle one is also respected with these aspects as individuals still receive care.

Confidentiality

Confidentiality for the participants encompasses all four principles of the CoE and is a mandatory from both an ethical and legal standpoint for researchers. The TCPS identifies the researcher's duty in protecting participants' privacy as an internationally recognized component of ethical research and outlines a participant's right to confidentiality and privacy to respect their intrinsic values and autonomy (CHIR, 2022). Principle one of the CoE requires that privacy and confidentiality is maintained, including the handling of the information gathered from the participants (CPA, 2017). Mirza et al. (2019) required a mailed-in self-report which could jeopardize the participants identifying information if handled incorrectly. Studies used telephone and video conferencing to communicate between researchers and interviewers and provide supervision. There was no discussion on how these communications were kept secure, or if any emails with participant information was encrypted when being sent between researchers.

Principle three of the CoE is integrity in relationships and outlines ways that researchers should maintain their responsibility to uphold the integrity of the field of psychology. All qualitative studies in this review were conducted via interviews with researchers. While the researchers own experience would have some impact on the interviews that were conducted and the data collected, this was minimized as much as possible to reduce bias from affecting the interpretation of the data gathered. Most of the studies included in this review were conducted through interviews. Li et al. (2017) made note that the interviewers were not individuals who cared for the participants to avoid bias responses and conflicts of interest for both the researchers and the participants. Researchers did not want participants to feel that their responses would affect the level of care that they were receiving. Studies that made use of interviewing participants, their caregivers, and their mental health professionals (Li et al., 2017; Naeem et al., 2024; Rathod et al., 2023) did not specify how identifying information was being handled

between interviewers. For example, it was not specified if the same interviewer conducted interviews with the participant, their caregiver, and their mental health professional, or if each interview was handled by a different interviewer.

Chapter 4: Application to Clinical Practice

The information gathered in the literature review can be integrated into both future research practices as well as current clinical practices. Examining how the information gathered can influence practitioners working with individuals from non-Western cultures and be put into practice in both non-Western cultures and Western cultures alike aims to improve current services and expand future service provision.

Clinical/Therapeutic Applications

Treating Comorbidities of Psychosis

The positive symptoms of psychosis, hallucinations and delusions, are viewed and experienced differently in non-Westernized cultures (Makanjuola et al., 2016; Mason et al., 2022). These positive symptoms can be exacerbated by comorbid diagnoses if the symptoms of these diagnoses are left untreated (Peters et al., 2022). As noted, treating the comorbid symptoms that can accompany a psychotic diagnosis, such as depression, post-traumatic stress disorder (PTSD), and anxiety, can improve the individual's quality of life and self-esteem without going against their religious or supernatural beliefs (Mason et al., 2022). CBTp is a modality that can be adapted to address symptoms of psychosis as well as symptoms of trauma-related distress. (Peters et al., 2022). Treating comorbid symptoms may also limit the amount of resistance that mental health professionals encounter when providing CBTp to individuals with a psychotic diagnosis.

Building Supportive Social Relationships through Group Therapy for Psychosis

Offering a safe space to build supportive social relationships for individuals from non-Western cultures who are diagnosed with psychosis would help improve their overall wellbeing. This could be done in a group therapy setting, providing CBTp as a treatment modality. Van der

Stouwe et al. (2021) performed a study implementing CBTp in group therapy for individuals with a psychotic diagnosis. As noted, group therapy is one way to increase the availability of CBTp, and CBTp was found to be effective when trialed within a group therapy setting (van der Stouwe et al., 2021). It can also be used to increase socialization among individuals with a psychotic diagnosis and reduce the stigmatization that they may feel. This is especially true for individuals who have a non-Westernized cultural background, as these cultures put more value on family and social relationships when compared to Western cultures. Individuals from non-Western cultures that experience symptoms of psychosis are more likely to isolate themselves socially for fear of judgement and suffer from lower self-esteem and confidence (Vyas et al., 2021). Providing them with a safe space where they are able to discuss their experiences with other individuals in the same situation could provide affected individuals with new social relationships, social supports, and increase their self-esteem.

