The Cognitive Behaviour Therapist (2023), vol. 16, e35, page 1 of 34
doi:10.1017/S1754470X23000302

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REVIEW PAPER

Cultural adaptations of group CBT for depressed clients from diverse backgrounds: A systematic review

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(Received 5 June 2023; revised 13 October 2023; accepted 17 October 2023)

Abstract

Cognitive behavioural therapy (CBT) is considered a frontline treatment for major depressive disorder (MDD) and is recommended as a preferred option in many Western healthcare settings. CBT has proven effective for clients from the majority population in Western countries, but to meet the needs of diverse clients it may require adaptation. The benefits of culturally adapted group CBT (CA-GCBT) for clients from diverse backgrounds remains uncertain. The objective of this review is to systematically identify, evaluate, and integrate the existing empirical literature on CA-GCBT for depressed clients from diverse backgrounds. A comprehensive search was conducted in April 2021 across various databases, including, MEDLINE, PsycINFO, Cinahl, Academic Search, and APA PsycArticle. Quantitative studies meeting the inclusion criteria resulted in a total of ten articles being included in the review. Results from the analysis revealed a statistically significant reduction in depressive symptoms following CA–GCBT in nine out of the ten studies, with one study providing descriptive results. Additionally, improvements were observed in dysfunctional beliefs, functioning, and quality of life ratings. These findings suggest promising outcomes for racially minoritised clients in Western countries and racial majority clients in non-Western countries. Adaptations in CA-GCBT primarily focus on modifying the group delivery, therapy content, staffing, processes, and client-specific factors. Overall, CA-GCBT shows promise as a treatment for depressed clients from diverse backgrounds. However, further evaluation is necessary to establish its efficacy in clinical practice more robustly, to identify which adaptations are most effective for specific populations and to explore the experiences of implementing or attending such group interventions.

Key learning aims

(1) To explore the benefits of CA-GCBT for depressed clients from diverse backgrounds. Although CBT is a frontline treatment for MDD and often delivered in group format, it remains unclear whether CA-GCBT is beneficial.
(2) To summarise findings about the benefits of CA-GCBT for racially minoritised clients in Western countries and racial majority clients in non-Western countries.
(3) To outline the modifications made to common CBT group approaches to enhance cultural responsiveness for clients from diverse backgrounds.
(4) To provide support to therapists, healthcare services, and broader healthcare structures seeking to implement evidence-based knowledge when adapting group CBT for diverse cultural groups. This enables them to modify existing group CBT protocols or consider specific CA-GCBT interventions.

Keywords: Cognitive behavioural therapy; culturally adapted; CA-GCBT; depression; group CBT; major depressive disorder

Table 1. *DSM-V* criteria for major depressive disorder

Five or more of the below symptoms must have been present for the same 2-week period with at least one of the symptoms being either depressed mood or loss of interest or pleasure, and symptoms cannot be clearly attributed to another medical condition.
1. Depressed mood most of the day, nearly every day
2. Diminished interest or pleasure in all, or almost all activities
3. Significant weight loss or gain, or changes in appetite
4. Insomnia or hypersomnia
5. Agitation or slowed movements
6. Fatigue or loss of energy
7. Feelings of worthlessness or excessive guilt
8. Difficulty thinking, concentrating, or making decisions
9. Recurrent thoughts of death or suicide
The above symptoms cause clinically significant distress or impairment in social occupational or other important areas of functioning
The episode is not attributable to the physiological effects of a substance or to another medical condition
The occurrence is not better explained by another disorder
There has never been a manic or hypomanic episode

From American Psychiatric Association (2013; p. 161).

Introduction

What is major depressive disorder?

Major depressive disorder (MDD) is a common mental health problem characterised by persistent feelings of sadness, hopelessness, and loss of interest in activities that were once enjoyable. Symptoms of MDD can vary from person to person but may include a persistent sadness, loss of energy, difficulty sleeping, changes in appetite or weight, feelings of guilt or worthlessness, difficulty concentrating or making decisions, and thoughts of suicide or self-harm. To meet the diagnostic criteria, a person must experience five or more symptoms for at least 2 weeks. See Table 1 for the diagnostic criteria for MDD from the *DSM-V* (American Pyschiatric Association, 2013).

Estimates of prevalence in 2000 were approximately 16 per 100,000 per year for men and 25 per 100,000 per year for women worldwide (Üstün *et al.*, 2004). The Global Burden of Disease (GBD, 2019) reported that depressive disorders accounted for the largest proportion of mental disorders in 2019 (approximately 37.3%). In addition, Santomauro *et al.* (2021) estimated a further 27.6% increase in MDD due to the COVID-19 pandemic. In terms of impact, MDD is associated with significant burdens including decreased quality of life, functional impairment, suicide, cardio/cerebral mortality, disability, and economic and family burdens (Lepine and Briley, 2011).

CBT as an effective treatment for MDD

In randomised control trials (RCTs), cognitive behavioural therapy (CBT) for the treatment of MDD has demonstrated efficacy compared with control/waitlist groups (Beltman *et al.*, 2010; Van Straten *et al.*, 2010) and is as effective as other forms of psychological therapy (Barth *et al.*, 2013; Cuijpers *et al.*, 2010; Cuijpers *et al.*, 2013; Hofmann *et al.*, 2012). CBT is more effective than relaxation (Jorm *et al.*, 2008) or psychodynamic therapy (Tolin, 2010). This is not only true within study conditions; more recently, a systematic review and meta-analysis by Öst *et al.* (2023) found that CBT for MDD is an effective treatment when delivered in routine clinical care, with outcomes comparable to those obtained in efficacy studies.

Although CBT is sometimes considered a monolith, it is more akin to a family of therapies with similarities and differences. Even within the treatment of MDD, there is cognitive therapy (CT) based on Beck (1979) and behavioural activation (BA) based on Martell *et al.* (2001) and Lejuez *et al.* (2001). In England, the National Institute for Health and Care Excellence (NICE) recommends these as front-line treatments delivered either individually or in groups. According

https://doi.org/10.1017/S1754470X23000302 Published online by Cambridge University Press

to NICE guidelines, these CBT-based treatments should be considered first before exploring other modalities such as group exercise, mindfulness, interpersonal therapy, SSRI anti-depressants, counselling, and short-term psychodynamic psychotherapy (NICE, 2022).

Group delivery of CBT for MDD

Initially developed as an individual therapy (Beck, 1979), CBT delivered in a group format has been found to be effective, with meta-analyses of RCTs of group CBT for MDD reporting good efficacy (Cuijpers *et al.*, 2008; Feng *et al.*, 2012; Huntley *et al.*, 2012). A more recent network meta-analysis by Cuijpers *et al.* (2019) highlighted that the efficacy of individual, group, telephone, and guided self-help CBT formats did not differ significantly. In addition, individual and group formats were more acceptable to clients.

In England, the majority of CBT for mild to severe MDD is delivered through the NHS Talking Therapies Programme (formerly known as Improving Access to Psychological Therapies or IAPT). This national initiative aims to improve access to evidence-based psychological therapies for individuals with common mental health disorders such as anxiety and MDD. Group CBT is a commonly offered treatment option within the NHS Talking Therapies programme, with a total of 23,868 clients receiving group CBT between 2021 and 2022 in England (NHS Digital, 2022). The data further indicate that group CBT for MDD yields promising results, reducing PHQ-9 scores from an average baseline score of 12.2 to an average final score of 9.2 over the same period (NHS Digital, 2022). The prevalence of group CBT in the NHS Talking Therapies programme is consistent with the NICE guidelines for MDD (NICE, 2022), which recommend group CBT as a second-line intervention.

In terms of benefits, group CBT provides frequent and varied opportunities for mutual reinforcement and peer modelling (Wolgensinger, 2015), which is much more powerful than reinforcement by a therapist alone (Rose, 1999). Group CBT is considered cost and time efficient for treating many patients (Kwon and Oei, 2003; Oei and Dingle, 2008). Therefore, given the need to improve access to talking therapies and meet targets, many services use group treatments (Wykes, 2013). The NICE guidelines for MDD (NICE, 2022) note benefits of connecting with others who are having similar experiences.

However, this is not to say that group CBT has no disadvantages. These may include possible confrontations between participants, the development of sub-group/cliques, and participants talking over each other (Tucker and Oei, 2007). Group CBT may not be suitable for people with recurrent MDD, co-morbidity, or those who need reasonable adjustments (e.g. language or accessibility). Finally, when reviewing the NHS Talking Therapies data from NHS Digital (2022), it is unclear what constitutes group CBT, as it is described as 'psychoeducational peer support' but it is not clear whether all services have a shared understanding of what this entails. For instance, do they all use the same interventions? Is there any difference in the intensity or number of sessions? Is there consensus about group size? Do they all involve rigorous quality assurance?

Influence of culture on the presentation and treatment of MDD

Culture can be described as the behaviours, norms, ideas, attitudes and traditions that exist within groups of people and are typically explicitly/implicitly communicated. Examples include whether one takes their shoes off or keep them on within the house, eating etiquette, rules around personal space, communication styles, greeting customs, and family structures. Whatever it is, if one has a typical pattern of behaviour; where did they learn this norm? Are there any explicit messages or implicit meanings that have been conveyed? If one has a typical pattern of behaviour, one's culture helps to understand the origins of such norms and their associated meanings.

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In the context of healthcare, culture inevitably impacts every aspect of illness and adaptations, such as responses to symptoms, explanations of illness, patterns of coping, help-seeking behaviour, adherence to treatment, and even emotional expression (Helman, 2007).

This is also true with MDD, as culture influences the expression of symptoms, illness explanation, and pathways to care (Patel, 2001). In many cultures, physical symptoms are the most common presenting feature, and they are more likely to be expressed than psychological symptoms (Aichberger *et al.*, 2008; Bhugra and Mastrogianni, 2004; Desjarlais *et al.*, 1995). Culturally bound descriptions are more likely to be used; for instance, clients from Iraq may be more likely to describe 'oppression in the chest' or 'hunger for air' than depression (Al-Krenawi and Graham, 2000). Some clients from Arabic backgrounds are more likely than Western clients to describe aches, pains and weakness (Sulaiman *et al.*, 2001).

In terms of the explanation of illness, this also varies too. With culturally specific presentations and understanding resulting in culturally specific syndromes such as 'Brain Fag', 'Ode-ori', 'Hwa-byung' or 'Neurastheni' (Kirmayer, 2001). Kleinman *et al.* (1986) reported that 30% of clients attending out-patient clinics in Hunan, China were diagnosed as 'neurathenic' (meaning having neural weakness) as this was more common and acceptable than depression. A more recent example comes from Taiwan, where Chen (2021) reported on the emergence and increasing prevalence of '*Zilushenjin shitiao*' (自律神經失調 or autonomic imbalance). Autonomic imbalance is not a formal diagnosis but refers to a wide range of physical and mental symptoms that are medically unexplained (Chen, 2022)

In terms of pathways to care, there is variation due to patterns of help-seeking behaviour ranging from traditional to informal, or semi-formal routes. This leads to variation between seeking help from religious leaders, family members and even internet forums (Markova *et al.*, 2020). GPs face challenges in supporting clients from other cultures due to a lack of knowledge of past experiences/norms, culturally based differences, e.g. understanding of the aetiology, and even misunderstandings in communication (Lehti *et al.*, 2009).

The influence on the presentation and treatment of MDD is not just limited to cultural differences but is also influenced by geopolitical events and historical processes. Considering the differences alone risks a simplistic, ahistorical, and decontextualised view. For instance, Okazaki *et al.* (2008) warn against the tendency in psychology to ascribe observed group differences to East–West binaries such as individualism–collectivism or Judaeo-Christian versus Confucian. Rather, it is necessary to be open to complex, multi-factorial influences and narratives. Due to historical and societal factors, some clients from diverse backgrounds face adversity, which may relate to an increased risk of mental health problems and is compounded by barriers to accessing mental healthcare (Lawton *et al.*, 2021).

In summary, all of this highlights the importance of clinicians gaining the necessary understanding of the client, their culture, and wider context to reach a shared understanding of the presenting problem and agree on a treatment approach (Kirmayer *et al.*, 2011).

Poorer access and outcomes for clients from diverse backgrounds

Discourse is increasingly focused on how CBT may be less effective and less acceptable to clients from diverse backgrounds when delivered in a generic manner (Bennett *et al.*, 2016). It may not be appropriate for individuals from non-Western backgrounds due to the significant role that culture plays in the conceptualisation of difficulties and the ethnocentric nature of psychosocial interventions, developed based on Western cultural values (Naeem *et al.*, 2019).

In the NHS Talking Therapies programme, many clients receive CBT, accounting for 46.3% of all treatment episodes in 2020–2021 (NHS Digital, 2022). Despite this large proportion receiving CBT, clients from diverse backgrounds tend to have lower access rates and poorer outcomes than their White British counterparts (Baker and Kirk-Wade, 2023). This trend is true across the years as individuals who identified as White British were more likely to complete treatment and

https://doi.org/10.1017/S1754470X23000302 Published online by Cambridge University Press

improve than those from any other background between 2018 and 2019 (Ahmad *et al*., 2022). Poorer outcomes were reported for clients from Yemeni, Pakistani and Somali background (Arafat, 2021) and women of Pakistani background (Kapadia *et al*., 2017). In addition, clients from Black Caribbean, Black other, and White other groups were more likely to be referred to other services than to be treated within NHS Talking Therapies (Harwood *et al*., 2023). Bhavsar *et al*. (2021) noted that individuals residing in the UK for less than 10 years are less likely to engage with NHS Talking Therapies, even after accounting for factors such as English proficiency or reason for moving.

Poorer outcomes are also true in relation to engagement and completion. NHS Talking Therapies data highlights lower completion rates for clients from diverse backgrounds than White British counterparts (Baker and Kirk-Wade, 2023). However, whether this is solely associated with not receiving culturally adapted or sensitive psychological interventions or other factors is unclear. Rathod *et al*. (2015) warn of the potential risk of clients disengaging if CBT is continually delivered in a generic way as it creates a perception or experience that their culture or they themselves are not understood.

Generic application of CBT could also obstruct the process of change, especially if the therapists' explanations are contradictory or not acceptable to the client's cultural model (Jameel *et al*., 2022). For example, when providing psychoeducation about the fight-or-flight response in practice, many therapists link this with the theory of evolution. However, this may contradict some clients' beliefs or cultural models. Similarly, when implementing BA, there is a risk of focusing solely on generic activities or those that are the norm for the majority, such as going for a night out, drinking, socialising between genders, or engaging in certain recreational activities. However, these activities may not align with those preferred by clients from diverse backgrounds and may even directly conflict with their cultural models, obstructing the process of change.

This highlights significant issues with access and outcome rates for clients from diverse cultural backgrounds. Historically, this trend was not fully acknowledged, and the explanation reinforced problematic narratives. Clients from diverse backgrounds tended to be portrayed as being 'hard to reach' (Naz *et al*., 2019).

