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**Therapist drift: The influence of clinicians’ and patients’ characteristics, and their cultural underpinnings**

By

M. E. Hernandez Hernandez

A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy

**2019**



**Therapist drift: The influence of clinicians’ and patients’ characteristics, and their cultural underpinnings**

By:

**Maria Elena Hernandez Hernandez**

A thesis submitted in partial fulfilment of the requirements for the degree of

**Doctor of Philosophy**

The University of Sheffield

Faculty of Science

Department of Psychology

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**Plagiarism declaration**

I declare that this thesis is my own work, based on my own personal research, and that I have acknowledged all the materials and sources utilised in its preparation.

I confirm that this thesis has not been previously submitted for assessment either at the University of Sheffield or elsewhere.

I am conscious that the incorporation of material from other works or a paraphrase of such material without acknowledgement will be treated as plagiarism.

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Maria Elena Hernandez Hernandez

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**Dissemination of results**

The results of the research studies on this thesis have been presented in the following conferences:

* **Chapter II** – X International and XV National Congress of Clinical Psychology. November 16-19, 2017. Santiago de Compostela, Spain. Poster presentation.
* **Chapter III** – International Conference on Eating Disorders 2017. June 8-10. Prague, Czech Republic. Poster presentation.
* **Chapter IV** – 48th European Association for Behavioural and Cognitive Therapies Conference. September 5-8, 2018. Sofia, Bulgaria. Oral presentation.
* **Chapter V** – BABCP Annual Conference 2019. September 3-5, 2019. Bath, UK. Oral presentation.

**Thesis summary**

The main aim of this thesis was to explore therapist drift in the delivery of Cognitive Behavioural Therapy (CBT) in contexts outside the Anglo/European one. Since most of the research on therapist drift has come from these Anglo/European locations, this investigation was based on the premise that therapist drift could manifest differently in different cultural settings. In addition to these cultural factors, this thesis also aimed to explore what clinician-related variables could influence CBT delivery (e.g. anxiety, experience, age, personality), along with other patient-centred variables (e.g. patients’ emotional state, gender, ethnicity, and preferences within the CBT delivery process). For the purposes of this thesis, a series of empirical studies were carried out to explore therapist drift in the delivery of CBT in several countries, but with particular emphasis in Latin American countries. The studies consisted of: 1) A systematic review regarding cultural adaptations of CBT for Latin American patients; 2) A comparative study assessing therapist drift in Latin America and the United Kingdom; 3) A vignette-based study evaluating the influence of patients’ mood and gender and clinicians’ country of origin on CBT delivery; and 4) A comparative study of clinicians’ and patients’ perceptions of the importance of CBT techniques. The results from these studies indicated that different patterns of drift can be found in different cultural settings. These patterns can be influenced by both patients’ and clinicians’ characteristics. Clinicians are encouraged to identify whether these aspects are affecting their practice, and to take actions to reduce such impacts. Researchers are also encouraged to keep investigating therapist drift and its cultural underpinnings, so we can obtain better insight about how patients from different cultural settings might benefit from therapy.

**Chapter I**

**Introduction**

**The impact of therapist drift**

Psychological therapies are constantly being refined and improved. However, evidence-based therapies are still far from being 100% effective, and using non-evidence-based approaches is even less effective (Addis & Waltz, 2002). The reasons behind the lack of success in many cases can be considered from different perspectives. Failures in therapy are often seen by therapists as the patient’s responsibility (e.g. the patient ‘was not ready’, dropped out, or did not engage in the treatment – Waller & Turner, 2016). However, the patient is not the only person responsible for therapies not working.

Evidence shows that many clinicians deliver therapies inappropriately, which could also lead to unsuccessful outcomes for patients. This phenomenon has been conceptualized as ‘therapist drift’, occurring when a clinician fails to deliver an evidence-based psychological therapy when it is available, or fails to deliver it appropriately (Waller, 2009). The reasons behind these failures in therapy implementation are related to *therapy competence* (how knowledgeable is the therapist about a certain therapy?), *therapy differentiation* (is the therapist actually delivering the therapy they intend to deliver?),and *therapy adherence* (whether the therapist follows manuals and protocols – Perepletchikova, Treat & Kazdin, 2007). Clinicians might drift away from best practice either because they lack the necessary competence to deliver a certain therapy (e.g. lack of knowledge to differentiate the core elements of a certain therapy), or because they *choose* not to follow manuals and protocols.

This lack of therapy adherence is particularly worrisome when it is based on clinicians’ own judgement. Prioritising judgement rather than standardised procedures has been criticised in the past. Meehl (1954) suggested that a standardised approach would make more reliable predictions in patients’ outcomes compared to clinical judgement. This suggestion was later confirmed in meta-analyses by Grove, Zald, Lebow, Snitz and Nelson (2000) and Hansen, Lambert and Foreman (2002), where they evidenced that clinician judgement is substantially less effective than protocol-driven approaches in delivering positive clinical and service outcomes.

Therapist drift has been extensively studied in recent years, especially in CBT, where there is a set of protocols with a strong evidence base (meaning that drift can be more readily identified). For example, a study by Waller, Stringer and Meyer (2012) found that older, more experienced, and more anxious therapists delivered fewer CBT techniques when treating eating disorders. Similarly, when Turner, Tatham, Lant, Mountford and Waller (2014) explored therapists’ main concerns about delivering CBT for the eating disorders, they found that clinicians with high prospective anxiety were more worried about cognitive techniques (e.g. cognitive restructuring, behavioural experiments) and exposure work (e.g. weighing the patient, starting diet changes). In contrast, clinicians with high inhibitory anxiety worried the most about more general techniques of the psychotherapeutic process (e.g., motivation work, ending the treatment).

Further studies have found an association between clinician’s anxiety and exposure techniques. Kosmerly, Waller and Robinson (2015) found that more anxious clinicians weighed their patients less frequently when delivering family-based therapy (FBT) for eating disorders. In a sample of therapists from different theoretical orientations, Meyer, Farrell, Kemp, Blakey and Deacon (2014) found that older and more anxious clinicians were more likely to exclude their patients from exposure therapy. The main reasons given by those clinicians for such exclusions included a comorbid psychotic disorder, the patient’s emotional fragility, or the patient’s reluctance to participate.

Personality and its influence in therapy has also been studied, although to a lesser extent than anxiety. Peters-Scheffer, Didden, Korzilius and Sturmey (2013) investigated procedural fidelity in applied behaviour analysis (ABA) for children with autistic spectrum disorder. They found that therapists with more “openness to experience” (a dimension of personality from the “big five” model) adhered less to the ABA procedures. The authors explained this finding as showing that individuals with high openness to experience have more difficulties in conforming to rules and schedules.

Although the topic of therapist drift has recently stimulated a considerable amount of research (see Waller & Turner, 2016), that research has been carried out only in highly developed countries. Since more and less developed countries have marked cultural differences from each other (Hofstede, Hofstede, & Minkov, 2010), these findings on therapist drift might not necessarily apply to different cultural settings. Given the increasing amount of literature recommending addressing cultural differences in clinical settings, more research is needed to explore therapist drift not only across different disorders or types of therapy, but also across countries and cultures.

**Cultural and psychological differences between countries**

Highly developed countries (including Western European countries, Canada, the United States and Australia) have been differentiated from less developed countries not only in terms of economy or language, but also in terms of citizens’ behaviours, values and beliefs. Hofstede et al. (2010) conducted one of the most comprehensive studies of cultural differences between countries. They evaluated six dimensions of culture in a wide range of different countries:

* Individualism: the extent to which identity is defined by personal decisions and accomplishments, or by the collective group to which we are attached to (collectivism).
* Power distance: the acceptance and respect existing between the superior and the subordinate positions.
* Uncertainty avoidance: to what extent a culture needs rules and a formal structure, and how it manifests its level of tolerance of ambiguity.
* Masculinity: Preference in society for achievement, heroism, assertiveness and material rewards for success. Its counterpart, femininity, represents a preference for cooperation, modesty, caring for the weak and quality of life.
* Long-time orientation: Encouragement of actions that are oriented toward future, long-term rewards (e.g., perseverance, thrift). In contrast, short-time orientation takes less of a future perspective, and involves promoting actions concerning the past and the present (e.g., conserving traditions, maintaining a reputation, satisfying social obligations).
* Indulgence: Tendency to satisfy natural human desires, related to enjoying life and having fun. In contrast, restraint indicates a belief that such desires need to be limited and controlled by social rules.