Psychoeducation/Visibility of Practice

The information that has been gathered in this review can inform practitioners on how they can better provide culturally relevant knowledge on CBTp and psychosis to patients and reduce stigmatization of mental illness. For practitioners in Alberta, Canada, the influx of immigrants from countries outside of Canada creates a new population who do not have knowledge of local availability of mental health services. It is integral that practitioners be visible within their communities spreading knowledge of their services and the benefits that they can provide. From the research in the current review, a lack of education around mental illness creates stigma in non-Western cultures and is a barrier to accessing services (Li et al., 2017; Naeem, 2019; Rathod et al., 2023; Vyas et al., 2021). To gain a better understanding of the needs of the local population and how to best adapt interventions and teaching strategies, it is

recommended that practitioners participate in community events and learn about the demographics in their service area. Being present in places of worship or local community centres allows clinicians to gain an understanding of the needs present in their potential client pool outside of a clinical setting (Vyas et al., 2021).

Language

An important aspect of cultural adaptation is the language being used. In this literature review, it was explained that adapting language to the target population would be more effective than simply translating the Westernized version to the native language (Li et al., 2017). This is something to consider for clinicians working in Western countries that have clients who speak the native language as a second language. Li et al. (2017) described how a specific concept present in Western cultures, assertiveness, was not a recognized concept in the non-Westernized culture that was being examined in the study. Adapting CBTp to ensure that concepts that are being focused on in treatment are understood within the cultural context is essential to patient acceptance and the efficacy of treatment. Adapting the words, phrases, and concepts being used to the cultural context of the patient is important in building the client's understanding and the efficacy of treatment in general.

Recommendations for Clinical Practice

Individualizing CBTp

CBTp was designed within a Western cultural context and therefore works best for individuals from Western cultures. When adapting it into non-Westernized cultures, cultural adaptation is necessary to ensure that it is being implemented in a culturally competent way and is of benefit to the population it is being used for. Part of this process should be to use a person-centered approach when initially interacting with an individual to gain an understanding of what

they view as the problem. For example, the mental health professional may view the patient's hallucinations as the main reason for their low self-esteem and self-stigmatization and attempt to focus treatment on that symptom. Meanwhile, the patient feels bad because they are woken up at night by their hallucinations and spend four hours screaming and waking up their loved ones, causing their loved ones to be angry with them, causing them to have low self-esteem and try to isolate themselves so they are not a problem to their family anymore. This understanding would enable the mental health professional to direct specific interventions towards comorbidities being caused by the patient's explanation of the problem, such as potential anxiety around falling asleep or depression around feeling like a burden to their family. Unless the mental health professional is open to learning from the patient what the problem is as they view it, the risk of the patient discontinuing treatment could be increased (Naeem et al., 2019).

When individualizing CBTp, thought needs to be given on how to approach the therapeutic relationship between the mental health professional and the patient. A teacher-student dynamic has been found to be preferred by patients in the research examined in this review (Li et al., 2017). This dynamic works for providing psychoeducation about mental health from the mental health professional to the patient, but when gaining an understanding of how the cultural values and beliefs affect the patient, the patient must become the teacher. Empowering the patient to share how their cultural values affect their self-esteem, interpretation of their mental illness, and feelings of stigmatization from themselves and others will provide what areas of CBTp need to be adapted in order to provide the best care for the patient.

Because of the differences present between cultures, it is necessary to individualize treatment based on what culture the CBTp modality is being implemented in. Individualizing interventions is recommended by Makanjuola et al. (2016) to reduce self-stigma and provide

better care for the individual. Individualizing the universal interventions that make CBTp effective in a Western culture may prove difficult, and more trials and studies will be necessary to build out the knowledge base and identify if it is the most effective way to treat psychosis in non-Westernized cultures.