There is a significant need to ensure that the delivery of CBT is not done in a copy-and-paste manner. It is worth noting that the author has chosen to use the term 'generic' rather than 'standard' as such copy-and-paste work is not consistent with CBT standards. Greenberger and Padesky (1995) warn against such an approach in the 1990s:

> 'Therapists can err in ignoring culture or over attributing cultural influence on problems. Therapists who do not even notice a client's race or do not inquire about religious beliefs are guilty of the first error.'
>
> (Greenberger and Padesky, 1995; p. 41)

If anything, CBT offers opportunities to ensure that psychological therapies are accessible and acceptable to clients from diverse backgrounds. Bhardwaj (2016) argues CBT has strengths lending itself to cultural adaptation, such as the flexibility to meet the needs of the individual, the focus on client empowerment, and attention to conscious processes and specific behaviours which are more appropriate.

Implicit cultural assumptions within CBT

CBT has been developed and studied predominantly with participants from the racial and cultural majority in Western countries, leading to criticism for being overly Western-centric and founded solely on cultural assumptions that align with Western societies (Summerfield and Veale, 2008). Some aspects of CBT may be contradictory or incompatible with the values and cultural

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assumptions of individuals from non-Western cultures or those from marginalised backgrounds (Jameel *et al*., 2022). Therefore, it can be helpful to consider inherent, implicit assumptions when considering CBT in diverse cultures.

One of the key assumptions of CBT is that thoughts and beliefs are the primary drivers of emotions and behaviour. However, some individuals and cultures may be less likely to attribute their emotions and behaviour to internal factors, and more likely to attribute them to external factors such as social context and relationships (Heine *et al*., 2007). Thus, CBT's focus on changing internal thought patterns invariably influences the acceptability and efficacy of CBT.

The degree to which a culture or individual is individualistic or collectivistic is worth considering. Guo and Hanley (2015) outline the challenges and opportunities for adapting CBT for Chinese clients and describe how CBT was developed based on the Western individualistic worldview. Such a worldview promotes the autonomy of the individual. It also emphasises the individual's need for self-development. However, such values may not be relevant in the Chinese collectivist culture, where the needs of the community are placed before the needs of the individual, and the individual's locus of control is often externalised.

Another culturally based assumption within CBT, rooted in Western cultural values, is a prioritisation of personal responsibility. Based on this cultural context, it is sometimes assumed that individuals are solely responsible for change, so much so, that personal responsibility for change is considered an indicator of suitability for CBT (Myhr *et al*., 2007). However, this assumption may not apply to individuals from collectivistic cultures, which emphasise interdependence, cohesion, and social harmony (Friedman *et al*., 2010; Heine *et al*., 1999). Individuals from collectivistic cultures may be more likely to prioritise the family or community needs.

Another culturally based assumption within CBT is that individuals clearly understand the content of their thoughts and beliefs and are comfortable expressing them. However, this assumption may not apply to individuals from cultures where expressing emotions and thoughts is not encouraged or is even discouraged. For example, in some Asian cultures, there is a strong emphasis on emotional control and suppression (Matsumoto and Yoo, 2006). Individuals from these cultures may be less likely to express their emotions and thoughts in a therapy session, which could influence the acceptability or effectiveness of CBT.

In CBT, there is an underpinning principle that early life experiences can significantly impact an individual's beliefs, attitudes and behaviours. Specifically, negative early life experiences can lead to the development of maladaptive thought patterns and coping strategies that persist into adulthood. However, what constitutes a negative experience often carries assumptions influenced by norms based on the Western majority, and the assumption may not apply equally to individuals from different cultures. For instance, in CBT, there can be an assumption of a norm about attachment and family dynamics. However, research has shown that attachment styles may vary across cultures, with some cultures emphasising secure attachment, while others may value more autonomous and independent attachment styles (Grossmann and Grossmann, 1991; Rothbaum *et al*., 1982). Research has shown that the impact of early life experiences on mental health may vary depending on cultural factors such as collectivism, individualism, and the importance of interdependence (Kirmayer, 2001).

There may be cultural differences in the types of early life experiences that are most likely to lead to negative outcomes in adulthood. For example, in some collectivist cultures, interpersonal stressors such as conflicts with family members or social ostracism may be more common and have an impact on mental health more than in cultures where individualism is prioritised (Kirmayer, 2001).

While CBT has been shown to be an effective treatment for many individuals, it is important to recognise that it is founded on culturally based assumptions that may not apply to everyone. Culture influences an individual's life experiences, beliefs and responses, which can influence the development and maintenance of psychopathology, shaping their beliefs about health and illness, pathways into care, and trust in mental health services (Rathod *et al*., 2019).

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It is important to acknowledge that the criticisms about being overly Western and the implicit assumptions noted above are applicable to CBT and most psychological therapies. As most psychological therapies and their underlying theories are rooted in Euro-American culture (Guo and Hanley, 2015), they have primarily been tested on individuals within Western countries. These therapies are also predominantly delivered in services that lack diversity and representation (Hays, 2019). Furthermore, the institutions and departments responsible for training therapists often do not reflect the broader diversity of society (Hays, 2019).

Addressing these issues requires a concerted effort from all, regardless of whether therapists, researchers and educators promote inclusivity within the field of psychological therapy, moving beyond the copy-and-paste delivery of Western-centric approaches to actively incorporate clients' diverse cultural perspectives into existing therapeutic frameworks. This involves recognising inherent assumptions, adapting therapeutic techniques to suit different cultural contexts, and fostering a diverse and inclusive community of therapists who can effectively cater to the needs of a multi-cultural clientele. It also progresses to a point where psychological therapies are developed, tested and disseminated by and for clients from diverse backgrounds. By embracing these changes, the field can progress towards a more equitable and effective practice of psychological therapy for all.

Culturally adapted CBT

Culturally adapted CBT (CA-CBT) involves adjustments to how therapy is delivered without compromising the theoretical underpinning of CBT. The adjustments are informed and achieved through developing awareness, knowledge, and skills related to a given culture (Naeem, 2012a). This may include integrating the distinctive and culturally influenced aspects of how mental health issues are expressed and comprehended (Beck, 2016). It also integrates the complex and multi-dimensional ways in which people conceptualise their identities (Hays, 2016). It acknowledges and integrates cultural factors, values, beliefs and norms into the therapeutic process to enhance the effectiveness of treatment and improve outcomes for individuals from diverse cultural backgrounds.

Depending on the presenting problem and the client's cultural background, different aspects of the delivery of CBT may be adjusted. Therefore, it is not a one-size-fits-all approach. While it is not feasible to outline all the different examples of adaptations, a range of examples are offered below:

One focus of modification is the integration of the client's cultural values, in understanding and resolving psychological issues. An example of this is a case study by Diaz-Martinez *et al.* (2010), integrating Latino values of 'marianismo' (selfless sacrificing for the family), 'respecto' (respect), 'familismo' (value of the family), and 'ser bien educado' (parents' responsibility for the behaviour of their children). Another example is the inclusion of Taoist principles of collective benefit, non-competition, moderation, acceptance, humility, flexibility, effortless action, and harmony with the laws of nature into cognitive therapy (Chang *et al.*, 2016). Such integration of values enables greater sense making, provides context for thoughts/beliefs, becomes a central component of the formulation, and influences the interventions.

There may also be focus on modifying the typical assessment process by gaining a greater understanding of the client through discussions about their culture, religion and ethnicity. For instance, discussions about cultural identity, acculturation, religious/spiritual orientation, and difficulties in cultural adjustments can help understand the levels of cultural adjustments and religious orientation (Naeem *et al.*, 2015). For other clients, once trust is established, there may be a need to enquire about experiences of racism or micro-aggressions and the impact these may have on the client and on their mental health (Beck, 2019).

Another focus is the use of culturally originating or appropriate metaphors, stories, proverbs and lessons to describe key aspects of the client's experience or principles within CBT. An example

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with Mauri clients is the metaphor of a house (Māori word – 'whare') to describe a formulation, with the foundation representing early childhood experiences. The first floor are the core beliefs, the next floor being rules for living and the roof being the coping strategies, which may or may not be helpful (Bennett *et al*., 2016). Another example is Washington (2012) who used the metaphor of the trickster coyote with Native American clients. This was useful for explaining how cognitive distortions can trick people and mislead them, but also described cognitive restructuring as knowing the names of the coyotes, which brought them out of the dark and into the light.

Modification may also focus on the therapy process or interventions to ensure they are congruent or originate from the client or their culture. For example, the greater involvement of family members or significant others in therapy can improve communication and share learning (Berry *et al*., 2018). Another example relates to whether to utilise cognitive or behavioural interventions, as some clients may encounter difficulties discussing thoughts due to cultural norms and a fear of being judged. Therefore, there may be a need to pick an intervention that aligns with a perceived cultural preference for behavioural work (Guo and Hanley, 2015). Alternative modifications may be focused on homework, whereby some may benefit more from writing in their native language, using symbols with less writing, regular reminders, audio, culturally bound counting (using beads), and involving the family (Naeem *et al*., 2015).

Such adjustments are not *ad hoc*; instead, they are systematic modifications of various research-based interventions to ensure that they are compatible (Bernal *et al*., 2009).

Several conceptual models have been developed and published to inform the systematic approach to adapting psychological therapies. However, within the scope of this review, it is not feasible to outline all of these. Rather, encourage the reader to consult Naeem *et al*. (2023) who summarises existing frameworks and provide guidance on the processes and elements involved in culturally adapting therapies. The Southampton Adaptation Framework (Naeem *et al*., 2009) was considered for this review. This involves a process of gaining awareness of relevant issues beforehand (through literature, experts, and community engagement), adapting assessment and engagement (assessing not just the presenting problem but the influence of culture, using culturally relevant formulations and modifying engagement approaches) and adjusting therapy processes or techniques (such as style of therapy, structural factors and even focus of interventions).

This field is gradually expanding and is beginning to address the lack of research on the effectiveness of CBT for MDD with clients from diverse backgrounds. However, there are only a few noteworthy systematic reviews in the current literature. Horrell (2008) reviewed the literature on the use of CBT with ethnic minority clients living in the United States of America (USA) across a range of psychological disorders (including MDD). Six studies reported findings on the effectiveness of CBT as a treatment for ethnic minority adults with MDD. The findings suggest that CBT is an effective intervention for Hispanic and Latina women and has promising results for African American women, but no definitive conclusions were drawn for other communities. Kalibatseva and Leong (2014) reviewed existing culturally adapted treatments for MDD across multiple modalities (including CBT) and found that the majority involved practical adaptations, e.g. translating materials.

However, there were some issues within these reviews, such as a small number of appropriate studies, an unclear assessment of quality or a lack of details on methodology within the reviews, appearing to be more critical reviews rather than fully systematic reviews.

Lehmann and Bördlein (2020) reviewed culturally adapted BA to examine the methods and outcomes of cultural adaptations. Adaptations were found in different dimensions, including language, content, methods and context. The results indicate the effectiveness of BA and its cultural adaptations across the studies. Anik *et al*. (2021) conducted a systematic review and meta-analysis on the efficacy of culturally adapted face-to-face psychological treatments (including CT and BA). Their findings highlighted how CT and BA were often selected because of their strong evidence base for effectiveness. While both contribute to the literature, there remains a gap in

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examining culturally adapted CBT specifically and a much larger gap in culturally adapted CBT groups for MDD.

In general, these studies recognised the shortage of research in this area, emphasise the need for continued efforts to incorporate ethnic minorities into research, and provided recommendations for future studies.

Rationale

Despite the literature exploring culturally adapted psychological therapies, there is a gap in research that examines whether CA-GCBT for MDD is effective. Okumura and Ichikura (2014) were the closest to answering this question, and explored the efficacy and acceptability of group CBT for depression generally. Their findings highlighted that group CBT had a superior efficacy with a standardised mean difference (SMD = −0.68) and similar acceptability compared with non-active controls. However, this had a large proportion of studies that were focused on clients from the racial majority and were not specifically focused on CA-GCBT.

To the researcher's knowledge, no systematic review has examined the effectiveness of CA-GCBT for depression in adults from diverse backgrounds.

Aim of the current study

The aim of this review is to systematically identify, evaluate, and integrate the findings of the existing empirical literature on the benefits of CA-GCBT for depressed clients from diverse backgrounds.

This systematic literature review explores whether group CBT is an effective treatment for clients from diverse backgrounds if culturally adapted.

It attempts to answer the following research questions: Are culturally adapted CBT groups beneficial for depressed clients from diverse backgrounds? What modifications have been made to make it culturally adapted group CBT?

Method

This systematic review examined whether CA-GCBT was beneficial for depressed clients from diverse backgrounds by examining:

- CA-GCBT for adults from racially minoritised communities residing within Western countries.
- CA-GCBT for adults from racial majority communities in non-Western countries.

Search strategy

Database search

Following ethical approval from Coventry University on 30 March 2021, an electronic literature search was conducted on 13 April 2021.

Due to the lack of research on this specific topic, searches were completed in five databases:

- MEDLINE
- Cinahl
- APA PsycINFO
- Academic Search Complete
- APA PsycArticle

https://doi.org/10.1017/S1754470X23000302 Published online by Cambridge University Press

Table 2. Search terms structured around PICO

P: Population	Depression OR Depress* OR MDD AND Adults OR Adult
I: Intervention	CBT OR Cognitive Behavioural therapy OR cognitive behavioral therapy OR cognitive therapy OR behavioural therapy OR behavioral therapy
C: Comparison	Cultur* adapt* OR cultur* sensitiv* OR cultur* competen*
O: Outcome	Efficacy OR outcome

Table 3. Potential search terms for Population in PICO

P: Population	Based on literature	BAME OR BME OR 'PEOPLE OF THE GLOBAL MAJORITY' OR & 'Racial minority' OR 'Racially minorit*ed' OR 'ETHNIC MINORITY POPULATION' OR ETHNIC* OR 'Diverse population' OR BIPOC
	Based on UK Census categories (Office for National Statistics, 2023)	Asian OR 'Asian British' OR Indian OR Pakistani OR Bangladeshi OR Chinese OR 'Any other Asian background'
		Black OR Black British OR Caribbean OR African OR Caribbean OR African OR 'Any other Black, Black British, or Caribbean background'
		'Mixed or multiple ethnic groups' OR 'White and Black Caribbean' OR 'White and Black African' OR 'White and Asian' OR 'Any other Mixed or multiple ethnic background'
		Gypsy OR 'Irish Traveller' OR Roma OR 'Any other White background'
		'Other ethnic group' OR 'Arab' OR 'Any other ethnic group'
	Based on NIH (NIH, 2015)	'American Indian'
		'Alaska Native'
		'Asian'
		'Black' OR 'African American'
		'Native Hawaiian OR Other Pacific Islander
		'Hispanic' OR 'Latino'

Search terms

The search terms, truncations and Boolean operators utilised are given in Table 2. These represent the main concepts of the research topic and are the words used in practice to describe the topic. PICO was utilised as it is a comprehensive search framework, appropriate where time and resources are limited, and more likely to identify relevant papers (Methley *et al.*, 2014).