For example, in Hofstede et al.’s studies (2010), Latin American countries showed high levels of uncertainty avoidance, indulgence, and power distance, but low individualism and long-term orientation. South and South East Europe had high scores on both uncertainty avoidance and power distance. North and North West Europe, as well as other English-speaking countries, had high scores on individualism and indulgence, but small power distance. Central Europe and ex-Soviet countries had high scores on uncertainty avoidance, power distance and long-time orientation, but low indulgence. Muslim and other African countries showed high uncertainty avoidance, but low scores in individualism, indulgence and long-time orientation. Lastly, East and South East Asia had high power distance, but low scores in long time orientation, individualism and indulgence.

The patterns found in Hofstede et al.’s study (2010) are shown in Table 1.1 This table indicates more clearly the ‘profiles’ of each culture by comparison with the others.

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| **Table 1.1 Mean scores for Hofstede et al.’s (2010) dimensions in different cultural settings** | | | | | | |
| Region | Power distance\* | Indivi-dualism\* | Mascu-linity\* | Uncertainty avoidance\* | Long-time orienta-tion\*\* | Indul-gence\*\* |
| Latin America | 69 | 24 | 49 | 81 | 19 | 74 |
| Europe (South, south east) | 60 | 51 | 48 | 92 | 48 | 50 |
| Europe (North, north west), English-speaking countries | 38 | 73 | 48 | 56 | 49 | 63 |
| Europe (Central, east), Ex-soviet countries | 68 | 48 | 46 | 78 | 66 | 25 |
| Muslim world, Middle East, Africa | 58 | 38 | 50 | 63 | 23 | 39 |
| Asia (east, south east) | 74 | 25 | 53 | 49 | 36 | 36 |
| Note: Scores are measured in a scale from 0 to 100. \*Scores obtained from 76 countries. \*\*Scores obtained from 93 countries | | | | | | |

Although Hofstede et al. (2010) state that differences among cultures do not necessarily describe differences between individuals, there is some evidence that these cultural differences manifest in the way that individuals within those cultures exhibit personality characteristics. A study that compared personality between English and Mexican non-clinical adults (Eysenck & Lara Cantú, 1989) indicated that Mexican participants had higher levels of ‘psychoticism’ (tendency to show aggressive and impulsive behaviours), extraversion and social desirability. In contrast, English women had higher levels of neuroticism than the rest of the participants. Likewise, Lara Cantú and Suzan-Reed (1988) validated the Marlowe and Crowne Social Desirability Scale, and found that Mexican university students had higher levels of social desirability than the American sample studied by Consalvi (1972). These psychological differences between countries need to be considered in the psychotherapeutic context, since a patient’s cultural background could have a significant effect on therapy, as could that of a therapist.

**The influence of culture on psychotherapy**

The concept of “culture” has been defined in different ways. Hofstede (1991) defines it as “the collective programming of the mind that distinguishes the members of one group or category from another”. In other words, it implies all the values, beliefs and attitudes that gives a group an identity that differentiates it from another. Although culture has been commonly associated only with location or spoken language, it is necessary to emphasize that culture also includes elements of shared history, customs, religion, moral values, self-identity, and the identity attributed by others (Organista & Muñoz, 1996).

Since most of the existing evidence-based therapeutic approaches have been originated in highly developed countries for Anglo/European individuals, the effectiveness of these therapies for patients from countries with dissimilar cultural backgrounds has been called into question (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009; Griner & Smith, 2006; Organista & Muñoz, 1996). In an attempt to make psychological therapies culturally relevant, guidelines and recommendations have been developed in countries with a high number of immigrants. For example, the American Psychological Association (2003) encourages practitioners to make culture-centred adaptations when necessary, and to be culturally sensitive. Similarly, the British Psychological Society recognizes that Western models of psychology need to be adapted to be used in a culturally appropriate way (British Psychological Society, 2011).

Such recommendations have been widely studied in research settings. A meta-analysis of culturally adapted interventions showed an average effect size of *d*=0.45 relative to non-adapted therapy, and the effect size for patient’s satisfaction was *d*=0.93 higher than for the non-adapted therapy (Griner & Smith, 2006). The clinical outcome effect size specifically for culturally-adapted studies with Latin American patients with low levels of acculturation was *d*=0.81 greater than that for non-adapted therapy. However, the descriptions of such adaptations are often vague, making it difficult to draw conclusions about their nature, relevance or efficacy (Bernal et al., 2009). Considering Latin American patients, Organista & Muñoz (1996) suggest including in therapy aspects such as traditional gender roles and religion, as well as integrating important values for Latin American people such as kindness, respect, trust and *familismo* (the importance of immediate and extended family ties). Chu and Leino (2017) conducted a systematic review, where they classified the most common cultural adaptations to therapy found in literature (Table 1.2).

|  |  |  |  |
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| **Table 1.2. Chu and Leino’s classification of cultural adaptations of therapy** | | | |
| **Core** | **Addition** of an extra module or element to the original therapy | | |
| **Modification** of a core component | | |
| **Complete change** of the component | | |
| **No change** at all | | |
| **Peripheral** | **Engagement** | **Entry/access** aspect of the therapy | |
| **Retention/completion** of the therapy | |
| **Psychoeducation** for patients with poor understanding of the psychological process | |
| **Delivery** | **Materials and semantics** relevant to the specific ethnic minority | |
| **Cultural examples and themes** | |
| **Therapy framework** | **Session structure** (number and duration of the sessions) |
| The **provider-client relationship** (interpersonal style) |
| **Person/place** (the involvement to other collaborators in the therapeutic process, such as family members, physicians, priests, etc.). |

**How might culture affect therapist drift?**

While these differences have been identified in patients from different cultures and some of the therapies developed for them, there has been less of a focus on how such cultural differences might manifest in clinicians’ delivery of evidence-based therapies. Given the importance that culture has been shown to have specifically for Latino patients (Griner & Smith, 2006), it is also necessary to address culture and its importance from the Latin American therapists’ perspective. Differences can be found between the ways that white/Caucasian and non-white/Caucasian patients engage and respond to therapy. However, it remains to be established whether such patterns can also be found in white/Caucasian and non-white/Caucasian therapists. For example, it can be hypothesised that clinicians who come from a more conflict-avoidant culture will be less likely to ask patients to undertake any tasks that they could see as emotionally-arousing.

The differences between cultures found in Hofstede et al.’s study (2010) could be a useful frame of reference to understand how Latin American clinicians could be delivering therapy. Table 1.2 shows how Hofstede et al.’s (2010) cultural dimensions could be reflected within the psychotherapeutic context. In particular, as shown in Table 1.1, Latin American cultures show differences in terms of four domains – high uncertainty avoidance, high power distance, low individualism, and short-term orientation. This combination of traits could make therapists from these countries less likely to impose some of the more demanding elements of CBT to their patients (Waller & Turner, 2016). For example, given the low individualism/high collectivism of Latin American cultures, Latin American therapists could have a higher need to like and to be liked by their patients. In order to achieve this, therapists might avoid delivering techniques that could distress their patients. Specifically for CBT, this drift could translate into a low use of the more ‘challenging’ behavioural techniques, such as exposure work, behavioural experiments, or behavioural activation.

|  |  |  |  |  |
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| **Table 1.3. Hofstede et al.’s (2010) dimensions and their possible impact in Latin American clinicians, relative to those in Anglo/European countries** | | | | |
| Dimension | Level in Latin American countries (relative to Caucasian countries) | Example for Latin American therapists | Possible general patterns of drift | Specific patterns of drift that might occur in CBT |
| Power distance | High | Hierarchy matters | Advise the patient, give orders, expect compliance | No Socratic questioning; no feedback |
| Individualism | Low  (high collectivism) | Need to like and to be liked | Avoiding upsetting the patient | No anxiety generation; no exposure work; no behavioural experiments no behavioural activation; reluctant to initiate therapy endings |
| Uncertainty avoidance | High | Must have certainty or do nothing | Do nothing | No active change; no exposure, no behavioural experiments; “wait and see”; talking therapy |
| Long-time orientation | Low  (short-time orientation) | Not setting goals | Not planning the sessions, talk about whatever is in patient’s head | No goal planning; not maintaining an agenda |
| Indulgence | High | Work less; more optimistic; care more for friendship | Minimise patient’s problems; focus excessively on the alliance | Not attending to therapy interfering behaviours; not identifying targets for change; sessions less regular/frequent |

It should be noted that the patterns of expected therapist behaviours exemplified in Table 1.2 are purely theoretical, as conceptualised by the researchers. This means that culture dimensions might not be good predictors of actual drift markers. It is also possible that these patterns of drift are not found in Latin American therapists, and that the theory that they are based on could be obsolete, given cultural changes. Furthermore, the impact of the clinician’s culture in the psychotherapeutic context is not necessarily an unfavourable one. There might also be benefits, such as the greater client satisfaction where cultural adaptations are made (Griner & Smith, 2006). Therefore, analysing the strengths that the clinician’s own culture can bring to therapy could potentially provide the means to improve the quality of the delivered therapy, and therefore, the outcomes for the patients. Understanding patients’ and clinicians’ cultural differences can also shed light into some therapy-related issues, such as how the patients’ cultural needs might lead to technique prioritisation in therapy, how to match clinicians’ and patients’ expectations about how to address culture in clinical settings, how supervision and education can enhance the clinicians’ cultural skills, and how to discern which patients’ characteristics can drive therapist behaviours.