Building out Family Support by Providing Family Therapy

While understanding how the symptoms of psychosis affect an individual experiencing them, it would be beneficial to gain an understanding of how the family members are affected. In non-Western cultures, family and social relationships play an important role in an individual's life and have been shown that they can be a help or a hinderance to treatment goals and adherence (Li et al., 2017; Naeem, 2019). Providing family therapy to individuals of non-Western cultures would give both the patient and their family a safe space to discuss how they understand the problem. This could lead to creating a united front as both the patient and their family members would gain an understanding of how the other is affected by the diagnosis and can then focus on building healthy relationships and interpersonal skills between all the individuals present in sessions.

Gain Understanding of how Traditional Healing Practices Impact Individuals Experiencing Psychosis in Non-Western Cultures

The research included in this review finds that individuals with symptoms of psychosis in non-Western cultures generally will seek out help initially from religious or spiritual healers (Ahmed et al., 2019; Li et al., 2017; Makanjuola et al., 2016; Mirza et al., 2019; Naeem et al., 2019; Rathod et al., 2023). Gaining an understanding of the effect that religion or supernatural beliefs have on the affected individual, as well as how the religious or spiritual healer behaves and reacts to the affected individual can help the mental health professional begin to understand

some of the root causes of stigmatization. Religious figures could behave differently around the individual experiencing symptoms of psychosis, such as talking to them differently or having different body language. As the religious or spiritual healers could hold a higher place within that cultures belief system, the impact that these individuals have on the patient could lead them to feel more stigmatized. As mental health professionals, there must be an understanding of how these religious or spiritual healers impact the patient on their path to recovery, with this understanding potentially being helpful in treatment of comorbid symptoms such as anxiety or depression.

Chapter 5: Conclusions and Recommendations

This review sought to answer the question of if cognitive behavioural therapy for psychosis could be culturally adapted for treatment in cultures with different causal attributions of mental illness. The studies in this review offer findings that indicate that with proper adaptations, such as individualizing CBTp interventions, offering family therapy to individuals of non-Western cultural backgrounds, and gaining knowledge of traditional cultural healing practices, it could be. Most of the studies included in this review offer an initial look into what cultural adaptations would be beneficial to implement in CBTp and ultimately more research is necessary to support these adaptations being implemented.

Non-Western cultures commonly hold beliefs that psychosis symptoms are caused by spiritual or religious means rather than biological causes (Li et al., 2017; Makanjuola et al., 2016; Rathod et al., 2023). This impacts what sources they seek help from when experiencing these psychotic symptoms, generally going to a spiritual or faith healer before considering a medical professional (Makanjuola et al., 2016; Rathod, 2023). Individuals with a mental illness in these cultures are heavily stigmatized and this causes them great distress (Lannin et al., 2016; Vyas et al., 2021). Non-Western cultures place more value on family and social relationships when compared to Western cultures. Being diagnosed with a mental illness can affect these relationships and cause the affected individual to socially isolate themselves, increasing their distress level (Mirza et al., 2019). This is applicable to both individuals who live in non-Westernized countries as well as individuals from non-Western cultures living in a Westernized country.

CBTp is an ideal treatment modality to adapt for use in non-Westernized cultures where psychosis may not be viewed as a mental illness. CBTp is an evidence-based intervention

strategy that provides exercises that would be easily adapted to other cultures. Culturally adapting CBTp for non-Western cultures by incorporating traditional healing practices that are more culturally acceptable to the local population into CBTp interventions would enhance the intervention acceptance and effectiveness with this population (Fendt-Newlin, Jagannathan, & Webber, 2020). This will require knowledge of how the traditional healing practices were beneficial to the affected individual so that they can be adapted appropriately with CBTp interventions. A person-centered start to treatment is recommended to gain an understanding of how the individual experiencing symptoms of psychosis is affected by their diagnosis within their cultural context. Mental health professionals need to consider the cultural context that the affected individual is living in to provide culturally appropriate treatment. This cultural context will also help the mental health professional to understand the potential comorbid symptoms that the affected individual is experiencing, stigmatization that they face from family, relatives, and members of their community, and the ways that the affected individual has changed themselves to try and cope with the symptoms of their diagnosis. Once these contexts are understood, ideally with the patient sharing them with the mental health professional in a healthy therapeutic relationship, CBTp interventions can be adapted in a culturally appropriate way to assist the affected individual in a culturally sensitive and beneficial way.