When generating search terms, it was apparent that identifying perfect search terms for the population may not be feasible because of the diversity of the communities in question and the variety of terms in common usage (see Table 3); therefore, the search term adults was utilised. It is important to note that the decision was made to leave the search term for the population as adults and invest more time in screening. It is recognised that terms such as BAME or BME may be unhelpful for communities (Milner and Jumbe, 2020). However, alternative terms used to describe racially minoritised populations may not convey the multiple facets of diversity or may not be commonly used (Lawton *et al.*, 2021).

Eligibility

Empirical, quantitative studies regarding the effectiveness of CA-GCBT either delivered to adults from racially minoritised communities residing within a Western country or adults from racial majority communities residing in non-Western countries. The focus on quantitative studies was chosen given their concise and delimited nature, which provides a more straightforward way of analysing the results of the included studies. Every study that specifically reported that it involved any type of cultural adaptation to the therapy was included (regardless of the extent of that adaptation).

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Table 4. Inclusion/exclusion criteria

Domain	Inclusion criteria	Exclusion criteria
Diagnosis	Primary problem of major depressive disorder (meeting *DSM-IV* criteria)	MDD is not the primary problem Other mental health diagnosis or physical health diagnosis is main presenting problem
Language	English language	Any other languages
Interventions	Interventions include CBT or culturally adapted cognitive behavioural therapy	Main intervention is any other
Population	Adults (over 18) from racially minoritised communities residing in a Western country or racial majority residing in a non-Western country	Children or adolescents (under 18)
Time frame	2000–2020	Outside of this range
Study type	Empirical	Meta-analysis Non-empirical study

Inclusion and exclusion criteria

The initial search resulted in 417 studies being identified; of which 165 duplicates were removed, giving a total of 252 studies to be considered for initial screening. A key inclusion criterion was that the population consisted of adults experiencing MDD who were either from racial minority communities residing within Western countries or from racial majority communities residing in non-Western countries. Exclusion criteria included studies where the presenting problem was another disorder (physical or mental) other than MDD, and interventions were not Culturally Adapted CBT, not group delivery, clients under 18, not written in English and not published between 2000 and 2020. As part of the initial screening, the titles and abstracts were assessed utilising the inclusion/exclusion criteria (Table 4); with a total of 224 being disregarded. The remaining 28 were full text screened; resulting in nine that were deemed acceptable. Hand searching of references was utilised to identify any relevant studies, with 11 studies identified; titles and abstracts were assessed utilising the inclusion/exclusion criteria (Table 4); with eight being disregarded, leaving three deemed acceptable. A total of 12 studies were included for quality assessment.

Systematic search results (PRISMA chart)

The procedure used for selecting articles follows the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Moher *et al.*, 2009). Please refer to Fig. 1.

Quality assessment

Quality assessment is crucial in systematic reviews, ensuring that the included studies meet methodological standards and provide reliable results. Systematic reviews aim to synthesise all available evidence on a specific topic for research or decision-making. By evaluating the study design, data collection methods, sample size, results and potential biases, reviewers can determine the strengths, weaknesses and limitations of the included studies. This process helps identify research gaps and inform areas where further investigation is required.

The Critical Appraisal Skills Programme (CASP, 2018) for Cohort Study was used as it has previously been used within healthcare-related systematic reviews and allows newer researchers to undertake a complex task involving many steps in a manageable way. It supports users in being systematic by ensuring that all important factors are considered. The assessment of quality was conducted independently by the main researcher and another researcher for all the papers. They independently reviewed all the papers and scored across the 12 items on the CASP. With each

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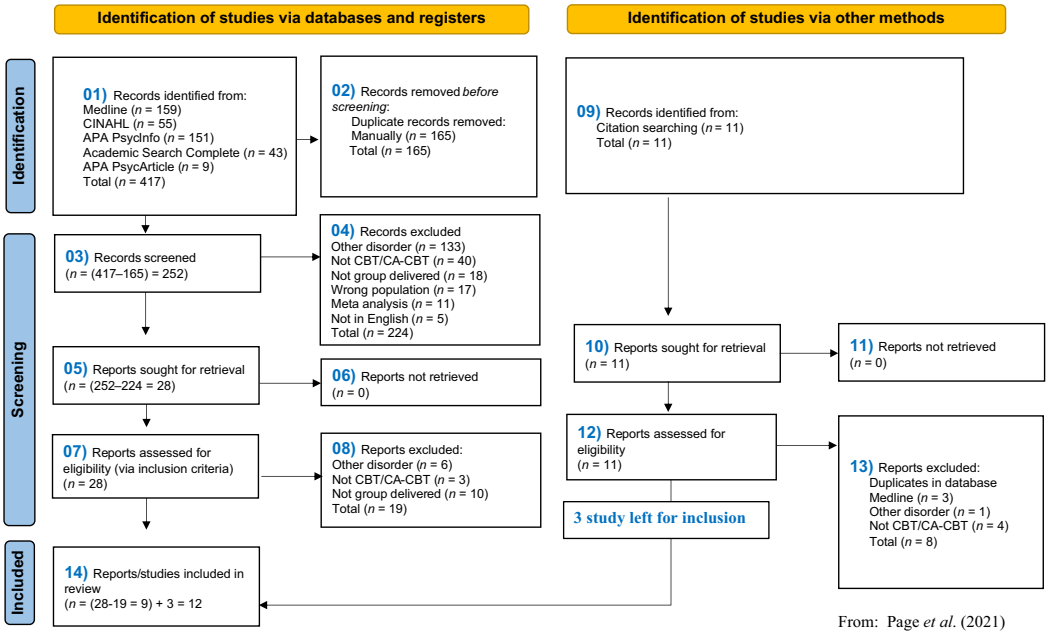

Figure 1. Search results: PRISMA flow diagram of study selection procedure.

item being scored, a score of 2 is given when a study fully meets the criteria, a score of 1 is given when it partially met/can't tell, and a score of 0 is given if it does not meet the criteria. See Table 5 for the CASP rating from two raters.

The CASP (CASP, 2018) for cohort study checklists has no pre-defined cut-off. Instead, the researcher computed the average midpoint (16.54) for all the studies, and studies scoring above the midpoint were classified as 'higher quality' and retained ($n = 10$). Meanwhile, two studies ($n = 2$) that scored below the midpoint were categorised as 'lower quality' and excluded. This was assumed to indicate that these studies could be methodologically weak or missing key components to make assumptions about their results. The two excluded studies were Aguilera *et al.* (2010) and Richardson and Bradbury (2012). Aguilera *et al.* (2010) reported on a Spanish speaking CA-GCBT manualised treatment in the USA and Richardson and Bradbury (2012) described the development of a CA-GCBT for South Asian women with MDD in England.

Following the quality assessment, it was necessary to check for inter-rater reliability to ensure systematic and valid quality assessment. This was done by calculating inter-rater reliability using Cohen's kappa (κ) using SPSS (outputs available upon request). κ inter-rater reliability coefficient scores for all studies that underwent the quality assessment process are shown in Table 6. The overall κ for all studies was 0.944 (strong); with a range from 0.789 to 1.00. A strong agreement was indicated, as a score of 0.902 or above represents a very strong agreement, below 0.8 represents a moderately strong agreement, and values below 0.6 represent low/poor agreement/reliability (Altman, 1990).

Results

Characteristics of the studies

Of the ten papers included in the review, nine focused on working age adults and one on older adults (65+ is generally considered older adults in England). One study did not clearly report on any exclusion criteria; the remainder had exclusion criteria such as suicidal ideation, bipolar

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Table 5. CASP rating from two raters

	Aguilera *et al.* (2010)		Aguilera *et al.* (2018)		Bowe (2013)		Fujisawa *et al.* (2010)		Ito *et al.* (2019)		Kohn *et al.* (2002)		Miranda *et al.* (2003b)		Miranda *et al.* (2003a)		Richardson and Bradbury (2012)		Ward and Brown (2015)		Wong (2008a)		Wong (2008b)	
	TK	CD	TK	CD	TK	CD	TK	CD	TK	CD	TK	CD	TK	CD	TK	CD	TK	CD	TK	CD	TK	CD	TK	CD
Q1	0	1	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Q2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Q3	1	1	1	1	2	2	1	1	1	1	2	2	2	2	2	2	1	1	1	1	2	2	2	2
Q4	0	0	1	1	2	2	1	1	1	1	2	2	2	2	2	2	1	1	1	1	2	2	2	2
Q5	0	0	2	2	2	2	2	2	2	2	1	1	2	2	2	2	0	0	0	0	2	2	2	2
Q5b	0	0	2	2	2	2	2	2	2	2	1	1	2	2	2	2	0	0	0	0	2	1	2	2
Q6	0	0	0	0	0	0	0	0	2	2	0	0	2	2	2	2	0	0	2	2	0	0	0	0
Q6b	0	0	0	0	0	0	0	0	2	2	0	0	2	2	2	2	0	0	2	2	0	0	0	0
Q9	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Q10	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Q11	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Q12	1	1	1	1	0	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Total	10	11	17	17	18	19	16	17	21	21	17	17	23	23	23	23	13	13	17	17	19	18	19	19
	Excluded																Excluded							

Scoring: yes = 2, partially = 1, no = 0 and can't tell = 0; N/A is not included within the final possible total.

Table 6. Kappa inter-rater reliability coefficient scores for all studies

	Value (κ)	Approximate significance
Aguilera *et al.* (2010)	.870	<.001
Excluded as lower quality		
Aguilera *et al.* (2018)	1.000	<.001
Bowe (2013)	.789	<.001
Fujisawa *et al.* (2010)	.855	<.001
Ito *et al.* (2019)	1.000	<.001
Kohn *et al.* (2002)	1.000	<.001
Miranda *et al.* (2003b)	1.000	<.001
Miranda *et al.* (2003a)	1.000	<.001
Richardson and Bradbury (2012)	1.000	<.001
Excluded as lower quality		
Ward and Brown (2015)	1.000	<.001
Wong (2008a)	.818	<.001
Wong (2008b)	1.000	<.001
Mean κ	0.944	

disorder, psychosis or substance misuse, unstable physical health states, bereavement, or perinatal care. Six studies were conducted in the USA with clients who belong to racially minoritised communities. Four studies were conducted with clients who are from racial majority communities residing in non-Western countries, with two studies based in Japan and two based in Hong Kong.

Most of the studies used a recognised CBT approach for treating MDD, either CT or BA, and modified it to suit the client group to ensure it was culturally appropriate. Out of the studies, four were based on CT (Beck, 1979); one utilised the Healthy Management of Reality framework (Muñoz, 2000) which contains elements of CT; one was BA (Lewinsohn, 1974; Martell *et al.*, 2001), one was based on Mind over Mood (Greenberger and Padesky, 1995); and another was based on Coping with Depression Group (Lewinsohn *et al.*, 1989). One study mentions that it was based on an amalgamation of BA and CT for depression but does not specify which interventions were selected or how they were amalgamated. Finally, one study, utilised 'Getting Out of the Abyss of Depression' (Wong, 2005), but the basis for this is unclear as the researcher could not access it, and it is uncertain which interventions were used or if these were aligned more with BA or with CT for depression.

To enable the systematic data analysis, key features of each included study were synthesised and organised utilising using a data extraction tool created by the researcher (Table 7).

Rationale for narrative synthesis

Consideration was given to carrying out a statistical analysis to combine the results of multiple studies. However, the researcher decided not to do this because the identified studies do not consistently answer the same research questions. There are methodological problems and inconsistencies, with several studies not following standard statistical reporting conventions. Therefore, this section provides more of a narrative description of the results.

Summary of findings

The researcher created a second data extraction tool (Table 8), to summarise the results of the studies included in the review. These outcomes include whether the intervention was statistically significant and the effect size on depressive symptomology. The studies were divided into two main groups, one encompassing racially minoritised communities residing within Western countries and the other encompassing racial majority communities residing in non-Western countries.

https://doi.org/10.1017/S1754470X23000302 Published online by Cambridge University Press

Table 7. Table of characteristics of studies

Author, date, country of origin, quality rating (QR) and kappa (κ)	Research aims	Design and sampling methodology	Participant details: (gender, age, ethnicity, context)	Intervention(s) and cultural adaptations	Data collection (definitions at the end of the table*)	Main findings
Aguilera *et al.* (2018) USA QR = 70.83% κ = 1.000	Examine attendance, homework completion and outcomes of CA–GCBT with low-income Latino clients	One-group pre-test–post-test design Opportunity sampling Excluded: psychosis or substance misuse	*N* = 96 Female (*n* = 79) Men (*n* = 17) Age (*M* = 53.3, *SD* = 12.1) Latino emigrated from Latin country	CA-GCBT (16 weekly, 1.5–hour sessions). Utilised the Healthy Management of Reality (Muñoz, 2000) Adaptations: (1) bilingual therapist (2) Latino therapist (3) Integrating cultural values (4) Warm and informal interpersonal conversation (5) More concrete language (6) Integrating religion (7) Activity scheduling modified due to economic or practical limitations	PHQ-9 Attendance Homework completion	Depressive symptoms significantly decreased over the course of therapy. Clients attended, on average, less than half (*M* = 6.67) sessions (*SD* = 5.06 sessions). Overall low homework completion rate average of 23% (*SD* = 30%)
Bowe (2013) USA QR = 77.08% κ = .789	Study 1: Test the feasibility and acceptability of CA-GCBT to two groups of African American clients Study 2: Test the efficacy of CA–GCBT for African American clients	Study 1: Two-group pre-test–post-test design Study 1: Opportunity sampling Excluded: suicidal ideation, bipolar, psychosis or substance misuse Study 2: Randomised control trial Study 2: Opportunity sampling Excluded: suicidal ideation, bipolar, psychosis or substance misuse	Study 1, Group 1 *N* = 7 Female (*n* = 5) Men (*n* = 2) Age (*M* = 55.83, *SD* = 4.22) Study 1, Group 2 *N* = 4 Female (*n* = 3) Men (*n* = 1) Age (*M* = 51.50, *SD* = 4.93) Study 2 *N* = 15 Group CBT - Female (*n* = 4), Male (*n* = 3) Group CBT Age (*M* = 50.86, *SD* = 6.54) Control Female (*n* = 2), Male (*n* = 6) Control Age (*M* = 44.71, *SD* = 9.07) African American	CA-GCBT (12 weekly, 2–hour sessions) Culturally enhanced BA based on Lewinsohn (1974); Martell *et al.* (2001) Adaptations: (1) Relevant icebreakers (2) Culturally relevant vignettes and examples (3) Values and goals clarification at mid-point and experiential activities (4) Relevant psychoeducation (5) Inclusion of population and context dependant items, e.g. physical health (6) Inclusion of managing anger (7) Social support and spirituality (8) Describing it as 'skills training group'	Study 1 BDI-II Study 2 HRSD BDI-II BADS-SF	Study 1 Depression symptoms were significantly lower at post-treatment, 1-week post-treatment and 1-month post-treatment Study 2 Six out of seven (85.7%) CA–GCBT participants and six out of eight (75%) waitlist participants did not complete. Due to attrition *post-hoc* analysis not completed