Therapist drift is a multifactorial topic with serious implications. Although the amount of information on such drift has considerably increased in recent years (Waller & Turner, 2016), it is necessary to explore whether patterns of drift are similar or different across cultures. It is hypothesised that different cultural settings will present different patterns of drift, and that the reasons behind such drift will also vary. However, these assumptions are yet to be tested. Therefore, the present investigation will explore to what extent therapist drift occurs in non-Western countries, specifically Latin America, and how cultural factors are related to such drift.

**Prelude to Chapter II**

As mentioned in the previous Chapter, psychological therapies are not always effective. One of the reasons behind this lack of effectiveness could rely on the fact that psychological therapies have been made by and for Anglo/European individuals. This cultural specificity might decrease therapy effectiveness for individuals from different cultural settings. Therefore, the aim of the study presented in Chapter 2 was to systematically review the literature on culturally-adapted therapy. The review focused on the specific case of CBT for Latin American patients, and it assessed the differences in outcomes when compared to regular, non-adapted CBT. The review also identified the type of adaptation made to therapy. Assessing the effectiveness of culturally-adapted therapy will reveal whether clinicians are engaging in practices that increase therapist drift by lacking cultural sensitivity towards their patients. On the other hand, it is possible that regular CBT is effective enough, and that clinicians are making these adaptations needlessly.

**Chapter II**

**Cultural adaptations of cognitive-behavioural therapy for Latin American patients: Unexpected findings from a systematic review**

**Abstract**

**Background:** The current literature extensively recommends making cultural adaptations to psychological therapies, in order to address the differences in values, beliefs and attitudes that patients from different ethnic groups might hold. Although this approach has shown positive outcomes in some settings, it is not well established yet whether such adaptations are needed for all therapies and in all cultures. Therefore, the main aim of this study was to systematically-review the literature regarding culturally-adapted and conventional CBT for Latin American patients, within Latin American and non-Latin American countries. **Method:** Sixty empirical studies regarding the effectiveness of culturally-adapted and conventional CBT were included in this review. The type of cultural adaptation made to the therapy was also assessed. **Results:** There were no differences between the sets of studies in terms of effectiveness, retention rates, methodological quality, or proportion of statistically significant interventions. Most of the cultural adaptations were peripheral or unspecified. **Conclusion:** The evidence to date indicates that both conventional and culturally-adapted CBT offer the same benefits for Latin American patients in terms of effectiveness and retention rates. Rather than focusing on cultural adaptations, clinicians are encouraged to improve the way they deliver CBT through training and supervision.

**Background**

CBT is one of the most effective interventions for treating several psychological problems (Magill & Ray, 2009; Mitchell, Gehrman, Perlis, & Umscheid, 2012; Twomey, O'Reilly, & Byrne, 2015). However, CBT originated in countries such as the United States and the UK – locations with a specific set of cultural and organizational traits. Most of the evidence about CBT effectiveness comes from countries culturally-similar to the United States and the UK (predominantly White, highly developed, wealthy countries, often referred as the “Western world”). This cultural specificity has led clinicians and researchers to question the validity of such interventions for individuals from other cultural backgrounds, where values, beliefs and attitudes can differ from those in the “Western world”, and where resources are often less (Hwang, 2005; Organista & Munoz, 1996).

To address the possible differences in the applicability of CBT between populations, extensive recommendations have been made by researchers and psychological associations, which promote training and education in ‘culturally-sensitive therapy’ (e.g., American Psychological Association, 2003; Bernal & Domenech Rodriguez, 2012; Bernal, Jimenez-Chaffey & Domenech Rodriguez, 2009; Miranda, Azocar, Organista, Dwyer, & Areane, 2003; Organista & Munoz, 1996; Sue, Zane, Hall, & Berger, 2009). Numerous studies have tested culturally-adapted CBT. Many were carried out in the United States with patients from diverse ethnic minorities (e.g. African American, Latin American). These approaches have shown positive outcomes (Miranda et al., 2003; Windsor, Jemal, & Alessi, 2015). Several meta-analyses have investigated the effectiveness of culturally-adapted therapies for Latin American patients (e.g., Benish, Quintana, & Wampold, 2011; Griner & Smith, 2006; Hall, Ibaraki, Huang, Marti & Stice, 2016; Huey & Polo, 2008) showing moderate benefits (effect sizes between *d*=0.45 and 0.52). However, it is important to consider whether it is the use of CBT per se or the cultural adaptation that is the key clinical variable here. Research on regular, non-adapted CBT’s effectiveness in Latin America has also shown positive results (Becerra Galvez, Reynoso Erazo, Garcia Rodriguez & Ramirez, 2016; Botero Garcia, 2005; Villalobos Perez, Araya Cuadra, Rivera Porras, Jarra Parra & Zamora Rodriguez, 2005). Therefore, it is unclear whether culturally-adapted CBT has additional benefits in comparison to regular CBT for non-European/Caucasian participants.

Some concerns about culturally adapted interventions rest with the fact that a consensus is still to be reached on when and how to adapt the therapies. Chu and Leino (2017) conducted a systematic review about the type of cultural modifications commonly made to therapies. Their findings showed that all of the studies had peripheral adaptations – modifications regarding to the engagement and treatment delivery. In contrast, 11.11% of the studies involved adaptations on the core elements of therapy. Their study provides a useful framework of common concepts and terms used when adapting psychological interventions.

Given the above, the aim of this systematic review is to evaluate the current evidence on the effectiveness of both regular and culturally-adapted CBT, and to assess if adapted therapy results in better outcomes for the patients. Given the existing research, the review will focus on the effectiveness of CBT for Latin American patients (e.g. Central and South America, Mexico, Cuba, Dominican Republic, and Puerto Rico), as conducted within Latin America vs non-Latin American countries.

**Method**

**Design**

This systematic review examined the effectiveness of CBT for a range of different disorders, comparing four types of studies evaluating:

* Culturally-adapted CBT in Latin American countries
* Regular CBT in Latin American countries
* Culturally-adapted CBT for Latinos in non-Latin American countries
* Regular CBT for Latinos in non-Latin American countries

In order to compare CBT outcomes, a narrative summary and descriptive statistics from individual and accumulated studies will be reported.

**Summary of search strategy**

The search of papers was made through the following electronic resources: Dialnet, Scielo, Redalyc, PubMed and PsycInfo. Dialnet, Scielo and Redalyc collect predominantly publications from Hispanic countries published in the Spanish language. Therefore, these search engines were utilized to gather mostly (but not exclusively) papers from Latin American countries. Likewise, PubMed and PsycInfo were used to gather papers published in the English language and carried out in non-Latin American countries (mostly the United States, in this case). A literature search was carried out in March 2019. No restrictions were made regarding the publication date of the papers. The different search strategies that were implemented for each database are shown on Table 2.1. The included search terms were intentionally broad, in order to gather as many studies as possible. The term “Hispanic” was omitted from the searches to avoid papers from Spain, which are not relevant for the purposes of this study. Likewise, the British spelling of the word “behavioural” was not included in the searches, given that the studies in the English language were more likely to be conducted in the United States.