Individuals with symptoms of mental illness in non-Westernized cultures face heavy stigmatization from family, relatives, and members of their community which can lead them to isolate themselves for fear of judgement. Social relationships hold more value in non-Westernized cultures compared to Westernized cultures, and therefore have more of an impact on help-seeking behaviours and treatment adherence of the diagnosed individual. Family therapy is recommended where possible to assist in building understanding of the patient's experiences

with their symptoms of psychosis with their family members. This also provides a safe space for all of the individuals present in the session to build healthy interpersonal skills and communication about the patient's diagnosis between the patient and each family member. By providing psychoeducation on psychosis in session to both the patient and their family members, mental health professionals work to reduce stigmatization around mental illness in non-Westernized cultures. Non-Western cultures were found to do well with homework, a core CBTp tenant, and providing exercises that individuals can practice when not in session minimizes the time that needs to be spent with a mental health professional and reduces the economic and social cost to the patient.

Currently, there is limited research into culturally adapting CBTp to non-Western cultures, and what research is available uses small sample sizes and qualitative methods. Using the Cultural Adaptation Framework referenced earlier in this review (Fendt-Newlin, Jagannathan, & Webber, 2020), many of the current studies (Ahmed et al., 2019; Li et al., 2017; Makanjuola et al., 2016; Mirza et al., 2019; Rathod et al., 2023; Vyas et al., 2021) are in phase one of this framework. This phase requires gathering information from patients, family members, caregivers, and mental health professionals. These studies gathered information that should be considered in adapting mental health and CBTp practices for non-Western cultures. Only a few studies (Habib et al., 2015; Muller et al., 2020; Naeem et al., 2024; Sonmez et al., 2020) moved to phase two and phase three of designing and implementing a study to attempt an initial adaptation given the information that had been gathered from phase one studies. A key aspect of this framework is that phases two and three are repeated to continue increasing the adaptation efficacy of the treatment, with the studies included in the current review only providing the initial trial without further refinement. While the current studies have provided useful results,

they are in no way finalized and further research should be undertaken to implement cultural adaptations to a specific population testing for effectiveness of the adaptation.

Current research in cultural adaptation is primarily conducted with South Asian cultures in terms of non-Western cultures (Ahmed et al., 2019; Li et al., 2017; Mirza et al., 2019; Naeem et al., 2024; Vyas et al., 2021). Only one study investigated African nations (Makanjuola et al., 2016) and limited studies investigated cultures in the Middle East (Habib et al., 2015; Rathod et al., 2023). While both inpatient and outpatient settings were used in studies, studies using outpatient settings were limited by participants' ability and willingness to travel to the research area. Research was done in large urban centres, limiting the number of rural participants and potentially skewing the data (Li et al., 2017; Rathod et al., 2023). While most studies used an age range of 18-65 to gather participants, in many studies the sample's average age was closer to the lower end of that range (Habib et al., 2015; Makanjuola et al., 2016; Naeem et al., 2024; Vyas et al., 2021). Studies on adapting CBTp up to the time of this review have been limited in scope. Studying larger, more diverse samples to determine the effectiveness of future adaptations will be necessary. In addition, making changes to expand the sampling process by attempting to diversify the population being sampled. In many of the studies in non-Westernized countries, mostly urban populations are used for the sample. Expanding this to include more rural populations would give the studies a more accurate view of the population of the country as a whole.

Future Research Questions/Recommendations

Based on the reviewed research and the limitations of the studies that were included in this review, several questions can be offered to provide recommendations for future research. First, how can CBTp be effectively adapted to treat individuals experiencing symptoms of

psychosis from non-Westernized cultures? Current literature is not conclusive, and more trials are needed to test out the current recommended adaptations. Using the framework researched by Fendt-Newlin, Jagannathan, and Webber (2020), this review found that much of the current literature on cultural adaptation of CBTp is in the information gathering phase one. Conducting more studies that actively work with making adaptations based on the information gathered from the current literature will help make CBTp more accepting in non-Westernized cultures.