(*Continued*)

Table 7. (*Continued*)

Author, date, country of origin, quality rating (QR) and kappa (κ)	Research aims	Design and sampling methodology	Participant details: (gender, age, ethnicity, context)	Intervention(s) and cultural adaptations	Data collection (definitions at the end of the table*)	Main findings
Fujisawa *et al.* (2010) Japan QR = 68.75% κ = .855	Test feasibility of CA-GCBT, by exploring the acceptability, complete/drop-out rates for major depressive disorder in Japan	Single group: pre-test–post-test design Opportunity sampling Excluded: suicidal intent, personality disorder, unstable physical conditions	$N = 27$ Female ($n = 18$) Men ($n = 9$) Age $M = 38.5$, $SD = 9.5$ Japanese	CA-GCBT (16 weekly, 1.5–hour sessions) Based on Beck (1979) Adaptations: (1) Delivered in Japanese (2) Manual/workbooks in Japanese (3) Problem solving focus (4) Focus on relational issues as cultural importance of interpersonal relationships/ cohesion more than self-fulfilment (5) Formulation shared early (6) Japanese therapist	BDI-II HAMD-17 GAF DAS-24 QIDS-SR SUBI	Depression symptoms showed reduction in mean score on BDI-II, QIDS-SR and HAMD–17 Function showed an improvement in mean score on GAF. Dysfunctional attitudes reduced with mean score on DAS-24. Improvement in subjective well-being on the SUBI Clients attended, on average, most sessions ($M = 15.3$ sessions, $SD = 2.8$ sessions); 26 completed the program (96%) with one drop-out at 5th session
Ito *et al.* (2019) Japan QR = 87.5% κ = 1.000	Evaluating efficacy of a work-focused CA-GCBT for Japanese workers on sick leave due to depression	One-group pre-test–post-test design No control groups Opportunity sampling Excluded: psychotic, personality, organic brain disorder, developmental delay, suicide risk, substance abuse and/or somatic disease	$N = 23$ Female ($n = 9$) Men ($n = 14$) Age ($M = 53.3$, $SD = 12.1$) Japanese	CA-GCBT (8 weekly, 2.5–hour sessions) Based on CT for depression (Beck, 1979) and BA based on (Lewinsohn, 1974; Martell *et al.*, 2001) Adaptations: (1) Combined with return to work programme (2) Sessions delivered in Japanese (3) Integrating cultural values and norms (4) Problem solving concerns of workplace dynamics, e.g. colleagues and bosses (5) BA included culturally appropriate exercise (6) Japanese therapist	K6 SASS DRW	There was a significant reduction in psychological distress on the K6. Improvement in social functioning on the SASS and reduction in difficulty in return to work (DRW) related to physical fitness. High completion rate with only one participant dropping out
Kohn *et al.* (2002) USA QR = 70.83% κ = 1.000	To determine the effectiveness of CA-GCBT for African American women	Pre-test–post-test design Demographically matched control Opportunity sampling No mention of exclusion criteria	$N = 12$ Female ($n = 12$) Age ($M = 47$, SD not reported) African American women	CA-GCBT (16 weekly, 1.5–hour sessions). Based on Beck (1979) Adaptations (structural) (1) Limited to African American (2) Closed to allow cohesion (3) Experiential meditative elements (4) Change language collaboratively (5) Population appropriate vignettes and anecdotes	BDI	Reduction in depressive symptomology on the BDI in comparison with control. However, the reporting does not clarify statistical tests and has not followed standard conventions

(*Continued*)

Table 7. (*Continued*)

Author, date, country of origin, quality rating (QR) and kappa (κ)	Research aims	Design and sampling methodology	Participant details: (gender, age, ethnicity, context)	Intervention(s) and cultural adaptations	Data collection (definitions at the end of the table*)	Main findings
				Adaptation (content) (1) Address social isolation (2) Deconstruct 'Black Superwoman Construct' (3) Exploration of faith based coping strategies (4) Generational patterns of behaviour within families (5) Reinforce history of strength (6) Combat negative images (7) Affirm Black Women		
Miranda *et al.* (2003b) USA QR = 95.83% κ = 1.000	Determine the impact of CA–GCBT for depression compared community care with low-income minority women	A randomised controlled trial Demographically matched control/ comparison (Medication-SSRI and Community Mental Health Care) Opportunity sampling Excluded: bereavement, substance misuse, pregnant, breastfeeding, or other mental health care	*N* = 16,286 (excluded *n* = 16,019) Female only CA-GCBT - *n* = 90 Age *M* = 29.3, *SD* = 7.9 Medication - *n* = 88, Age *M* = 28.7, *SD* = 6.6 Community care - *n* = 89 Age *M* = 29.5, *SD* = 9.1 Black, Latina or non-US-born White	CA-GCBT (8 weekly, 1.5–hour sessions). Based on Beck (1979) Adaptations: (1) Provided with handbook and materials (2) Materials also available in Spanish (3) Bilingual therapist (4) Modification to account for financial constraints	HDRS SAS (role functioning) SF-36 (social functioning)	Significant reduction in depressive symptomology for the medication and CA-GCBT interventions more than the community referral on the HDRS. The medication intervention also resulted in improved instrumental role and social functioning. CA–GCBT resulted in improved social functioning
Miranda *et al.* (2003a) USA QR = 95.83% κ = 1.000	Examined the impact of supplementing CA-GCBT with Case Management (+CM)	Randomised control trial Demographically matched groups Opportunity sampling Excluded: psychotic disorders or current substance abuse	*N* = 199 CA-GCBT (*n* = 103) English: Male (*n* = 6) Female (*n* = 36) Age M = 49.6, *SD* = 11 Spanish: Male (*n* = 23) Female (*n* = 38) Age *M* = 48.5, *SD* = 13 Group + CM (*n* = 96) English: Male (*n* = 27) Female (*n* = 34) Age *M* = 49.0, *SD* = 9 Spanish: Male (*n* = 9) Female (*n* = 26)	CA-GCBT (12 weekly, 1.5–hour sessions). Based on Beck (1979) Adaptations: (1) Delivered in Spanish (2) Materials in appropriate literacy levels (English and Spanish) (3) Bicultural therapist (4) Focusing on pleasant activities that are largely free of charge (5) Therapist following cultural norms, e.g. 'respeto', i.e. respect (6) Culturally appropriate cultural interpersonal norms, e.g. 'simpatia', i.e. somewhat warmer	BDI SAS Attrition rate	Greater reduction in depressive symptomology for Group + CM than CA-GCBT for clients whose first language was Spanish but was less effective for those whose first language was English. However, the reporting has not followed standard conventions. Spanish group CBT + CM reported greater improvement in functioning on the SAS. Patient who received CBT + CM less likely to drop out before session 8 than those who receive CA-GCBT alone

(*Continued*)

Table 7. (*Continued*)

Author, date, country of origin, quality rating (QR) and kappa (κ)	Research aims	Design and sampling methodology	Participant details: (gender, age, ethnicity, context)	Intervention(s) and cultural adaptations	Data collection (definitions at the end of the table*)	Main findings
			Age $M = 49.7$, $SD = 11$ Latino, African American and non-US-born White	+CM involved telephone outreach when referred and flexibly through a 6-month period. Focused on addressing self-reports areas of difficult, e.g. problems in housing, employment, recreation, and relationships with family and friends		
Ward and Brown (2015) USA QR = 70.83% κ = 1.000	Examine short-term effects of CA-GCBT in reducing symptoms of MDD in African American adults	Pilot 1 One-group pre-test–post-test design Opportunity Sampling Pilot 2 One-group pre-test–post-test design Opportunity sampling Exclusion for both: dual diagnosis, cognitive impairment, other psychological treatments, suicidal ideation	Pilot 1 ($N = 15$) Age $M = 75$, $SD = 5.52$ Female African Americans Pilot 2 ($N = 35$) Age $M = 51$, $SD = 8.02$ African Americans Male ($n = 18$) Female ($n = 17$)	CA-GCBT – Oh Happy Day (12 weekly, 2.5–hour sessions). Based on Coping with Depression group (Lewinsohn *et al.*, 1989) Adaptations: (1) Use of community appropriate language (2) Recognition of role of race, ethnicity, and culture (client and therapist) (3) Community specific symbols, concepts, and sayings (4) Therapist sharing or having knowledge of culture, values, socioeconomics, history, and politics unique to the group (5) Description of concepts congruent with clients' culture and context (6) Goals aligned cultural values and context (7) Recognition of clients' context which might include economic, cultural and social (8) Discussion of religious coping mechanisms (9) Inclusion of Afrocentric Principles (Nguzo Saba) (10) First 30 minutes a light meal is provided, and background music is played	Pilot 1 CES-D HAM-D SF12 PHO Recruitment and retention Pilot 2 CES-D PHO Recruitment and retention	Pilot 1 Depressive symptomology decreased significantly on CES-D and HAM-D. Significant improvement in quality of life as measured with the SF-12. 73% ($n = 15$) of the women were retained over the 6–month course of the study. All women who completed the study reported being very satisfied with the treatment Pilot 2 Depressive symptoms decreased significantly on the CES-D. 87% of participants were retained over the 6–month course of the study. Overall, 66% completed the CA-GCBT intervention

(*Continued*)

Table 7. (*Continued*)

Author, date, country of origin, quality rating (QR) and kappa (κ)	Research aims	Design and sampling methodology	Participant details: (gender, age, ethnicity, context)	Intervention(s) and cultural adaptations	Data collection (definitions at the end of the table*)	Main findings
Wong (2008a) Hong Kong QR = 79.16% κ = .818	Effectiveness of a CA-GCBT for Chinese people with depression in Hong Kong	Randomised control trial Randomly assigned to CBT and control groups Excluded: psychosis, severely acute depressive or suicidal attempt/ ideation in the last 3 months	*N* = 101 Male (*n* = 21), Female (*n* = 75) Age *M* = 37.4, *SD* = 9.4 Chinese ethnicity	CA-GCBT (10 weekly, 2.5–hour sessions). Based on Mind over Mood (Greenberger and Padesky, 1995) Adaptations: (1) Using more directive than a non-directive approach (2) Therapists to play an active role (3) Technical terms were translated into colloquial expressions, e.g. 'automatic thoughts' was renamed 'thought traps' (4) Designed worksheets and exercises in Chinese to facilitate understanding (5) Exploration and modification of dysfunctional rules relating to family and interpersonal relationships (6) Therapist actively structuring and facilitating the group processes in the initial stages (7) Therapist delivered mini-lectures and detailed explanation of exercises/worksheets (8) Chinese therapist	C-BDI COPE DAS Emotions Checklist	CA-GCBT showed a greater reduction in the severity of depression symptomology than control on the C-BDI. Also showed more adaptive coping skills than control on the COPE and fewer dysfunctional attitudes on the DAS and fewer negative emotions than control on Emotion Checklist
Wong (2008b) Hong Kong QR = 79.16% κ = 1.000	Efficacy of a territory-wide CA-GCBT for Chinese people with depression in Hong Kong	Randomised wait-list control study Randomly assigned to group CBT and control group Opportunity sampling Excluded: psychosis, severely acute depressive or suicidal attempt/ ideation in the last 3 months	*N* = 347 Male (*n* = 97), Female (*n* = 250) Age *M* = 42.72, *SD* = 8.73 Chinese ethnicity	CA-GCBT (10 weekly, 3–hour sessions). Based on Getting out of the abyss of depression (Wong, 2005) Adaptations: (1) Using more directive than a non-directive approach (2) Therapists to play an active role (3) Technical terms were translated into colloquial expressions (4) Designed worksheets and exercises in Chinese to facilitate understanding	C-BDI Q-LES DAS APS-R	CA-GCBT showed a greater reduction in the severity of depression symptoms and perfectionism

(*Continued*)

Table 7. (*Continued*)

Author, date, country of origin, quality rating (QR) and kappa (κ)	Research aims	Design and sampling methodology	Participant details: (gender, age, ethnicity, context)	Intervention(s) and cultural adaptations	Data collection (definitions at the end of the table*)	Main findings
				(5) Exploration and modification of dysfunctional rules relating to family and interpersonal relationships (6) Therapist actively structuring and facilitating the group processes in the initial stages (7) Therapist delivered mini-lectures and detailed explanation of exercises/worksheets (8) Chinese therapist		

*PHQ-9 (Patient Health Questionnaire: Kroenke *et al*., 2001), BDI-II (Beck Depression Inventory-II: Beck *et al*., 1996), HDRS (Hamilton Rating Scale for Depression: Hamilton, 1967), BADS-SF (Behavioural Activation for Depression Scale-Short Form; Manos *et al*., 2011), HAMD-17 (Hamilton Rating Scale for Depression-17: Hamilton, 1967), GAF (Global Assessment of Functioning: American Psychiatric Association, 1994), DAS-24 (Japanese Version of Dysfunctional Attitude Scale: Tajima *et al*., 2007), QIDS-SR (Quick Inventory of Depressive Symptomatology: Rush *et al*., 2003), SUBI (Subjective Well-Being Inventory: Sell, 1994), BDI (Beck Depression Inventory: Beck *et al*., 1961), K6 (Japanese version of the Kessler-6: Furukawa *et al*., 2008), SASS (Japanese version of the Social Adaptation Self-evaluation Scale: Goto *et al*., 2005), DRW (Difficulty in Returning to Work Inventory: Tanoue *et al*., 2012), SAS (Social Adjustment Scale: Weissman and Paykel, 1974), SF-36 (Short Form 36-Item Health Survey: Ware and Sherbourne, 1992), CES-D (Center for Epidemiologic Studies Depression Scale: Radloff, 1977), CSI-SF (Client Satisfaction Inventory: McMurtry and Hudson, 2000), CSI-SF (Quality of life: Resnick and Nahm, 2001), PHO (Physical Health Outcome: Miech and Hauser, 2001), C-BDI (Chinese version of the Beck Depression Inventory: Shek, 1990), Emotions Checklist (Hackney and Cormier, 2008), COPE (Carver *et al*., 1989), DAS (Dysfunctional Attitude Scale: Weissman and Beck, 1978), Q–LES (Quality of Life Enjoyment and Satisfaction Questionnaire: Endicott *et al*., 1993) and APS-R (Almost Perfect Scale-Revised Version: Slaney *et al*., 2001)

Note: Emails were sent out to lead authors of all paper to request further information and missing data. Awaiting response at the time of submission.