**Table 2.1. Systematic review’s search terms and filters (both in Spanish and English)**

|  |  |  |
| --- | --- | --- |
| Resource | Terms | Filters |
| Dialnet | “cognitivo conductual” AND “intervención” AND “eficacia” | - Journal paper |
| “cognitive behavioral” AND “intervention” |
| Scielo | “cognitivo conductual” | - Latin American countries  - Spanish / English papers  - Paper / Journal paper |
| “cognitive behavioral therapy” |
| Redalyc | (advanced search)  Title: cognitivo conductual  Discipline: Psychology | --- |
| (advanced search)  Title: cognitive behavioral  Content: intervention  Discipline: psychology |
| PubMed | cognitive behavioral AND Latino | - Clinical trial |
| PsycInfo | (multifield search)  cognitive behavioral [all fields] AND Latino [abstract] OR Latina [abstract] AND intervention [abstract] | - Intervention  - Peer reviewed journal |

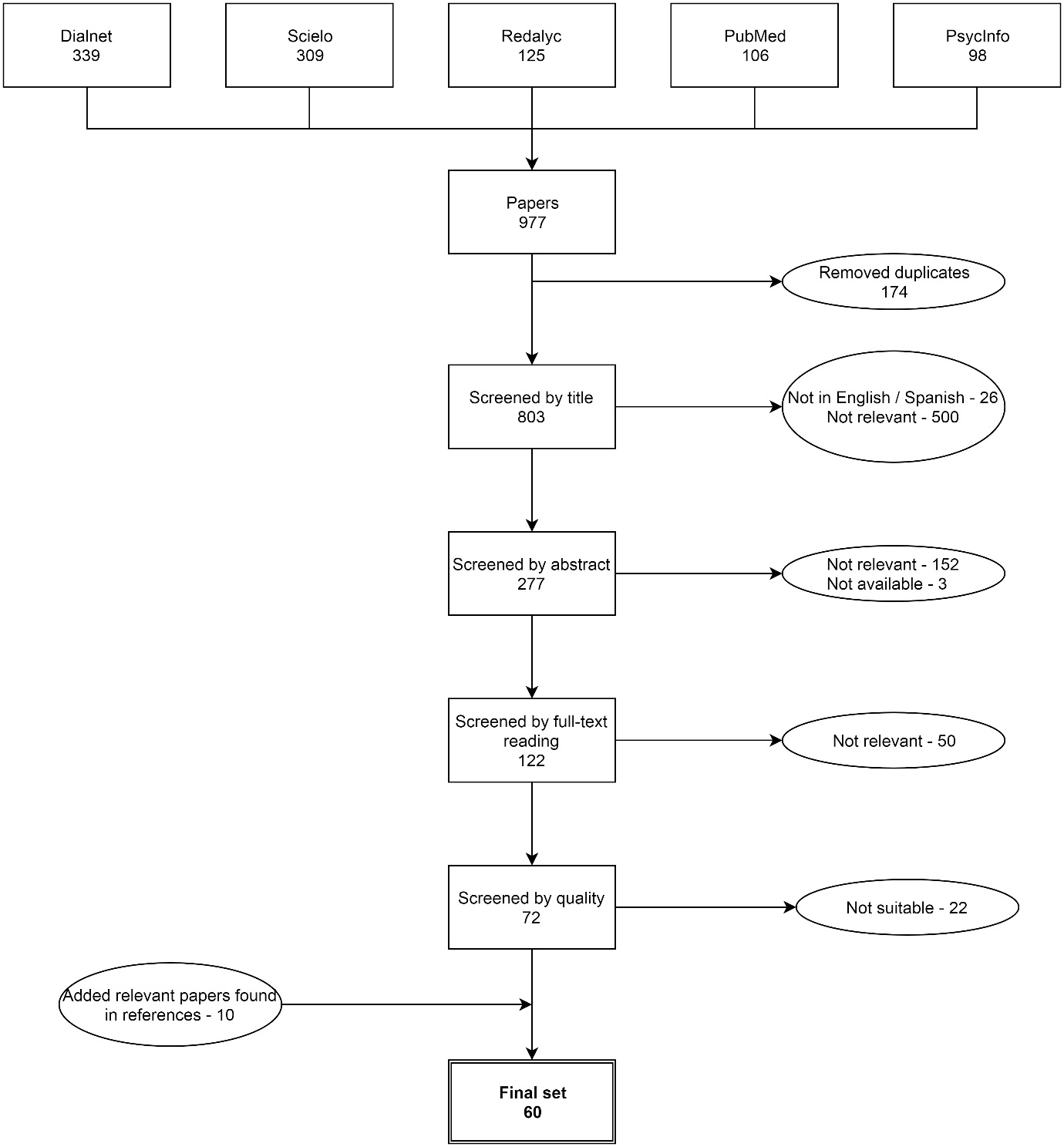
**Eligibility**

Empirical, quantitative studies regarding the effectiveness of culturally-adapted conventional CBT were included in this review. Every study that specifically identified that it involved any type of cultural adaptation to the therapy was included (regardless of the extent of that adaptation). However, the simple use of translated/validated measures was not considered as a cultural adaptation of the therapy. Participants were Latin American, residing in Latin American countries (Mexico, Puerto Rico, Dominican Republic, Central or South America and Cuba) or in other highly developed countries. The included papers were published in the English or the Spanish language. Brazilian studies were considered if they were in the English or the Spanish language. To obtain a better estimate of the effectiveness of CBT alone, studies that included the simultaneous use of medication were omitted.

**Papers found and included/excluded**

The search in the electronic databases resulted in 977 papers, which after removing the duplicates resulted in 803 papers. After the screening process (see Figure 2.1), 60 papers were included in the final review.

**Figure 2.1 PRISMA diagram**

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**Classification of final paper set by type of cultural adaptation**

To enable the systematic analysis of the data, the information from the 60 included papers was synthesized and organized utilising a data extraction tool, which was created by the researcher. This data extraction tool classified the most relevant information of the included papers, namely: study aims, intervention, participants, measures, outcome, and type of cultural adaptation (see Table 2.2). As expected, the studies that evaluated regular and adapted CBT for Latin American patients in non-Latin American countries were all carried out in the United States. Therefore, these four groups (defined by the use of adapted vs non-adapted CBT either inside or outside Latin America) will be used here henceforth.

The typology of cultural adaptation was based on Chu & Leino’s (2017) classification. This classification sorts cultural adaptations into two main categories: **core** and **peripheral**.

* **Core** adaptations could include:
* An addition of an extra module or element to the original therapy;
* A modification of a core component;
* A complete change of the component; or
* No change at all.
* **Peripheral** adaptations might relate to:
  + Engagement, which includes:
    - The *entry/access* aspect of the therapy;
    - The *retention/completion* of the therapy; and
    - *Psychoeducation* for patients with poor understanding of the psychological process.
  + The delivery of the therapy can be subdivided in three areas:
  + *Materials and semantics* relevant to the specific ethnic minority;
  + *Cultural examples and themes;* and
  + *Therapy framework*, which can imply aspects about:
    - *Session structure* (number and duration of the sessions);
    - The *provider-client relationship* (interpersonal style); and
    - *Person/place* (the involvement to other collaborators in the therapeutic process, such as family members, physicians, priests, etc).

Most of the studies included in this review had peripheral adaptations. Only a handful of papers included core modifications, and some studies only mentioned making a “cultural adaptation”, without providing any further details.