While culturally adapting CBTp has so far shown some positive returns, a knowledge base of what adaptations are effective for non-Westernized cultures is still being gathered. Researchers must now ask: What specific adaptations should be prioritized for non-Westernized cultures? Rather than sending researchers to foreign countries to conduct research on if culturally adapted CBTp would be helpful for individuals with a psychotic diagnosis from non-Westernized cultures, it would be more cost effective to conduct studies in Western countries with individuals from non-Westernized cultures. Using the framework laid out by Fendt-Newlin, Jagannathan, and Webber (2020), there are a handful of studies that are already in phase one of the framework examining the stigmatization of South Asian populations and what barriers prevent them from accessing mental health treatment (Ahmed et al., 2019; Mirza et al., 2019; Naeem et al., 2024; Vyas et al., 2021). Using the information gathered by these studies, future research should focus on trials for culturally adapting CBTp for South Asian populations, starting with populations living in Western countries. This will enable researchers to gather information about their cultural values and beliefs while keeping cost of research lower than if they were to travel to other countries. Conducting this research would also expand the availability of CBTp in the countries that trials are being performed in. Current availability of CBTp in Western cultures is low due to CBTp generally being provided in an individual setting and the level of education

necessary to provide psychological treatment (Kopelovich et al., 2022; Van der Stouwe et al., 2021). In the Netherlands, 70-75% of individuals with a psychotic diagnosis have no access to psychological treatment (Van der Stouwe et al., 2021). As CBTp itself was developed in the West, it needs to be adapted to be best applied to non-Western cultures, increasing its availability in non-Westernized populations both in Westernized countries and non-Westernized countries (Li et al., 2017). As discussed in this review, the availability and access of culturally adapted CBTp is limited for individuals of non-Westernized cultures (Naeem, 2019). Referral systems to psychological supports are not available, and seeking treatment from psychological supports is heavily stigmatized and reduces the likelihood of individuals seeking treatment from mental health professionals. These same barriers exist for individuals of non-Westernized cultures living in Western countries.

Exploring ways that psychoeducation can be presented effectively to non-Westernized cultures would help to reduce stigmatization of individuals with a psychotic diagnosis. Studies in this review showed that when psychoeducation was done with affected individuals and their families, the level of stigmatization dropped and treatment was more accepted (Li et al., 2017; Vyas et al., 2021). When considering culturally adapting an entire treatment model and the effect that psychoeducation is found to have, further research must be done to answer the question of what model of psychoeducation would prove most effective for non-Western cultures. Li et al. (2017) found gaps in knowledge about psychosis in both patients and caregivers surrounding the presenting problems and the effect of schizophrenia, causes and awareness of illness, and knowledge of treatment and expectations. Vyas et al. (2021) explained that being present in the community and interacting with different cultural components, such as religious organizations, can help build the clinician's knowledge of values and strengths of the local community. This can

then inform what the clinician provides for psychoeducation and adapt it to the cultural particularities of the chosen community (Vyas et al., 2021).

A final question that should be explored in future research is: can CBTp be combined with more traditional cultural healing techniques to increase acceptance of treatment and reduce stigmatization? In the reviewed literature, researchers acknowledged how traditional practices such as spiritual or faith healers are the initial treatment option chosen by many in non-Western cultures. Having mental health professionals reach out to these other healers and work collaboratively with them could help the affected individual receive treatment faster and reduce the time they spend in distress.

Personal Reflection

During my time working on this review, I have considered how I approach clients in session and the way that I prepare for sessions. While I do not work with individuals with a psychotic diagnosis currently, the principles of keeping an open mind to clients and what beliefs they bring into session is valuable and beneficial to me as a therapist and to my client as well. I do not have to share the client's beliefs, but they are important to them and influence their personal values and goals in life. These are valuable to the work that will be done in session, and adapting treatment methods to use those beliefs as an asset will help make me a better therapist overall.

From a research perspective, before this project, I did not have a large research background and have not completed a project of this magnitude before. The skills that I have gathered in searching for literature and resources to complete this project will help me most in my clinical practice to find treatment methods or exercises that will be beneficial for my clients.

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