Table 8. Summary of main outcomes

	Reference	Was CA-GCBT an effective intervention for reducing depressive symptomology?	Effect size (*d*)	Was it an effective intervention for other outcomes?	Effect size (*d*)
Culturally adapted group CBT for adults from racially minoritised communities residing within a Western country	Aguilera *et al.* (2018)	$p < .001$ on PHQ-9	No reported effect size	No other outcomes measured	N/A
	Bowe (2013)	Study 1 $p < .05$ on BDI-II Study 2 Due to attrition *post-hoc* analysis not completed.	Study 1 No effect size reported Study 2 Due to attrition *post-hoc* analysis not completed	Study 1 No other outcomes measured Study 2 Due to attrition *post-hoc* analysis not completed	Study 1 N/A Study 2 Due to attrition *post-hoc* analysis not completed
	Kohn *et al.* (2002)	Only offers descriptive statistics (BDI)	No reported effect size	N/A	N/A
	Miranda *et al.* (2003b)	$p = 0.006$ on the HDRS	No reported effect size	Improvement in social functioning $p = 0.02$ (SASS)	No reported effect size
	Miranda *et al.* (2003a)	Reports significant reduction, but does not specify	No reported effect size	Offers descriptive statistics	No reported effect size
	Ward and Brown (2015)	Pilot 1 $p < .019$ on the CES–D $p = 0.01$ on the HAM–D Pilot 2 $p < .000$ on the CES–D	Pilot 1 $d = 0.38$ Pilot 2 $d = 1.01$ for the men $d = 0.41$ for women	Pilot 1 $p < 0.017$ improvement in quality of life (SF12) Pilot 2 N/A	Pilot 1 No reported effect size Pilot 2 N/A
Culturally adapted group CBT for adults of racial majority residing in a non-Western country	Fujisawa *et al.* (2010)	$p < 0.001$ on the BDI– $p < 0.001$ on the HAMD-17 $p < 0.001$ on the QIDS-SR	$d = 2.64$ $d = 2.81$ $d = 2.14$	$p < 0.001$ for functional improvement (GAF) $p < 0.001$ for reduction in dysfunctional attitudes (DAS-24) Improvement in subjective wellbeing with $p < 0.001$ on the SUBI Fatigue subscale	$d = 2.99$ (GAF) $d = 0.89$ (DAS-24) $d = 1.79$ (SUBI Fatigue)
	Ito *et al.* (2019)	$p = 0.005$ on the K6	$d = 1.12$	Improvement in social functioning $p = .005$ (SASS) Reduction in difficulty returning to work $p = .005$ (DRW)	$d = -.77$ $d = .69$

(*Continued*)

Table 8. (*Continued*)

	Reference	Was CA-GCBT an effective intervention for reducing depressive symptomology?	Effect size (*d*)	Was it an effective intervention for other outcomes?	Effect size (*d*)
	Wong (2008a)	$p = 0.00$ on C-BDI	$d = 0.76$	$p = 0.00$ improvement in adaptive coping skills (COPE) $p = 0.00$ reduction in dysfunctional attitudes (DAS) $p = .02$ fewer negative emotions (Emotion Checklist)	$d = 0.57$ $d = 0.88$ $d = 0.13$
	Wong (2008b)	$p = 0.00$ on C-BDI	$d = 0.74$	$p = 0.00$ reduction in dysfunctional attitudes (DAS) $p = .02$ fewer perfectionistic beliefs (APS-R) $p = 0.00$ better quality of life (Q-LES)	$d = 0.44$ $d = 0.32$ $d = 0.61$

PHQ-9 (Patient Health Questionnaire: Kroenke *et al*., 2001), BDI-II (Beck Depression Inventory-II: Beck *et al*., 1996), HDRS (Hamilton Rating Scale for Depression: Hamilton, 1967), BADS-SF (Behavioural Activation for Depression Scale-Short Form; Manos *et al*., 2011), HAMD-17 (Hamilton Rating Scale for Depression-17: Hamilton, 1967), GAF (Global Assessment of Functioning: American Psychiatric Association, 1994), DAS-24 (Japanese Version of Dysfunctional Attitude Scale: Tajima *et al*., 2007), QIDS-SR (Quick Inventory of Depressive Symptomatology: Rush *et al*., 2003), SUBI (Subjective Well-Being Inventory: Sell, 1994), BDI (Beck Depression Inventory: Beck *et al*., 1961), K6 (Japanese version of the Kessler-6: Furukawa *et al*., 2008), SASS (Japanese version of the Social Adaptation Self-evaluation Scale: Goto *et al*., 2005), DRW (Difficulty in Returning to Work Inventory: Tanoue *et al*., 2012), SAS (Social Adjustment Scale: Weissman and Paykel, 1974), SF-36 (Short Form 36-Item Health Survey: Ware and Sherbourne, 1992), CES-D (Center for Epidemiologic Studies Depression Scale: Radloff, 1977), CSI-SF (Client Satisfaction Inventory: McMurtry and Hudson, 2000), CSI-SF (Quality of life: Resnick and Nahm, 2001), PHO (Physical Health Outcome: Miech and Hauser, 1998), C-BDI (Chinese version of the Beck Depression Inventory: Shek, 1990), Emotions Checklist (Hackney and Cormier, 2008), COPE (Carver *et al*., 1989), DAS (Dysfunctional Attitude Scale: Weissman and Beck, 1978), Q–LES (Quality of Life Enjoyment and Satisfaction Questionnaire: Endicott *et al*., 1993) and APS-R (Almost Perfect Scale-Revised Version: Slaney *et al*., 2001).
Note: Emails were sent out to lead authors of all paper to request further information and missing data. Awaiting response at the time of submission.

CA-GCBT for adults from racially minoritised communities residing within Western countries

Five out of the six studies had significant positive outcomes on depressive symptomology, meaning that the interventions had beneficial effects for the patients. The remaining study did not disclose whether the results of the intervention were significant but reported positive effects. Of the studies that reported significant positive outcomes, only one reported the effect size, making it difficult to draw conclusions. Within these studies, CA-GCBT also had significant positive outcomes for social functioning and quality of life. However, the effect size was not reported for measures of social function and quality of life.

CA-GCBT for adults from racial majority communities residing in non-Western countries

All four studies had significant positive outcomes for depressive symptomology, meaning that the interventions had beneficial effects for the patients. The effect sizes ranged from medium to well above large, which indicates a considerable effect of CA–GCBT on depressive symptomology. Three of the four studies showed a significant reduction in dysfunctional attitudes, with the effect sizes ranging from medium to large, which indicates a moderate effect. In these studies, CA-GCBT also had significant positive outcome on functioning, subjective wellbeing, social functioning, adaptive coping, quality of life, perfectionistic beliefs, negative emotions, and a reduction in ratings of difficulty returning to work. The effect sizes ranged from medium to large, indicating a moderate effect of CA-GCBT on related outcomes.

What are the focuses of adaptation within CA-GCBT?

This review provides insights into potential modifications that can be made to adapt group CBT. The variety of modifications is in line with the description of CA-CBT, which includes adjustments to the delivery of therapy without compromising the theoretical underpinnings of CBT (Naeem, 2012b).

A common focus of modification was around language, with seven studies (Aguilera *et al.*, 2018; Fujisawa *et al.*, 2010; Ito *et al.*, 2019; Miranda *et al.*, 2003a; Miranda *et al.*, 2003b; Wong, 2008a; Wong, 2008b) delivering sessions in the community language through the use of bilingual therapists, more culturally appropriate language, and translated materials. The remaining studies (Bowe, 2013; Kohn *et al.*, 2002; Ward and Brown, 2015), which were delivered in English, considered culturally appropriate CBT terminology and made adaptations to some of the standard CBT terms. For example, rather than referring to it as group therapy, Bowe (2013) described it as 'skills training'.

Another common focus of adaptation was having therapists from the same background or culture as the participants, with eight studies (Aguilera *et al.*, 2018; Fujisawa *et al.*, 2010; Ito *et al.*, 2019; Miranda *et al.*, 2003a; Miranda *et al.*, 2003b; Ward and Brown, 2015; Wong, 2008a; Wong, 2008b) mentioning this. In most of these studies it was unclear whether this was done intentionally, or just happened due to circumstance. Ward and Brown (2015) specifically stated that they wanted therapists who share or at least had knowledge of the culture, values, socioeconomics, history, and politics unique to the group.

Aguilera *et al.* (2018) and Miranda *et al.* (2003a) reported adapting the interpersonal dynamic and matching it with the cultural norms. In doing so, they acknowledge that cultural norms vary and at times a change in this dynamic to fit these norms could be beneficial. For instance, Miranda *et al.* (2003a) reported an adaptation whereby the therapist was aware of and followed cultural norms of 'respeto' (i.e. respect) and 'simpatia' (i.e. the tendency to create warmer social interactions and avoid conflict).

Two other studies adapted the collaborative stance within their CA-GCBT to be more culturally appropriate by using more directive than non-directive approaches. Wong (2008a) and

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Wong (2008b) had group leaders give 'mini-lectures' and provide a detailed explanation of the exercises and worksheets.

Most studies mention adaptations, which focused on taking typical CBT interventions for MDD and integrating cultural values, norms, metaphors, appropriate vignettes, and culturally appropriate psychoeducation. This takes into account the participant's frame of reference, whether it be economic, cultural, social, or political context. Some studies specify changes to certain interventions to make them more appropriate. For example, Aguilera *et al.* (2018); Miranda *et al.* (2003a) and Miranda *et al.* (2003b) adapted behavioural activation to take account of economic constraints by ensuring it could be done at no extra cost. Ito *et al.* (2019) included culturally appropriate physical activity. Other adaptations of typical interventions were more cognitive, such as exploring and modifying dysfunctional rules related to family and interpersonal relationships (Wong, 2008a; Wong, 2008b). This was done to account for some common cultural norms. Adaptations were also made by emphasising the focus on problem solving (Fujisawa *et al.*, 2010; Ito *et al.*, 2019). For instance, Ito *et al.* (2019) adapted problem solving by focusing on workplace dynamics with colleagues and bosses upon return to work as there was a cultural emphasis and importance of work.

Adaptation also included adding of specific content to the CBT group that was deemed relevant and necessary based on knowledge of the communities or challenges they may face. Discussions and integration of the participants' religious and faith beliefs were included by Aguilera *et al.* (2018), Kohn *et al.* (2002) and Ward and Brown (2015), as well as inclusion of population and context dependent topics such as managing physical health problems (Bowe, 2012) or acknowledging identity and systemic issues faced such as racism (Kohn *et al.*, 2002).

Other adaptations were more participant centred, encouraging group affiliation, addressing feelings of isolation, and even developing a sense of community. This was done through the inclusion of activities promoting cohesion. Bowe (2013) for example, used culturally relevant icebreakers to promote cohesion, and Ward and Brown (2015) invited participants to share a meal at the start of each session, to check-in and bond.

Finally, adaptations were made to the delivery components of the groups, such as recruiting specific demographics, closed groups rather than rolling enrolment, session length, being embedded within another programme, and flexibility with did not attend policy. Examples include being embedded within a return-to-work scheme (Ito *et al.*, 2019) or being delivered to clients living in a nursing home (Bowe, 2013).

In summarising these findings, the focus on modification is consistent with the examples listed in the introduction but also within the wider literature. However, it is important to recognise that there is not a copy-and-paste approach; rather the adaptation varies to meet the needs of the clients and the specific community. What is considered acceptable or desirable in one culture may be considered inappropriate or even offensive in another; for instance, whether the style is 'warmer' or more formal 'mini lectures'. Cultural differences can affect how people perceive and interpret information, leading to different responses and outcomes. Therefore, researchers and clinicians need to consider the cultural context when conducting studies and interpreting results, rather than assuming that findings from one culture can be applied to another.

Conceptually, these have been grouped into the domains of a focus on group delivery, a focus on group process, a focus on group content, a focus on client modifications, and a focus on staff modifications. See Table 9 for a summary of the different domains and examples based on the studies. It is important to note that these areas are not mutually exclusive and can be implemented in conjunction with each other.

It is also worth noting that all the studies provided some description of the adaptations; however, only some studies provided rationales for the adaptation, and none explicitly referred to the adaptation framework they employed. For those studies that did provide a rationale for the adaptation, details of participant co-creation and community acceptability would align with the Southampton Adaptation Framework (Naeem *et al.*, 2009) as they included some degree of

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Table 9. Focus of cultural adaptation for CBT groups

Type of adaptation	Description	Examples
Group process	This refers to modifications made to ensure aspects of the process are culturally appropriate at the very least or even culturally appealing	Adjusting interpersonal by using culturally appropriate verbal and non-verbal behaviour, e.g. levels of warmth or hugs Adjusting of the degree of collaboration to match culturally appropriate behaviours and norms, e.g. levels of didactic teaching
Group content	This refers to modifications made to ensure that either existing content integrates cultural values and norms, or culturally appropriate content is introduced	Adjusting the typical interventions to consider frame of reference, e.g. culturally appropriate activities in BA Introduction of new interventions or topics that are requested by participants or address specific challenges, e.g. identity and encountering racism
Client facing	These refer to modifications made to facilitate group dynamics or group cohesion	Inclusion of culturally appropriate icebreaker activities, rather than those that typically originate from western cultures Inclusion of a more community approach to therapy and actively promoting bonding within the group
Therapist facing	This refers to modifications with or by the therapist who will be facilitating the group	Sharing or gaining knowledge of culture, values, socioeconomics, history, and politics unique to the community Delivering the session within community languages, using translated materials and inclusion of culturally appropriate terminology
Group delivery	This refers to the modifications being made to the organisational aspects of the group	Amending the group organisation elements of the group delivery to be more flexible with attendance expectations Amending the group to be embedded within existing community groups or organisations. Even promotion and recruiting via community groups to overcome potential mistrust of mental health services

gaining awareness of relevant issues beforehand, adapting assessment and engagement, and adjusting therapy processes or techniques.

However, without explicitly stating it, this is more of an inference. Explicitly citing the framework provides transparency and clarity regarding the theoretical and methodological basis for the adaptation process. It allows readers and researchers to understand the conceptual underpinnings guiding the modifications made to the therapeutic approach. Moreover, citing the framework enhances the replicability and comparability of the study.

In future research, it is recommended that scholars and researchers explicitly cite the specific adaptation framework they utilise. This practice enhances the research's clarity, transparency and credibility, ultimately contributing to the growth and development of culturally adapted psychological therapies. As the field continues to expand, incorporating this practice can help establish a strong foundation for evaluating and implementing culturally adapted interventions.