**Table 2.2 Raw data extracted from the analysed studies**

| **Authors** | **Goal** | **Intervention** | **Participants** | **Measures** | **Outcome** | **Type of adaptation** |
| --- | --- | --- | --- | --- | --- | --- |
| **Adapted CBT in Latin American countries** | | | | | | |
| 1. Cabiya, Padilla-Coto, Gonzalez, Sánchez-Cestero, Martinez-Tabola & Sayers, 2008 | To evaluate the effectiveness of a cognitive-behavioural intervention for children with disruptive disorders and depressed mood. | Twelve group sessions, average 50-minutes long on average (additional 10 minutes for social interaction). | 278 participants, ages 8 to 13, were assigned to one of the two experimental groups (intervention and wait-list). | Bauermeister school behaviour inventory; Child Depression Inventory. | Significant reductions in depressed mood and disruptive behaviours were found in the experimental group compared with control. Children in the treatment group showed further reductions at follow-up in both areas. | **Peripheral** – Delivery – Materials and semantics  **Peripheral** – Delivery - Cultural examples and themes  **Peripheral** – Delivery - Therapy framework – Provider-Client relationship |
| 1. Díaz-Martínez, Díaz-Martínez, Rodríguez-Machain, Díaz-Anzaldúa, Fernández Varela & Hernández-Ávila, 2011 | Examining the efficacy of individual or group Motivational therapy or CBT in reducing drinking among undergraduate students diagnosed with alcohol dependence | Patients were divided into four groups: Individual motivational therapy; group motivational therapy; individual CBT; group CBT. These were 1-hour manualized interventions, contextually adapted, and delivered in the course of 8 weeks. | 158 university students diagnosed with alcohol dependence. | Spanish version of the Alcohol Use Disorders Identification Test; Composite International Diagnostic Interview, Retrospective Baseline adapted for Mexican population | There was a significant decrease of alcohol consumption frequency and quantity in all four study groups. There were no significant differences among groups. | **Unclear** - The study stated that the intervention was based on a manual adapted to the Mexican population. The individual cultural elements included in the therapy were not specified. |
| 1. De la Rosa Gomez & Cardenas Lopez, 2012 | To investigate the efficacy of virtual reality exposure therapy vs imaginal exposure for victims of criminal violence | Bi-weekly, 90-minute long individual sessions of CBT with emphasis in prolonged exposition (virtual reality or imagination). | 30 participants with PSTD symptoms were randomly allocated on both experimental conditions. Only 20 ended the treatment. | PTSD symptoms scale; State-trait anxiety inventory; Beck depression inventory | Statistically significant changes in all PSTD symptom scale and associated anxious and depressive symptoms on both treatment groups. Higher therapeutic gains in prolonged virtual reality exposure. | **Unclear** - The study stated that the intervention was based on a manual adapted to the Mexican population. The individual cultural elements included in the therapy were not specified. |
| 1. Rossello & Bernal, 1999 | To evaluate the efficacy of CBT and Interpersonal Therapy in reducing depression, and improving self-esteem, social adaptation, and behavioural and family functioning, compared with each other and with a wait-list control. | Twelve one-hour long individual therapy sessions (CBT or IPT), held once a week over a period of 12 weeks. | 71 adolescents between 13 and 17 years old, with diagnosis for major depressive disorder, dysthymia or both. | Children depression inventory; Piers-Harris children’s self-concept scale; Social adjustment scale for children and adolescents; Family emotional involvement and criticism scale; Child Behavior checklist for adolescents. | Both treatments significantly reduced depressive symptoms when compared with waiting-list control. | **Peripheral** – Delivery – Materials and semantics  **Peripheral** – Delivery - cultural examples and themes  **Peripheral** – Delivery - Therapy framework – Provider-client relationship |
| 1. Rossello & Jimenez-Chafey, 2006 | To adapt and pilot test a cognitive-behavioural group therapy to treat depressive symptoms and improve glycaemic control in adolescents with type 1 diabetes | Twelve sessions of group CBT with a 2-hour duration. The sessions were based on the adapted CBT treatment manual. | 11 Puerto Rican adolescents with T1DM completed the treatment (two males and nine females). Their ages ranged from 12 to 16 years old. | Children’s depression inventory; Diabetic management information sheet; Beck anxiety inventory; Hopelessness scale for children; Piers-Harris children’s self-concept scale; Summary of self-care activities; Self-efficacy for diabetes scale; Glycosylated haemoglobin. | Participants showed a significant improvement in depressive symptoms, self-concept, diabetes self-efficacy, anxiety and hopelessness. However, no changes were observed in glycaemic control or self-care behaviours. | **Peripheral** – Delivery – Cultural examples and themes |
| 1. Rossello, Duarte-Vélez, Bernal & Zuluaga, 2011 | To examine treatment response to a cognitive behavioural therapy for depression that integrated a protocol for the management of suicide risk in adolescents. | Twelve manualized CBT sessions in individual format. | 120 one Puerto Rican adolescents between 13 and 17.5 years old participated on this study. One hundred and fifteen completed the intervention. | Children’s depression inventory; Suicide ideation questionnaire junior; Hopelessness scale for children; Global assessment scale for children. | CBT reduced the severity of suicide ideation on the 89% of the participants. | **Unclear** - The study stated that the intervention was based on a manual adapted for Hispanic adults diagnosed with depression. The individual cultural elements included in the therapy were not specified. |
| **Non-adapted CBT in Latin American countries** | | | | | | |
| 1. Aguilera-Sosa, Lejía-Alva, Rodriguez-Choreno, Trejo-Martínez & Lopez-De la Rosa, 2009 | From the identification of maladaptive schemes in obese subjects, to evaluate the effectiveness of a group treatment with cognitive-behavioural bases for its modification, as well as anthropometry. | Group cognitive behavioural therapy, developed over 14 sessions, with an approximate duration of one and a half hour. | 22 females from 18 to 40 years old, and a BMI between 30 and 40. | Young schema questionnaire (long form); Anthropometric measures (weight and height). | Significant decrease in maladaptive cognitive schemes such as emotional deprivation, abandonment, social instability, and failure. Participants decreased on average 4.7 kg after the intervention. | N/A |
| 1. Alcázar-Olán, Merckel-Niehus, Toscano-Barranco, Barrera-Muñoz & Proal-Sánchez (2018) | To evaluate the effects of a group cognitive behavioural intervention in individuals with rumination and anger issues | 9 manualized group CBT sessions | 30 adult participants (28 female; 2 male) with anger issues | Inventario Multicultural Latinoamericano de la Expresión de la Cólera y la Hostilidad (ML-STAXI) | Participants with high session attendance  showed statistically significant changes in variables such as revenge, angry afterthoughts, angry memories, and understanding  the causes of anger | N/A |
| 1. Arrivillaga Quintero, Varela Arévalo, Caceres de Rodriguez, Correa Sanchez & Holguin Palacios, 2007 | To determine the efficacy of a program to decrease the levels of blood pressure in Colombian population. | Eighteen weekly sessions of cognitive behavioural therapy, lasting one hour and 30 minutes. | 100 patients randomly allocated into the experimental or control group (wait list). | Systolic and diastolic levels of blood pressure; Perceived stress scale; Questionnaire of treatment adherence for hypertension. | The intervention significantly decreased systolic blood pressure, as well as perceived stress and treatment adherence. No changes in diastolic blood pressure. | N/A |
| 1. Becerra Gálvez, Reynoso Erazo, Garcia Rodriguez & Ramirez, 2016 | To decrease anxiety levels in female patients who underwent breast incisional biopsy for the first time. | The intervention consisted in proportioning psychoeducation and training in passive relaxation trough videos, audio files, and printed information. | Non-probabilistic sample conformed by 10 female patients between 25 and 54 years old, who attended for the first time at the oncologic service in a Mexican hospital. | State-trait anxiety inventory; Facial expression scale for anxiety | Scores significantly decreased on state anxiety and on the facial expression scale. | N/A |
| 1. Botero Garcia, 2005 | To assess the effectiveness of cognitive-behavioural therapy for Colombian veteran soldiers with PSTD | CBT based in prolonged exposure and stress inoculation procedures, along with other standard CBT techniques. Daily sessions of 2 to 3 hours, for 4 weeks | 42 air force veterans in process of rehabilitation for illness or injury, with a PTSD diagnosis | Post-traumatic stress scale; Beck Depression Inventory; Subjective  Units of Distress Scale | Significant decrease in symptomatology and severity level after the intervention both in depression and PTSD symptoms. | N/A |
| 1. Cáceres-Ortiz, Labrador-Encinas, Ardila-Mantilla & Parada-Ortiz, 2011 | To evaluate the effectiveness of a psychological treatment focused in the trauma of women victims of intimate partner violence | Group CBT focused on relaxation, pleasant activities, exposure, assertiveness and coping. Eight sessions with a duration of 100 minutes. | 73 women, 40 years old or less, from medium-low socioeconomic status. | Interview; Beck anxiety inventory; Beck depression inventory; PSTD Severity Scale; Rosenberg’s Inventory (self-esteem); Maladjustment Scale; Inventory of posttraumatic cognitions | Improvement on each dependent variable for most of the participants. The results were maintained during the follow-ups, on a clinical and statistical level | N/A |
| 1. Castro, Daltro, Campos Kraychete & Lopes, 2012 | To test the effectiveness of CBT in patients with chronic musculoskeletal pain as for intensity of pain, presence of anxiety and depressive symptoms, and quality of life. | 10 weeks of CBT. | 93 patients with musculoskeletal pain were divided in experimental (n=48) and control group (n=45). | Visual analogue  Scale; Hospital anxiety and depression scale; Quality of life scale. | The intervention reduced the intensity of pain and depressive symptoms, and to improved quality of life. The experimental group presented higher reduction on the intensity of pain compared to the control group. | N/A |
| 1. Contreras, Moreno, Martínez, Araya, Livacic-Rojas & Vera-Villaroel, 2006 | To evaluate a brief cognitive behavioural intervention targeted to a sample of elder adults, aiming to decrease anxiety and depression symptoms. | Eight sessions delivered bi-weekly and with a 2-hour duration. | 38 Chilean elder adults diagnosed with low/moderate depression and anxious symptomatology. | State-trait anxiety inventory; Geriatric depression scale. | Results indicated statistically significant differences between experimental and control group in all measures. Effects were moderate/high for state anxiety and depression, and moderate for trait anxiety. | N/A |
| 1. Cordioli, Heldt, Bochi, Margis, De Sousa, Tonello, Teruchkin & Kapczinski, 2002 | To develop a cognitive-behavioural group therapy protocol and to verify its efficacy to reduce obsessive-compulsive symptoms. | Behavioural group therapy protocol composed by 12 weekly sessions of 2 hours each. | 32 subjects (22 females and 10 males), suffering obsessive-compulsive symptoms. | Yale-Brown obsessive-compulsive scale; Hamilton anxiety scale;  Hamilton depression scale. | Short cognitive-behavioural group therapy reduced the intensity of obsessions and compulsions. A decrease in symptoms of anxiety and depression was also found. The treatment was efficient in 78.1% of the patients. | N/A |
| 1. Cruz-Almanza, Gaona-Márquez & Sánchez-Sosa, 2006 | To evaluate a cognitive behavioural intervention over assertiveness, self-esteem and coping, to rehabilitate women abused by their problem-drinker spouses. | Treatment was administered through 18, 150-minute weekly group sessions. | Initial pool of 35 women; only 18 completed the treatment. | Assertion inventory; Self-esteem inventory; Birmingham coping inventory | The intervention generated relatively stable middle and long-term improvements in three out of the four dimensions featured in the study (self-esteem, coping strategies, and likelihood of behaving assertively). | N/A |
| 1. De Souza, Salum, Jarros, Isolan, Davis, Knijnik, Manfro & Heldt, 2013 | To evaluate the effectiveness of a group CBT protocol for youths with anxiety disorders in a community sample of low- and middle-income countries. | Manual-based group CBT targeted at treating anxiety in children. The intervention consisted of 14 weekly, 90-minute long sessions. Two more concurrent sessions with parents were included. | 28 youths between 10 and 13 years old were included. Twenty patients completed the treatment. | Clinical global impression rating scale; Paediatric anxiety rating scale; Screen for child anxiety related emotional disorders; Children’s global assessment scale; Children’s depression inventory; Youth quality of life instrument-Research version; Assessment of attention deficit hyperactivity. | CBT produced substantial treatment effects for anxiety symptoms, although it did not result in a significant decrease in depressive symptoms, nor an improvement in quality of life. | N/A |
| 1. Duchesne, Appolinario, Pimentel Range, Fandino, Moya & Freitas, 2007 | To assess the effectiveness of a manual-based cognitive Behaviour therapy, adapted to a group format, in a sample of Brazilian obese subjects with binge-eating disorder. | Nineteen sessions of group CBT, for 22 weeks, 90-minute long | 21 adult patients (85.7% female) diagnosed with binge eating disorder, and a BMI between 30 and 45. | Frequency of binge-eating assessed as the number of days per week in which patients had at least one binge-eating episode; Binge-eating scale; Beck depression inventory; Body shape questionnaire; Changes in weight and BMI | Significant improvement in binge-eating frequency, body shape concerns and depressive symptoms, along with a considerable decrease in body weight. | N/A |
| 1. Escoto Ponce de León, Camacho Ruiz, Rodríguez Hernández & Mejía Castrejón, 2010 | To evaluate the impact of a selective prevention program designed to modify body image alteration on three levels (perceptual, cognitive-affective, and behavioural). | Seven bi-weekly CBT sessions, with a 2-hour duration. | 15 Mexican females from 15 to 18 years old, sampled from a public high school. | Body shape questionnaire; Body image avoidance questionnaire. | Reduction in body dissatisfaction and avoidance of social activities. | N/A |
| 1. Furlan, 2013 | To evaluate the effectiveness of a program to decrease anxiety towards exams, academic procrastination, and to increase regulatory self-efficacy. | Twelve sessions, 2-hour long, with a weekly frequency. | 19 students (13 females and 6 males) between 22 and 41 years old. | Tuckman procrastination scale; German test anxiety inventory; Self-efficacy for learning form | Comparing pre and post results, moderate improvements were found in all measures. | N/A |
| 1. Garduno, Riveros & Sanchez-Sosa, 2010 | To examine the effects of a cognitive behavioural intervention on the quality of life of patients with breast cancer | Individual CBT in weekly, one-hour consultations. Average of 16 sessions. | 60 Mexican women between 31 and 67 years of age, with confirmed, non- terminal breast cancer | Inventory of Quality of Life and Health | Most patients showed positive changes, clinically and statistically in the following domains:  Daily life, free time, preoccupations, body perception and isolation | N/A |
| 1. Gil-Bernal & Hernandez Guzman, 2009 | To investigate the efficacy of the “Intervention in adolescents with social phobia” (Olivares, 2005), adapted for Mexican children with social phobia. Likewise, investigate the role of information to parents on the disorder when their children undergo treatment. | The intervention consists of 9 sessions lasting 90 minutes each. Participants were randomly assigned to the three experimental conditions: (1) treatment of social phobia only to children, (1) information to parents about social phobia while their children underwent treatment, and (C) waiting list. | 17 children between 7 and 12 years old, with a diagnose of social phobia | Children Behavior Checklist; Diagnostic instrument for social phobia; Spence children’s anxiety scale. | Both groups exposed to treatment showed improvement after treatment. No advantage was detected in the case of parental involvement. | N/A |
| 1. Gomez, Leyton & Nunez, 2009 | To examine the efficacy of cognitive-behavioural therapy in patients suffering from drug-resistant obsessive-compulsive disorder | Standard CBT with a maximum duration of 1 year, conducted in weekly, fortnightly, or monthly sessions | 23 adult outpatients diagnosed with drug-resistant OCD (at least 2 different drugs had been prescribed) | Interview; DSM IV-TR criteria for OCD; Yale-Brown Obsessive-Compulsive Scale; Clinical Global Impression Scale | From the 18 patients who completed the process, eight recovered completely, nine remitted, and one had a full response. | N/A |
| 1. Gonzalez Fragoso, Ampudia Rueda & Guevara Benitez, 2012 | To test the effects of a program to develop social skills on institutionalized children, as well as its impact on psychological variables such as depression, self-esteem and anxiety. | Fourteen sessions of cognitive behavioural therapy in group format, with a 2-hour duration. | 36 children under the care of an institution, ranging from 8 to 12 years old. | Assertive behavior scale for children; Depression scale for children; Self-esteem inventory for children; Scale of manifest anxiety on children. | Children on both experimental and control (wait list) conditions showed an improvement on social skills. Children on experimental condition additionally reduced their depressive symptomatology. | N/A |
| 1. Gonzalez García, Gonzalez Hurtado & Estrada Aranda, 2015 | To show the efficacy of CBT in patients with breast cancer, which objective was reducing levels of anxiety and depression, as well as developing coping skills to improve quality of life perception. | Manual-based CBT, 10 sessions (average), 60-minutes long, with a frequency of 2 to 4 weeks. | 15 patients diagnosed with breast cancer in non-advanced stage. | Healthcare anxiety and depression scale; Stress coping questionnaire for oncologic patients; World Health Organization Quality of Life (brief). | Improvement in quality of life subscales (physical health and interpersonal relationships), as well as healthcare anxiety and depression. | N/A |