Further critique of studies

A major critique is the lack of sufficient comparison against a standard group CBT (TAU). Comparing an intervention with a TAU can provide important information about the practical utility of the intervention in real-world settings. Overall, not comparing an intervention with TAU

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can limit the ability to determine the effectiveness and practical utility of the intervention, as well as the generalisability of the study findings.

The identified studies have small sample sizes, ranging from 11 to 267, resulting in limited statistical power, a high risk of bias, and a limited scope of findings. This can increase the likelihood of false positives or negatives, which can compromise the study's internal validity due to attrition bias. For instance, in the second study of Bowe (2013), six out of seven (85.7%) CA-GCBT participants and six out of eight (75%) waitlist participants dropped out. No *post-hoc* analysis of the second study was completed because of this attrition.

Another critique is the lack of clarity regarding the CBT approach and interventions utilised. This does not allow us to identify which interventions worked better or even the specific mechanisms of change. Research lacking clarity in this way risks ambiguity as it is difficult to understand what the study is measuring, making it difficult for other researchers to replicate the study or use the same methods in future research.

There was a lack of specificity in some of the studies about who delivered the intervention or how they quality assured the intervention. This makes it difficult to determine whether the results are generalisable. Without this information, it is difficult to determine whether the intervention was delivered in a consistent and standardised manner or if there were differences in the quality of the intervention across participants.

Discussion

Summary of findings

The results of this systematic review highlight that CA-GCBT is a promising treatment for clients from diverse backgrounds experiencing MDD. CA-GCBT offers promising results in reducing depressive symptomology and positive changes identified in other domains (dysfunctional beliefs, improvement in functioning and quality of life) regardless of whether the participants were from racially minoritised communities living in Western countries or from racial majority communities living in non-Western countries. In addition to the findings about whether CA-GCBT can be beneficial for clients from diverse backgrounds, this review provides some insight into the potential modifications that can be made to adapt group CBT. These were grouped into the domains of group delivery, group process, group content, client modifications, and staff facing modifications.

Relation to previous literature

Despite being developed and more extensively studied with clients from racial majority in Western countries and criticisms of being based exclusively on Western cultural assumptions (Summerfield and Veale, 2008), this suggests that CA-GCBT shows promise in treating MDD with clients from diverse backgrounds. The results show a pattern of improvements in depressive symptomology, dysfunctional beliefs, functioning, and quality of life. This is consistent with Horrell (2008) who found that culturally adapted CBT was effective for ethnic minority clients living in the USA across a range of psychological disorders (including depression). Kalibatseva and Leong (2014) also found that psychological therapies (including CBT) could be culturally adapted effectively.

These findings align with the CBT-specific literature on its effectiveness when culturally adapted, whether focused on BA (Lehmann and Bördlein, 2020) and/or cognitive therapy (Anik *et al.*, 2021). This contributes to the literature as it has focused on group delivery, which had previously not been addressed. The summary of domains in which groups could be modified, is in keeping with the description of culturally adapted CBT.

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These results align with recommendations for adapting one-to-one therapy through prior awareness of relevant issues, assessment and engagement, and adjustments in therapy techniques (Naeem *et al*., 2019). The current findings complement the recommendations within BAME Positive Practice Guide (Beck et al., 2019) to consider service level changes, adapting therapy and staff adaptations by extending these to considering group CBT modifications.

This research offers insights into and considerations for adapting group interventions specifically for clients from diverse backgrounds who are experiencing MDD. By acknowledging the unique cultural and contextual factors that influence the expression and understanding of mental health issues, therapists can tailor group interventions to better meet the needs of these individuals. The identified domains for group modification provide a framework for integrating culturally mediated aspects into the group CBT. It is hoped that by adapting group interventions for clients from diverse backgrounds it enhances the cultural sensitivity and relevance of the interventions, allowing participants to engage more deeply and meaningfully in the therapeutic process. By acknowledging and addressing cultural nuances, therapists can foster a sense of belonging and validation, which can promote trust and openness within the group. In addition, group interventions offer a unique opportunity for participants to connect and share experiences with others who may have similar cultural backgrounds or have faced similar challenges.

Limitations

This review has limitations that need to be considered, including the relatively small number of studies included in the review ($n = 10$). This may be related to the lack of research on this specific topic, as mentioned earlier, or the potential for publication bias. Within this review, there was clinical heterogeneity (variance in participants), methodological heterogeneity (variability in study design), and statistical heterogeneity (data analysis), which introduces a risk of bias (Cochrane, 2011).

The studies identified focused on clients from African American, Latino, Japanese, Chinese, and non-USA-born white communities. It therefore is difficult to generalise findings across client groups because different cultures have unique values, beliefs, customs, and behaviours that shape how people think, feel and act. Researchers must consider the cultural context when conducting studies and interpreting results, rather than assuming that findings from one culture can be applied to another.

Another limitation is that the studies included were based in the USA, Japan, and Hong Kong. Although this provides some useful breadth, it is by no means a comprehensive overview of CA-GCBT across a large range of contexts. It is notable that it does not consider anything specific to the UK as Richardson and Bradbury (2012) was excluded following the quality assessment. Thus, it is difficult to draw concrete conclusions applicable for UK services. Based on the included studies, the findings are more relevant to CBT groups based on BA and CT for MDD.

The decision to exclude studies in languages other than English may have resulted in the omission of crucial findings paradoxically, unintentionally reinforcing the dominance of Western, English language perspectives in the field of CBT. Although it is understandable that the lack of translations creates difficulties, it raises the question of whether vital research conducted in non-English speaking countries is being overlooked.

Finally, the CASP was utilised for quality appraisal. However, small studies may be more difficult to assess for quality because of limited information or insufficient reporting of key methodological details. For example, all papers were consistently rated as 'can't tell' or 'no to CASP question 12, which asked whether the paper being reviewed states implications for practice.

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Clinical implications and research recommendations

This review contributes to the discourse on CA-GCBT by providing a starting point for determining that CA-GCBT can be effective treatment for MDD in adults from racially minoritised communities residing in Western countries or from racial majority communities residing in non-Western countries. The results suggest potentially significant benefits such as a reduction in depressive symptomology, dysfunctional beliefs, and improvement in functioning, subjective wellbeing, quality of life, and adaptive coping. It also provides some initial thoughts on potential cultural adaptations within CA-GCBT.

The clinical implications of these findings are important, as they may allow clinicians and services to build a case for trialling CA-GCBT in the communities they serve. This may address issues of poor access and outcomes for clients from diverse backgrounds. It may also provide an initial focus for developing such a group by reflecting on whether the delivery, client, staff, process, or content components need to be adapted. At the very least, it offers some thoughts on how to modify generic group CBT to be more appealing or effective for clients from diverse backgrounds.

Based on the above-mentioned limitations, a key research recommendation would be to conduct larger, high-quality studies to explore whether CA-GCBT is effective. It would be beneficial to compare key components and explore which adaptations are associated with efficacy, accessibility and acceptability. Once such studies have been completed, conducting an updated review with a larger number of high-quality studies in more countries would be helpful. The dissection of studies to understand which adaptations work for whom, qualitative focus on exploring therapist and client experiences of CA-GCBT for MDD, across a range of disorders and various populations may also be promising areas for further research. Despite the extensive research of CBT, there is a lack of research about cultural adaptations and the inclusion of ethnic minorities in research is essential.

Conclusion

This review contributes to the existing literature on the efficacy of culturally adapted CBT for clients from diverse backgrounds. Systematically identifying, evaluating and integrating the findings of existing empirical literature suggests that CA-GCBT is effective for depressed clients from diverse backgrounds, with a reduction in depressive symptomology, dysfunctional beliefs, and increase in functioning and quality of life. It summarises some of the adaptations implemented within CA-GCBT. However, these adaptations should not be assumed to be applicable to all diverse communities, rather, the broad domains of adaptation should be used to consider how best to suit the community with whom one is working.

The findings add to the evidence base and provide a rationale for further research. This review offers a starting point for developing or delivering CA-GCBT within clinical practice. Within the context of practice, this will be a step towards addressing the low access and poor outcome rates for clients from diverse communities.

Key practice points

(1) Culturally adapted group cognitive-behavioural therapy (CA-GCBT) has shown effectiveness in reducing depressive symptoms, dysfunctional beliefs, and improving functioning and quality of life for depressed clients from diverse backgrounds.
(2) When adapting a therapy group, consider modifications in group delivery, group process, group content, client modifications and staff facing modifications. These adaptations can be implemented individually or in combination.
(3) Further research is needed to fully evaluate the efficacy of CA-GCBT for diverse populations and to explore the experiences of both therapists and clients in implementing or attending such groups.

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Further reading

Beck, A. (2016). *Transcultural Cognitive Behaviour Therapy for Anxiety and Depression: A Practical Guide*. Routledge.

Beck, A., Naz, S., Brooks, M., & Jankowska, M. (2019). *Improving Access to Psychological Therapies (IAPT) Black, Asian and Minority Ethnic Service User Positive Practice Guide*. https://babcp.com/Therapists/BAME-Positive-Practice-Guide

Hays, P. A. (2001). *Addressing Cultural Complexities in Practice: Assessment, Diagnosis, and Therapy*. Washington, DC: American Psychological Association.

Hinton, D. E., & Patel, A. (2017). Cultural adaptations of cognitive behavioral therapy. *Psychiatric Clinics*, *40*, 701–714.

Rathod, S., Kingdon, D., Pinninti, N., Turkington, D., & Phiri, P. (2015). *Cultural Adaptation of CBT for Serious Mental Illness: A Guide for Training and Practice*. John Wiley & Sons.

Williams, M. T., Faber, S. C., & Duniya, C. (2022). Being an anti-racist clinician. *the Cognitive Behaviour Therapist*, *15*.

Data availability statement. The data that support the findings of this study are available on request from the corresponding author, T.K.

Acknowledgments. The author would like to thank Chris Denmark for his support in the quality assessment of the papers included in this review. Special thanks also go to Magda Marczak, who supervised this research as part of the MSc in Cognitive Behavioural Therapy (Top Up) at the University of Coventry. Additionally, the author expresses gratitude to Kate Sheldon, Pawel Kaliniecki, Katy Emerson, Sarah Cantwell, Jessica Hottinger and Liz Ruth for their encouragement and assistance with proofreading.

Author contribution. **Taf Kunorubwe:** Conceptualization (lead), Data curation (lead), Formal analysis (lead), Investigation (lead), Methodology (lead), Project administration (lead), Writing – original draft (lead), Writing – review & editing (lead).

Financial support. This research received no specific grant from any funding agency, commercial or not-for-profit sectors.

Competing interests. The author declares no conflict of interest with respect to this publication.

Ethical standards. The study was approved by the Faculty of Health and Life Sciences at the University of Coventry before it was conducted (reference P120955). The author has abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the BABCP and BPS.

An important note about terminology. The terminology used when talking about race and ethnicity in research can have a real-world impact. Therefore, due consideration has been given to the language and terminology used in this report. There is a recognition that terms such as BAME or BME may be unhelpful for some communities (Milner and Jumbe, 2020); however, alternative terms used to describe racially minoritised populations may not provide a term that conveys the multiple facets of diversity or may not be in common usage (Lawton *et al.*, 2021).

Therefore, in this review, whenever possible, specific language is utilised to describe ethnic, religious, or linguistic groups. Collective terminology is a last resort and where there is a legitimate need to do so. In instances requiring collective terminology, decisions are guided by the context at hand, and refrain from adopting a generic term such as BAME or BME unless absolutely necessary. If the context does not provide a decisive direction, terms such as 'ethnic minority', 'racial minority' or 'diverse backgrounds' are used interchangeably. This approach recognises that no single term is universally suitable and serves to uphold the dignity of individuals and communities. Practitioners, researchers and all stakeholders in the field of mental health are encouraged to consider the terminology they employ when referring to individuals from diverse ethnic, cultural and faith backgrounds. Engaging with groups and individuals is advisable to ascertain their preferred terminology and co-produce whenever feasible.

References

Aguilera, A., Bruehlman-Senecal, E., Liu, N., & Bravin, J. (2018). implementing group cbt for depression among Latinos in a primary care clinic. *Cognitive and Behavioral Practice*, *25*, 135–144. https://doi.org/10.1016/j.cbpra.2017.03.002

Aguilera, A., Garza, M. J., & Muñoz, R. F. (2010). Group cognitive-behavioral therapy for depression in Spanish: culture-sensitive manualized treatment in practice. *Journal of Clinical Psychology*, *66*, 857–867. https://doi.org/10.1002/jclp.20706

Ahmad, G., McManus, S., Cooper, C., Hatch, S. L., & Das-Munshi, J. (2022). Prevalence of common mental disorders and treatment receipt for people from ethnic minority backgrounds in England: repeated cross-sectional surveys of the general population in 2007 and 2014. *British Journal of Psychiatry*, *221*, 520–527. https://doi.org/10.1192/bjp.2021.179

Aichberger, M. C., Schouler-Ocak, M., Rapp, M. A., & Heinz, A. (2008). Transcultural aspects of depression. *Bundesgesundheitsblatt-Gesundheitsforschung-Gesundheitsschutz*, *51*, 436–442. 10.1007/s00103-008-0512-y

Al-Krenawi, A., & Graham, J. R. (2000). Culturally sensitive social work practice with Arab clients in mental health settings. *Health & Social Work*, *25*, 9–22. https://doi.org/10.1093/hsw/25.1.9

Altman, D. G. (1990). *Practical Statistics for Medical Research*. Chapman and Hall. https://doi.org/10.1201/9780429258589

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV* (vol. *4*). Washington, DC.

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders: DSM-5* (vol. *5*). Washington, DC.

Anik, E., West, R. M., Cardno, A. G., & Mir, G. (2021). Culturally adapted psychotherapies for depressed adults: a systematic review and meta-analysis. *Journal of Affective Disorders*, *278*, 296–310. https://doi.org/10.1016/j.jad.2020.09.051

Arafat, N. (2021). One size does not fit all: key messages from Pakistani, Somali, and Yemeni (PSY) patients in Sheffield, UK, regarding the language and cultural challenges of the IAPT programme. *Perspectives in Public Health*, *141*, 266–268. https://doi.org/10.1177/175791392110115

Baker, C., & Kirk-Wade, E. (2023). *Mental Health Statistics: Prevalence, Services, and Funding in England*. House of Commons. https://researchbriefings.files.parliament.uk/documents/SN06988/SN06988.pdf

Barth, J., Munder, T., Gerger, H., Nüesch, E., Trelle, S., Znoj, H., Jüni, P., & Cuijpers, P. (2013). Comparative efficacy of seven psychotherapeutic interventions for patients with depression: a network meta-analysis. *PloS Medicine*, *10*, e1001454. https://doi.org/10.1371/journal.pmed.1001454

Beck, A. (2016). *Transcultural Cognitive Behaviour Therapy for Anxiety and Depression: A Practical Guide*. Routledge.