| 1. Guerra Vio, Fuenzalida Vivanco & Hernandez Morales, 2009 | To evaluate the efficacy of a CBT workshop, aiming to increase self-care behaviours and decrease the levels of secondary traumatic stress on clinical psychologists. | CBT workshop focused on self-care based on Fuenzalinda et al (2008) model. Five weekly, 90-minutes sessions. | 21 clinical psychologists with high scores of secondary traumatic stress. Nine participated in the intervention, and 12 remained in the control group (no intervention). | Scale of self-care behaviours for psychologists; Secondary traumatic stress scale | The experimental group increased significantly self-care behaviours, and decreased secondary traumatic stress levels. In contrast, participants in control group remained stable on self-care frequency, but increased their levels of secondary traumatic stress. | N/A |
| 1. Habigzang, Pinto Pizarro de Freitas, Von Hohendorff & Koller, 2016 | To evaluate the effectiveness of a cognitive-behavioural group therapy model in reducing symptoms of depression, anxiety, stress and PTSD in child and adolescent victims of sexual violence. In addition, its effectiveness was investigated when applied by trained practitioners and by the researchers / psychologists who developed it. | Cognitive-behavioural group therapy based in Habigzang et al (2013) model, consisting of 16 semi-structured weekly sessions with an average duration of one hour and thirty minutes. | 103 Brazilian girls victims of sexual violence, aged between 7 and  16 years old. | Children’s depression inventory; Childhood stress scale; State-trait anxiety inventory for children; Structured interview based on the DSM IV. | Significant reduction in the symptoms of depression, anxiety, stress, and PTSD. The comparison between the results obtained by the two groups of practitioners in the application of the model indicated no significant differences in the rates of improvement of the participants. | N/A |
| 1. Habigzang, Schneider, Petroli Frizzo & Pinto Pizarro de Freitas 2018 | To develop and evaluate an intervention protocol, based on cognitive-behavioural therapy, for women in situations of domestic violence | Individual cognitive-behavioural intervention consisting of 13 sessions with a weekly frequency. The sessions included structured activities of one-hour duration. | 11 women that were  victims of psychological, physical, and/or sexual violence perpetrated by their partners | Beck Anxiety Inventory (BAI); Beck Depression Inventory (BDI); Satisfaction with Life Scale (SWLS); Lipp Inventory of Stress Symptoms for  Adults (LISS); Structured interview based on DSM-IV/  SCID to assess PTSD | Significant reduction in depression, anxiety and stress symptoms; increase in life satisfaction. No change in PTSD symptoms. | N/A |
| 1. Meyer, Shavitt, Leukefeld, Heldt, Souza, Knapp & Cordioli, 2010 | To examine if adding two individual sessions of Motivational interview + thought mapping before starting CBT in an adult OCD outpatient treatment program would facilitate changes in the OC symptoms when compared with CBGT alone. | CBGT was conducted in a closed-ended group during the course of 12 weekly two-hour sessions, based on a structured, manual-based approach.  The MI+TM approach consisted of two 60-minute individual weekly sessions before the patients started the 12 CBGT sessions.  In the control group, the therapist provided information only. | 40 outpatients  with a primary diagnosis of obsessive-compulsive disorder | Dimensional Yale-Brown obsessive-compulsive scale; Yale-Brown obsessive compulsive scale; Clinical global impressions scale (severity sub-score) | Both groups significantly improved.  MI+TM treatment had slightly better outcomes in aggression, contamination, and compulsions. | N/A |
| 1. Montero Pardo, Jurado Cárdenas, Robles García, Aguilar Villalobos, Figueroa López & Méndez Venegas, 2012 | To develop and evaluate a cognitive behavioural intervention to decrease burden in informal primary caregivers of children with cancer, and to decrease their anxious and depressive symptoms. | Manualized intervention delivered in a Mexican hospital once per day for five days. | 20 women with a mean age of 34 years old. | Caregiver Burden Interview; Beck depression inventory; Beck anxiety inventory. | The intervention showed a moderate effect on depression, affective-cognitive symptoms, and burden; however, the effect on depression increased at the follow-up. The intervention had a small effect on anxiety. | N/A |
| 1. Pegado, Alckmin-Carvalho, Leme, Carneiro, Kypriotis, Camacho & Fleitlich-Bilyk (2018) | To assess the applicability and eﬀects of a group CBT program for Brazilian adolescents with anorexia nervosa, compared to usual care | 24 manualized sessions held in a group setting, lasting 90 minutes, over a six-month period. The group was led by psychotherapists specialized in CBT | 22 patients diagnosed with anorexia nervosa | Eating disorders examination questionnaire; Development and Well-Being Assessment | Participants in both groups regained weight and decreased symptoms of eating disorders at the end of groups. The CBT group presented a statistically significant diﬀerence in restraint | N/A |
| 1. Pérez Baquero, Ruiz Santos & Parra Ocampo, 2014 | To determine the effects of a cognitive-behavioural intervention in a marital conflict for infidelity | 10 weekly sessions of CBT based in Baucom et al (2009) model, with techniques such as infidelity management impact, examination of context and decision making | 5 Colombian couples;  4 cases of male infidelity and one of female infidelity | Couple needs inventory; Scale of difficulties in emotional regulation; Self-registry of frequency of discussions; Self-registry of positive interactions | Significant increase in positive interactions on three couples, and significant decrease in the frequency of discussions on all couples. |  |
| 1. Reyes Jarquin & Gonzalez-Celis Rangel, 2016 | To assess the effects of a cognitive behavioural intervention for formal caregivers of elder adults, aiming to diminish burnout. | Cognitive behavioural intervention delivered in 9, hour-long sessions. | 15 caregivers with a mean age of 46 years old (14 females and 1 male). | Questionnaire to assess burnout syndrome; World Health Organization quality of life scale (brief version) | Decrease in burnout dimensions such as physical wear, work disappointment and guilt. Improvement in quality of life, particularly physical health, psychological health and social relationships. | N/A |
| 1. Riveros, Ceballos, Laguna & Sanchez-Sosa, 2005 | To examine the effects of a cognitive-behavioural procedure over anxiety, therapeutic adherence, well-being, and other quality of life-related areas, in hypertensive patients. | Sixty-minute-long CBT sessions on individual format. Participants received 16 to 30 sessions, according to each case. | 20 patients diagnosed with hypertension. | Inventory of quality of life and health; Beck anxiety scale; Moos’ coping scale; Behavioral self-registration system (to evaluate therapeutic adherence). | Clinical and statistically significant changes for most patients on quality of life, therapeutic adherence, wellbeing and anxiety in pre and post-test, as well as follow-up measures. | N/A |
| 1. Tapia, Chana, Araneda, Canales, Curihual, Rivas, Salazar & Baldwin, 2014 | To evaluate the effectiveness of thermal-tactile stimulation in addition to cognitive-behavioural treatment, aiming to decrease the salivation perception in patients with Parkinson | CBT plus thermal-tactile stimulation (technique that triggers the swallowing reflex with cold stimulation in the isthmus of the fauces), compared to CBT alone. The intervention was carried out two times per week. | 18 patients with Parkinson disease, presenting  sialorrhea | Sialorrhea Clinical Scale for Parkinson Disease | Both groups showed a statistically significant difference pre-post intervention. There were no differences between groups; both treatments resulted effective. | N/A |
| 1. Vergara Lope-Tristan & Gonzalez-Celis Rangel, 2009 | To adapt a manualized cognitive behavioural intervention to the specific characteristics of elderly people, as well as evaluate its effect on irrational ideas, depression, anxiety and subjective wellbeing. | Eight sessions with a duration of 2 hours. | 37 elder adults between 57 and 85 years old. | Mini-mental state examination; Beck anxiety inventory; Subjective wellbeing scale; Questionnaire of irrational ideas; Geriatric depression scale; Behavioral registry | Small improvement on irrational ideas, depression and behavioural registry. Moderate and large improvement on depression and subjective wellbeing, respectively. | N/A |
| 1. Villalobos Pérez, Araya Cuadra, Rivera Porras, Jara Parra & Zamora Rodriguez, 2005 | To decrease depression through cognitive behavioural group therapy in patients with fibromyalgia | 15 sessions of cognitive-behavioural group therapy, 2 hours each, 2 sessions per week | 10 female participants diagnosed with fibromyalgia, with a score over 60 in the Multiscore Depression Inventory | Berndt’s Multiscore Depression Inventory | Decrease of depression scores in an average of 50% | N/A |