Beck, A. (2019). Understanding Black and Minority Ethnic service user's experience of racism as part of the assessment, formulation, and treatment of mental health problems in cognitive behaviour therapy. *the Cognitive Behaviour Therapist*, *12*. https://doi.org/10.1017/S1754470X18000223

Beck, A., Naz, S., Brooks, M., & Jankowska, M. (2019). *Improving Access to Psychological Therapies (IAPT) Black, Asian and Minority Ethnic Service User Positive Practice Guide*. https://babcp.com/Therapists/BAME-Positive-Practice-Guide

Beck, A. T. (ed). (1979). *Cognitive Therapy of Depression*. Guilford Press.

Beck, A. T., Steer, R. A., & Brown, G. (1996). Beck Depression Inventory-II. *Psychological Assessment*.

Beck, A. T., Ward, C., Mendelson, M., Mock, J., & Erbaugh, J. J. A. G. P. (1961). Beck Depression Inventory (BDI). *Archives of General Psychiatry*, *4*, 561–571.

Beltman, M. W., Voshaar, R. C. O., & Speckens, A. E. (2010). Cognitive-behavioural therapy for depression in people with a somatic disease: meta-analysis of randomised controlled trials. *British Journal of Psychiatry*, *197*, 11–19. https://doi.org/10.1192/bjp.bp.109.064675

Bennett, S. T., Flett, R. A., & Babbage, D. R. (2016). Considerations for culturally responsive cognitive-behavioural therapy for Māori with depression. *Journal of Pacific Rim Psychology*, *10*, e8. https://doi.org/10.1017/prp.2016.5

Bernal, G., Jiménez-Chafey, M. I., & Domenech Rodríguez, M. M. (2009). Cultural adaptation of treatments: a resource for considering culture in evidence-based practice. *Professional Psychology: Research and Practice*, *40*, 361–368. https://doi.org/10.1037/a0016401

Berry, K., Day, C., Mulligan, L. D., Seed, T., Degnan, A., & Edge, D. (2018). Culturally adapted Family Intervention (CaFI): case examples from therapists' perspectives. *the Cognitive Behaviour Therapist*, *11*. https://doi.org/10.1017/S1754470X18000156

Bhardwaj, M. A. (2016). Multicultural applications of cognitive behavior therapy: a psychosocial review. *The International Journal of Indian Psychology*, *3*(4), 23–28.

Bhavsar, V., Jannesari, S., McGuire, P., MacCabe, J. H., Das-Munshi, J., Bhugra, D., & Hatch, S. L. (2021). The association of migration and ethnicity with use of the Improving Access to Psychological Treatment (IAPT) programme: a general population cohort study. *Social Psychiatry and Psychiatric Epidemiology*, *56*. https://doi.org/10.1007/s00127-021-02035-7

Bhugra, D., & Mastrogianni, A. (2004). Globalisation and mental disorders: overview with relation to depression. *British Journal of Psychiatry*, *184*, 10–20. https://doi.org/10.1192/bjp.184.1.10

Bowe, W. (2013). *Refinement and Pilot Testing of a Culturally Enhanced Treatment for Depressed African Americans*. [Doctoral thesis]. University of Wisconsin-Milwaukee. https://dc.uwm.edu/etd/229

Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: a theoretically based approach. *Journal of Personality and Social Psychology*, *56*(2), 267.

CASP (2018). *CASP Cohort Study Checklist*. Available at: https://casp-uk.net/images/checklist/documents/CASP-Cohort-Study-Checklist/CASP-Cohort-Study-Checklist-2018_fillable_form.pdf.

Chang, D. F., Hung, T., Ng, N., Ling, A., Chen, T., Cao, Y., & Zhang, Y. (2016). Taoist cognitive therapy: treatment of generalized anxiety disorder in a Chinese immigrant woman. *Asian American Journal of Psychology*, *7*, 205–216. https://doi.org/10.1037/aap0000052

Chen, J. S. (2021). What is in a name? Autonomic imbalance and medically unexplained symptoms in Taiwan. *Sociology of Health & Illness*, *43*, 881–894. https://doi.org/10.1111/1467-9566.13262

Chen, J. S. (2022). Neurasthenia and autonomic imbalance as minor diagnoses: comparison, concept, and implications. *Social Theory & Health*. https://doi.org/10.1057/s41285-022-00184-6

Cochrane (2011). *What is Heterogeneity?* https://handbook-5-1.cochrane.org/chapter_9/9_5_1_what_is_heterogeneity.htm

Cuijpers, P., Berking, M., Andersson, G., Quigley, L., Kleiboer, A., & Dobson, K. S. (2013). A meta-analysis of cognitive-behavioural therapy for adult depression, alone and in comparison, with other treatments. *Canadian Journal of Psychiatry*, *58*, 376–385. https://doi.org/10.1177/0706743713058007

Cuijpers, P., Muñoz, R. F., Clarke, G. N., & Lewinsohn, P. M. (2010). Psychoeducational treatment and prevention of depression: the 'Coping with Depression' course thirty years later. *Clinical Psychology Review*, *29*, 449–458. https://doi.org/10.1016/j.cpr.2009.04.005

Cuijpers, P., Noma, H., Karyotaki, E., Cipriani, A., & Furukawa, T. A. (2019). Effectiveness and acceptability of cognitive behavior therapy delivery formats in adults with depression: a network meta-analysis. *JAMA Psychiatry*, *76*, 700–707. https://doi.org/10.1001/jamapsychiatry.2019.0268

Cuijpers, P., van Straten, A., Andersson, G., & van Oppen, P. (2008). Psychotherapy for depression in adults: a meta-analysis of comparative outcome studies. *Journal of Consulting and Clinical Psychology*, *76*, 909–922. https://doi.org/10.1037/a0013075

Desjarlais, R., Eisenberg, L., Good, B., & Kleinman, A. (1995). *World Mental Health: Problems and Priorities in Low-Income Countries*. Oxford University Press.

Diaz-Martinez, A. M., Interian, A., & Waters, D. M. (2010). The integration of CBT, multicultural and feminist psychotherapies with Latinas. *Journal of Psychotherapy Integration*, *20*, 312–326. https://psycnet.apa.org/doi/10.1037/a0020819

Endicott, J., Nee, J., Harrison, W., & Blumenthal, R. (1993). Quality of Life Enjoyment and Satisfaction Questionnaire: a new measure. *Psychopharmacology Bulletin*, *29*, 321–326.

Feng, C.-Y., Chu, H., Chen, C.-H., Chang, Y.-S., Chen, T.-H., Chou, Y.-H., Chang, Y.-C., & Chou, K.-R. (2012). The effect of cognitive behavioral group therapy for depression: a meta-analysis 2000–2010. *Worldviews on Evidence-Based Nursing*, *9*, 2–17. https://doi.org/10.1111/j.1741-6787.2011.00229.x

Friedman, M., Rholes, W. S., Simpson, J., Bond, M., Diaz-Loving, R., & Chan, C. (2010). Attachment avoidance and the cultural fit hypothesis: a cross-cultural investigation. *Personal Relationships*, *17*, 107–126. https://doi.org/10.1111/j.1475-6811.2010.01256.x

Fujisawa, D., Nakagawa, A., Tajima, M., Sado, M., Kikuchi, T., Hanaoka, M., & Ono, Y. (2010). Cognitive behavioral therapy for depression among adults in Japanese clinical settings: a single-group study. *BMC Research Notes*, *3*, 160. https://doi.org/10.1186/1756-0500-3-160

Furukawa, T. A., Kawakami, N., Saitoh, M., Ono, Y., Nakane, Y., Nakamura, Y., Tachimori, H., Iwata, N., Uda, H., Nakane, H., Watanabe, M., Naganuma, Y., Hata, Y., Kobayashi, M., Miyake, Y., Takeshima, T., & Kikkawa, T. (2008). The performance of the Japanese version of the K6 and K10 in the World Mental Health Survey Japan. *International Journal of Methods in Psychiatric Research*, *17*, 152–158. https://doi.org/10.1002/mpr.257

GBD (2019). Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. *The Lancet Psychiatry*, *9*, 137–150. https://doi.org/10.1016/S2215-0366(21)00395-3

Goto, M. (2005). Reliability and validity of the Japanese version of the Social Adaptation Self-evaluation Scale (SASS). *Clinical Psychiatry*, *47*, 483–489.

Greenberger, D., & Padesky, C. A. (1995). *Mind over Mood: A Cognitive Therapy Treatment Manual for Clients*. Guilford Press.

Grossmann, K. E., & Grossmann, K. (1991). *Attachment Quality as an Organizer of Emotional and Behavioral Responses in a Longitudinal Perspective. Attachment Across the Life Cycle*. Tavistock/Routledge.

Guo, F., & Hanley, T. (2015). Adapting cognitive behavioral therapy to meet the needs of Chinese clients: opportunities and challenges. *PsyCh Journal*, *4*, 55–65. https://doi.org/10.1002/pchj.75

Hackney, H. L., & Cormier, S. (2008). *The Professional Counselor: A Process Guide to Helping* (6th edn). Pearson.

Hamilton, M. (1967). Development of a rating scale for primary depressive illness. *British Journal of Social and Clinical Psychology*, *6*, 278–296. https://doi.org/10.1111/j.2044-8260.1967.tb00530.x

Harwood, H., Rhead, R., Chui, Z., Bakolis, I., Connor, L., Gazard, B., & Hatch, S. L. (2023). Variations by ethnicity in referral and treatment pathways for IAPT service users in South London. *Psychological Medicine*, *53*, 1084–1095.

Hays, P. A. (2016). The new reality: Diversity and complexity. In P. A. Hays (eds.), *Addressing Cultural Complexities in Practice: Assessment, Diagnosis, and Therapy* (pp. 3–18). American Psychological Association. https://doi.org/10.1037/14801-001

Hays, P. A. (2019). Introduction. In G. Y. Iwamasa & P. A. Hays (eds), *Culturally Responsive Cognitive Behavior Therapy: Practice and Supervision* (pp. 3–24). American Psychological Association. https://doi.org/10.1037/0000119-001

Heine, S. J., Lehman, D. R., Markus, H. R., & Kitayama, S. (1999). Is there a universal need for positive self-regard? *Psychological Review*, *106*, 766–794. https://doi.org/10.1037/0033-295X.106.4.766

Helman, C. (2007). *Culture, Health, and Illness* (5th edn). CRC Press.

Hofmann, S. G., Asnaani, A., Vonk, I. J. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: a review of meta-analyses. *Cognitive Therapy and Research*, *36*, 427–440. https://doi.org/10.1007/s10608-012-9476-1

Horrell, S. C. V. (2008). Effectiveness of cognitive-behavioral therapy with adult ethnic minority clients: a review. *Professional Psychology: Research and Practice*, *39*, 160–168. https://doi.org/10.1037/0735-7028.39.2.160

Huntley, A. L., Araya, R., & Salisbury, C. (2012). Group psychological therapies for depression in the community: systematic review and meta-analysis. *British Journal of Psychiatry*, *200*, 184–190. https://doi.org/10.1192/bjp.bp.111.092049

Ito, D., Watanabe, A., Takeichi, S., Ishihara, A., & Yamamoto, K. (2019). A preliminary study of work-focused cognitive behavioural group therapy for Japanese workers. *Behavioural and Cognitive Psychotherapy*, *47*, 251–256. https://doi.org/10.1017/S1352465818000280

Jameel, S., Munivenkatappa, M., Arumugham, S. S., & Thennarasu, K. (2022). Cultural adaptation of cognitive behaviour therapy for depression: a qualitative study exploring views of patients and practitioners from India. *the Cognitive Behaviour Therapist*, *15*. https://doi.org/10.1017/S1754470X22000137

Jorm, A. F., Morgan, A. J., & Hetrick, S. E. (2008). Relaxation for depression. *Cochrane Database of Systematic Reviews*, (*4*).

Kalibatseva, Z., & Leong, F. T. (2014). A critical review of culturally sensitive treatments for depression: recommendations for intervention and research. *Psychological Services*, *11*, 433–450. https://doi.org/10.1037/a0036047

Kapadia, D., Brooks, H. L., Nazroo, J., & Tranmer, M. (2017). Pakistani women's use of mental health services and the role of social networks: a systematic review of quantitative and qualitative research. *Health & Social Care in the Community*, *25*, 1304–1317. https://doi.org/10.1111/hsc.12305

Kirmayer, L. J. (2001). Cultural variations in the clinical presentation of depression and anxiety: implications for diagnosis and treatment. *Journal of Clinical Psychiatry*, *62* (suppl), S22–S28.

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., Hassan, G., Rousseau, C., & Pottie, K. (2011). Common mental health problems in immigrants and refugees: general approach in primary care. *Canadian Medical Association Journal*, *183*, 959–967. https://doi.org/10.1503/cmaj.090292

Kleinman, A., Anderson, J. M., Finkler, K., Frankenberg, R. J., & Young, A. (1986). Social origins of distress and disease: depression, neurasthenia, and pain in modern China. *Current Anthropology*, *24*, 499–509.

Kohn, L. P., Oden, T., Muñoz, R. F., Robinson, A., & Leavitt, D. (2002). Adapted cognitive behavioral group therapy for depressed low-income African American women. *Community Mental Health Journal*, *38*, 497–504. https://doi.org/10.1023/a:1020884202677

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine*, *16*, 606–613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

Kwon, S.-M., & Oei, T. P. S. (2003). Cognitive change processes in a group cognitive behavior therapy of depression. *Journal of Behavior Therapy and Experimental Psychiatry*, *34*, 73–85. https://doi.org/10.1016/s0005-7916(03)00021-1

Lawton, L., McRae, M., & Gordon, L. (2021). Frontline yet at the back of the queue–improving access and adaptations to CBT for Black African and Caribbean communities. *the Cognitive Behaviour Therapist*, *14*. https://doi.org/10.1017/S1754470X21000271

Lehmann, D. C., & Bördlein, C. (2020). A systematic review of culturally adapted behavioral activation treatments for depression. *Research on Social Work Practice*, *30*, 688–702. https://doi.org/10.1177/1049731520915635

Lehti, A., Hammarström, A., & Mattsson, B. (2009). Recognition of depression in people of different cultures: a qualitative study. *BMC Family Practice*, *10*. https://doi.org/10.1186/1471-2296-10-53

Lejuez, C. W., Hopko, D. R., & Hopko, S. D. (2001). A brief behavioral activation treatment for depression. Treatment manual. *Behavior Modification*, *25*, 255–286. https://doi.org/10.1177/0145445501252005

Lepine, J.-P., & Briley, M. (2011). The increasing burden of depression. *Neuropsychiatric Disease and Treatment*, *7*, 3–7. https://doi.org/10.2147/NDT.S19617

Lewinsohn, P. M. (1974). A behavioral approach to depression. In R. J. Freedman, & M. Katz (eds), *The Psychology of Depression* (pp. 157–174). Wiley.

Lewinsohn, P. M., Clarke, G. N., & Hoberman, H. M. (1989). The Coping with Depression Course: review and future directions. *Canadian Journal of Behavioural Science*, *21*, 470–493. https://doi.org/10.1037/h0079846

Manos, R. C., Kanter, J. W., & Luo, W. (2011). The Behavioural Activation for Depression Scale-short form: development and validation. *Behavior Therapy*, *42*, 726–739. https://doi.org/10.1016/j.beth.2011.04.004

Markova, V., Sandal, G. M., & Pallesen, S. (2020). Immigration, acculturation, and preferred help-seeking sources for depression: comparison of five ethnic groups. *BMC Health Services Research*, *20*. https://doi.org/10.1186/s12913-020-05478-x

Martell, C. R., Addis, M. E., & Jacobson, N. S. (2001). *Depression in Context: Strategies for Guided Action*. WW Norton & Co.

Matsumoto, D., & Yoo, S. H. (2006). Toward a new generation of cross-cultural research. *Perspectives on Psychological Science*, *1*, 234–250. https://doi.org/10.1111/j.1745-6916.2006.0001

McMurtry, S. L., & Hudson, W. W. (2000). The Client Satisfaction Inventory: results of an initial validation study. *Research on Social Work Practice*, *10*, 644–663. https://doi.org/10.1177/104973150001000506

Methley, A. M., Campbell, S., Chew-Graham, C., McNally, R., & Cheraghi-Sohi, S. (2014). PICO, PICOS and SPIDER: a comparison study of specificity and sensitivity in three search tools for qualitative systematic reviews. *BMC Health Services Research*, *14*. https://doi.org/10.1186/s12913-014-0579-0

Miech, R. A., & Hauser, R. M. (2001). Socioeconomic status and health at midlife: a comparison of educational attainment with occupation-based indicators. *Annals of Epidemiology*, *11*(2), 75–84. https://doi.org/10.1016/S1047-2797(00)00079-X

Milner, A., & Jumbe, S. (2020). Using the right words to address racial disparities in COVID-19. *The Lancet. Public Health*, *5*, 419–420. https://doi.org/10.1016/S2468-2667(20)30162-6

Miranda, J., Azocar, F., Organista, K. C., Dwyer, E., & Areane, P. (2003a). Treatment of depression among impoverished primary care patients from ethnic minority groups. *Psychiatric Services*, *54*, 219–225. https://doi.org/10.1176/appi.ps.54.2.219

Miranda, J., Chung, J., Green, B., Krupnick, J., Siddique, J., Revicki, D., & Belin, T. (2003b). Treating depression in predominantly low-income young minority women: a randomized controlled trial. *Journal of the American Medical Association*, *290*, 57–65. https://doi.org/10.1001/jama.290.1.57

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & PRISMA Group (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *Annals of Internal Medicine*, *151*, 264–269. https://doi.org/10.1371/journal.pmed.1000097

Muñoz, R. F. (2000). *Group Therapy Manual for Cognitive-Behavioral Treatment of Depression*. Rand Corporation.

Myhr, G., Talbot, J., Annable, L., & Pinard, G. (2007). Suitability for short-term cognitive-behavioral therapy. *Journal of Cognitive Psychotherapy*, *21*, 334–345. https://doi.org/10.1891/088983907782638743

Naeem, F. (2012a). *Adaptation of Cognitive Behaviour Therapy for Depression in Pakistan*. Doctoral dissertation, University of Southampton.

Naeem, F. (2012b). *Adaptation of Cognitive Behaviour Therapy for Depression in Pakistan*. Lambert Academic Publishing.

Naeem, F., Ayub, M., Gobbi, M., & Kingdon, D. (2009). Development of Southampton Adaptation Framework for CBT (SAF-CBT): a framework for adaptation of CBT in non-western culture. *Journal of Pakistan Psychiatric Society*, *6*, 79–84.

Naeem, F., Phiri, P., Munshi, T., Rathod, S., Ayub, M., Gobbi, M., & Kingdon, D. (2015). Using cognitive behaviour therapy with South Asian Muslims: findings from the culturally sensitive CBT project. *International Review of Psychiatry*, *27*, 233–246. https://doi.org/10.3109/09540261.2015.1067598

Naeem, F., Phiri, P., Rathod, S., & Ayub, M. (2019). Cultural adaptation of cognitive-behavioural therapy. *BJPsych Advances*, *25*, 387–395. https://doi.org/10.1192/bja.2019.15

Naeem, F., Sajid, S., Naz, S., & Phiri, P. (2023). Culturally adapted CBT – the evolution of psychotherapy adaptation frameworks and evidence. *the Cognitive Behaviour Therapist*, *16*. https://doi.org/10.1017/S1754470X2300003X

Naz, S., Gregory, R., & Bahu, M. (2019). Addressing issues of race, ethnicity, and culture in CBT to support therapists and service managers to deliver culturally competent therapy and reduce inequalities in mental health provision for BAME service users. *the Cognitive Behaviour Therapist*, *12*. https://doi.org/10.1017/S1754470X19000060

NHS Digital (2022*). Psychological Therapies, Annual Report on the Use of IAPT Services, 2021–22*. https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2021-22

NICE (2022). *Depression in Adults: Treatment and Management* (NG 222). https://www.nice.org.uk/guidance/ng22

NIH (2015). *Racial and Ethnic Categories and Definitions for NIH Diversity Programs and for Other Reporting Purposes*. https://grants.nih.gov/grants/guide/notice-files/not-od-15-089.html

Oei, T. P., & Dingle, G. (2008). The effectiveness of group cognitive behaviour therapy for unipolar depressive disorders. *Journal of Affective Disorders*, *107*, 5–21. https://doi.org/10.1016/j.jad.2007.07.018

Office for National Statistics (2023). *Ethnic Group, National Identity, and Religion*. https://www.ons.gov.uk/methodology/classificationsandstandards/measuringequality/ethnicgroupnationalidentityandreligion

Okazaki, S., David, E. J. R., & Abelmann, N. (2008). Colonialism and psychology of culture. *Social and Personality Psychology Compass*, *2*, 90–106. https://doi.org/10.1111/j.1751-9004.2007.00046.x

Okumura, Y., & Ichikura, K. (2014). Efficacy and acceptability of group cognitive behavioral therapy for depression: a systematic review and meta-analysis. *Journal of Affective Disorders*, *164*, 155–164. https://doi.org/10.1016/j.jad.2014.04.023

Öst, L.-G., Enebrink, P., Finnes, A., Ghaderi, A., Havnen, A., Kvale, G., Salomonsson, S., & Wergeland, G. J. (2023). Cognitive behavior therapy for adult depressive disorders in routine clinical care: a systematic review and meta-analysis. *Journal of Affective Disorders*. https://doi.org/10.1016/j.jad.2023.03.002

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., & Moher, D. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *International Journal of Surgery*, *88*, 105906.

Patel, V. (2001). Cultural factors and international epidemiology: depression and public health. *British Medical Bulletin*, *57*, 33–45. https://doi.org/10.1093/bmb/57.1.33

Radloff, L. S. (1977). The CES-D scale: a self-report depression scale for research in the general population. *Applied Psychological Measurement*, *1*, 385–401.

Rathod, S., Kingdon, D., Pinninti, N., Turkington, D., & Phiri, P. (2015). *Cultural Adaptation of CBT for Serious Mental Illness: A Guide for Training and Practice*. John Wiley & Sons.

Rathod, S., Phiri, P., & Naeem, F. (2019). An evidence-based framework to culturally adapt cognitive behaviour therapy. *the Cognitive Behaviour Therapist*, *12*. https://doi.org/10.1017/S1754470X18000247

Resnick, B., & Nahm, E. S. (2001). Reliability and validity testing of the Revised 12-Item Short-Form Health Survey in older adults. *Journal of Nursing Measurement*, *9*, 151–161. https://doi.org/10.1891/1061-3749.9.2.151

Richardson, T., & Bradbury, K. (2012). Group CBT for depression and anxiety in South Asian women: description and preliminary evaluation through a small case series. *Clinical Psychology Forum*, *239*, 45–49.

Rose, S. D. (1999). Group therapy: a cognitive-behavioral approach. In J. R. Price, D. R. Hescheles, A. Rae Price, & A. R. Price (eds), *A Guide to Starting Psychotherapy Groups* (pp. 99–113). Academic Press. https://doi.org/10.1016/B978-012564745-8/50015-7

Rothbaum, F., Weisz, J. R., & Snyder, S. S. (1982). Changing the world and changing the self: a two-process model of perceived control. *Journal of Personality and Social Psychology*, *42*, 5.

Rush, A. J., Trivedi, M. H., Ibrahim, H. M., Carmody, T. J., Arnow, B., Klein, D. N., & Keller, M. B. (2003). The 16-Item Quick Inventory of Depressive Symptomatology (QIDS), clinician rating (QIDS-C), and self-report (QIDS-SR): a psychometric evaluation in patients with chronic major depression. *Biological Psychiatry*, *54*, 573–583.

Santomauro, D. F., Herrera, A. M. M., Shadid, J., Zheng, P., Ashbaugh, C., Pigott, D. M., Abbafati, C., Adolph, C., Amlag, J. O., Aravkin, A. Y., Bang-Jensen, B. L., Bertolacci, G. J., Bloom, S. S., Castellano, R., Castro, E., Chakrabarti, S., Chattopadhyay, J., Cogen, R. M., Collins, J. K., & Ferrari, A. J. (2021). Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic. *The Lancet*, *398*, 1700–1712. https://doi.org/10.1016/S0140-6736(21)02143-7

Sell, H. (1994). The Subjective Well-Being Inventory (SUBI). *International Journal of Mental Health*, *23*, 89–102.

Shek, D. T. (1990). Reliability and factorial structure of the Chinese version of the Beck Depression Inventory. *Journal of Clinical Psychology*, *46*, 35–43.

Slaney, R., Rice, K., Mobley, M., Trippi, J., & Ashby, J. (2001). The Revised Almost Perfect Scale. *Measurement and Evaluation in Counseling and Development*, *34*, 130–145. https://doi.org/10.1080/07481756.2002.12069030

Sulaiman, S. O., Bhugra, D., & de Silva, P. (2001). Perceptions of depression in a community sample in Dubai. *Transcultural Psychiatry*, *38*, 201–218. 10.1177/136346150103800204

Summerfield, D., & Veale, D. (2008). Proposals for massive expansion of psychological therapies would be counterproductive across society. *British Journal of Psychiatry*, *192*, 326–330. https://doi.org/10.1192/bjp.bp.107.046961

Tajima, M., Akiyama, T., Numa, H., Kawamura, Y., Okada, Y., Sakai, Y., Miyake, Y., Ono, Y., & Power, M. J. (2007). Reliability and validity of the Japanese version of the 24-item Dysfunctional Attitude Scale. *Acta Neuropsychiatrica*, *19*, 362–367. https://doi.org/10.1111/j.1601-5215.2007.00203.x

Tanoue, A., Ito, D., Shimizu, K., Ohno, M., Shirai, M., Shimada, H. (2012). Depression, social function, and employees' difficulties in returning to work because of depression. *Japanese Journal of Behavior Therapy*, *38*, 11–22. https://doi.org/10.1017/S1352465818000280

Tolin, D. F. (2010). Is cognitive-behavioral therapy more effective than other therapies? A meta-analytic review. *Clinical Psychology Review*, *30*, 710–720. https://doi.org/10.1016/j.cpr.2010.05.003

Tucker, M., & Oei, T. P. S. (2007). Is group more cost effective than individual cognitive behaviour therapy? The evidence is not solid yet. *Behavioural and Cognitive Psychotherapy*, *35*, 77–91. https://doi.org/10.1017/S1352465806003134

Üstün, T. B., Ayuso-Mateos, J. L., Chatterji, S., Mathers, C., & Murray, C. J. L. (2004). Global burden of depressive disorders in the year 2000. *British Journal of Psychiatry*, *184*, 386–392. https://doi.org/10.1192/bjp.184.5.386

Van Straten, A., Geraedts, A., Verdonck-de Leeuw, I., Andersson, G., & Cuijpers, P. (2010). Psychological treatment of depressive symptoms in patients with medical disorders: a meta-analysis. *Journal of Psychosomatic Research*, *69*, 23–32. https://doi.org/10.1016/j.jpsychores.2010.01.019

Ward, E. C., & Brown, R. L. (2015). A culturally adapted depression intervention for African American adults experiencing depression: Oh, Happy Day. *American Journal of Orthopsychiatry*, *85*, 11–22. https://doi.org/10.1037/ort0000027

Ware Jr, J. E., & Sherbourne, C. D. (1992). The MOS 36-item short-form health survey (SF-36): I. Conceptual framework and item selection. *Medical Care*, 473–483.

Washington, B. (2012). Coyote thoughts: a Native explains mental health. *Indian Country Today*. https://newsmaven.io/indiancountrytoday/archive/coyote-thoughts-a-native-explains-mental-health-PMJLklx4xUGMPdkvNgBB6Q/

Weissman, A. N., & Beck, A. T. (1978). *Development and Validation of the Dysfunctional Attitude Scale: A Preliminary Investigation*. https://eric.ed.gov/?id = ED167619

Weissman, M. M., & Paykel, E. S. (1974). *The Depressed Woman: A Study of Social Relationships*. University of Chicago Press.

Wolgensinger, L. (2015). Cognitive behavioral group therapy for anxiety: recent developments. *Dialogues in Clinical Neuroscience*, *17*, 347–351. 10.31887/DCNS.2015.17.3/lwolgensinger

Wong, D. F. K. (2005). *Getting Out of the Abyss of Depression: A Cognitive Therapy Self-Help Manual*. Hong Kong: Joint Publishing Co.

Wong, D. F. K. (2008a). Cognitive behavioral treatment groups for people with chronic depression in Hong Kong: a randomized wait-list control design. *Depression and Anxiety*, *25*, 142–148. https://doi.org/10.1002/da.20286

Wong, D. F. K. (2008b). Cognitive and health-related outcomes of group cognitive behavioural treatment for people with depressive symptoms in Hong Kong: randomized wait-list control study. *Australian & New Zealand Journal of Psychiatry*, *42*, 702–711.

Wykes, C. F. (2013). *Are Gains made in IAPT Psychoeducational Groups Maintained over Time? A Qualitative Study*. Unpublished doctoral thesis, UCL (University College London). https://discovery.ucl.ac.uk/id/eprint/1405908/

Cite this article: Kunorubwe T. Cultural adaptations of group CBT for depressed clients from diverse backgrounds: A systematic review. *The Cognitive Behaviour Therapist*. https://doi.org/10.1017/S1754470X23000302