| 1. Zimmer, Duncan, Laitano, Ferreira & Belmonte-de-Abreu, 2007 | To determine the effect of a twelve-session cognitive-behavioural intervention compared to that of treatment as usual on the social functioning of schizophrenic patients. | CBT delivered in weekly 60-minute sessions for a period of 3 months. | 56 participants (20 intervention, 36 treatment as usual) between 18 and 65 years of age, diagnosed with schizophrenia or schizoaffective disorder | Operational criteria checklist for psychotic illness; Brief psychiatric rating scale; Mini-mental state examination and word-span; Global assessment of functioning scale; Social and occupational functioning assessment scale; World Health Organization brief quality of life assessment instrument;  Social adjustment scale | The intervention demonstrated superiority over treatment as usual in its effects on cognition, social adjustment and quality of life. | N/A |
| **Adapted CBT for Latinos in the United States** | | | | | | |
| 1. Alegria, Ludman, Kafali, Lapatin, Vila, Shrout, Keefe, Cook, Ault, Li, Bauer, Epelbaum, Alcantara, Pineda, Tejera, Suau, Leon, Lessios, Ramirez & Canino, 2014 | To evaluate treatment effectiveness of telephone or face-to-face cognitive behavioural therapy and care-management intervention for low-income Latinos, as compared to usual care for depression. | CBT intervention delivered by telephone or face-to-face. The first four sessions were conducted weekly, and the 5th and 6th were biweekly, up to a total of 8 sessions. | 257 adult Latinos, who scored 10 or more on the Patient health questionnaire-9, and met criteria for major depressive disorder. Patients were either living in the US or Puerto Rico. | Patient Health Questionnaire-9; Hopkins Symptom Checklist; World Health Organization disability assessment schedule. | Both telephone and face-to-face versions of the intervention were more effective than usual care. Larger effect was reached in the US sample than in the Puerto Rico sample. | **Peripheral** – Engagement – Psychoeducation  **Peripheral** – Delivery – Materials and semantics, Cultural examples and themes |
| 1. Burrow-Sanchez & Wrona, 2012 | Evaluating the feasibility and initial efficacy of a culturally relevant group CBT intervention in Latino adolescents with substance abuse. | Standard vs culturally accommodated CBT, delivered in a group format via weekly one and a half-hour sessions, over consecutive 12-week periods. | 35 Latino adolescents who ranged in age from 13 to 18, diagnosed with drug abuse or dependence. The 80% of the sample completed the treatment. | Timeline follow back; Structured clinical interview for DSM–IV; Client satisfaction questionnaire; Acculturation rating scale for Mexican Americans-II; The multiethnic identity measure; Familism scale | Substance use levels significantly decreased from pre to posttreatment, and then slightly increased at 3-month follow-up for both treatment conditions. Parents with adolescents in the experimental condition were more satisfied with the program compared to parents in the control condition; however, the satisfaction scores for adolescents by condition did not differ. | **Core** – Addition  **Peripheral** – Delivery – Cultural examples and themes  **Peripheral** – Delivery – Therapy framework – Person / place |
| 1. Cachelin, Shea, Phimphasone, Wilson, Thompson & Striegel, 2014 | To examine the feasibility, acceptability and preliminary efficacy of a culturally adapted CBT-based self-help intervention with a community sample of Mexican-American women with binge eating disorders. | The intervention consisted of following a self-help manual, and eight guidance sessions (25 minutes in duration each). They were distributed in weekly sessions followed by four biweekly sessions over a 12-week period. | 31 Mexican-American women experiencing problems with overeating or binge eating. Only 20 ended the treatment. | Clinical interview for the DSM-IV-TR; Acculturation rating scale for Mexican Americans-II; Eating disorder examination; Beck depression inventory; Brief symptom inventory; Rosenberg self-esteem scale; Body mass index; Client satisfaction questionnaire; Program evaluation questionnaire | Sixty-two percent of the participants agreed to enrol in the program, which indicates a good rate of acceptability. Significant reduction in episodes of binge eating between baseline and post-treatment. Significant improvement in secondary associated variables of eating pathology, BMI and self-esteem. | **Core** – Addition  **Peripheral** – Engagement – Retention/Completion  **Peripheral** – Delivery – Cultural examples and themes  **Peripheral** – Delivery – Provider-client relationship |
| 1. Dwight-Johnson, Aisenberg, Golinelli, Hong, O'Brien & Ludman, 2011 | To test the effectiveness of culturally tailored, telephone-based CBT for improving depression outcomes among Latino primary care patients living in rural settings. | CBT was provided at no charge in eight telephone sessions; each focused on a chapter from a patient workbook that had been translated to Spanish for this study. | 101 participants were enrolled. Half of them were randomly assigned to the experimental condition, and the other half to the control. | Hopkins Symptom Checklist depression items; Patient health questionnaire-9; Patient satisfaction measure. | Participants in the experimental condition were more likely to experience improvement in depression over the six-month follow-up period compared to control group. Patients in the CBT group reported high treatment satisfaction. | **Peripheral** – Delivery – Materials and semantics  **Peripheral** – Delivery – Cultural examples and themes  **Peripheral** – Delivery – Therapy framework – Session structure  **Peripheral** – Delivery – Therapy framework – Person/Place |
| 1. Evans-Hudnall, Stanley, Clark, Bush, Resnicow, Liu, Kass & Sander, 2014 | To pilot a brief stroke self-care treatment adapted for underserved ethnic minority groups, improving their stroke knowledge and assessing the effects on health behaviours. | Three 30 to 45-minute-long CBT sessions focused on self-care. The first session was provided after the baseline assessment in the acute care setting, and the remaining two sessions were delivered bi-weekly via phone over the 4 weeks after discharge. | 52 primarily African American and Hispanic participants of low socioeconomic status, from the stroke intensive care unit of a large county hospital. | Behavioral surveillance survey; Brief symptom inventory depression and anxiety subscales. | Intervention group improved stroke knowledge, and significantly reduced tobacco and alcohol use. Some effects of anxiety on stroke self-care behaviours were also found. | **Peripheral** – Delivery – Materials and semantics  **Peripheral** – Delivery – Therapy framework – Person/Place |
| 1. Feldman, Matte, Interian, Lehrer, Lu, Scheckner, Steinberg, Oken, Kotay, Sinha & Shim, 2016 | To compare the effect of a culturally adapted cognitive behaviour psychophysiological intervention (CBPT) to music and relaxation therapy (MRT) in panic disorder (PD) severity, asthma control, and other anxiety and asthma-related measures. | Both treatments were administered on a weekly basis over 8 weeks | 53 Latino (primarily Puerto Rican) adults with asthma and PD | Structured Clinical Interview for DSM-IV Axis I Disorders; Panic Disorder Severity Scale  - Clinical Global Impression Scale (CGI) | Both groups showed improvements in PD severity, asthma control, and several other anxiety and asthma outcome measures from baseline to post-treatment and 3-month follow-up. CBPT showed an advantage over MRT for improvement in adherence to inhaled corticosteroids. | **Peripheral –** Delivery – Materials and semantics; Cultural examples and themes  **Peripheral –** Delivery – Therapy framework – Provider-Client relationship  **Core –** Addition |
| 1. Gallagher-Thompson, Gray, Dupart, Jimenez & Thompson, 2008 | To compare “Coping with caregiving” (CWC) group intervention to a telephone-based control condition (TSC) in the treatment of non-Hispanic White and Hispanic-Latino female caregivers. Also, to determine if the caregivers were learning and implementing new skills, and to ascertain the effects of skill utilization on level of stress and depressive symptoms | CWC is based on cognitive behavioural principles. Both interventions were 13 to 16 week-long, protocol driven treatments. It was conducted in a small-group format (4-8 caregivers per group) and met weekly for 2-hour sessions. | 156 female adults completed the assessments. They provide a minimum of 8h of care per week (for at least 6 months) to an elder relative with significant memory loss/ deterioration in cognitive ability | Centre for epidemiologic studies depression scale; Perceived stress scale; Revised Memory and Behaviour Problem Checklist (conditional bother subscale); 21-item questionnaire of various cognitive and behavioural strategies helpful for caregivers to improve their coping skills | Improvement in depressive symptoms, reduction in overall “life stress”, and reduction in caregiving-specific stress for the experimental group. Caregivers in experimental group also greater increase in coping strategies. | **Peripheral** – Delivery – Therapy Framework –Provider-Client relationship |
| 1. Gesell, Katula, Strickland & Vitolis, 2015 | To evaluate feasibility and initial efficacy of a 12-week excessive gestational weight gain intervention among low-income minority women (Latinas). | The experimental condition consisted of twelve weekly 90-min CBT group sessions (8–10 women and one facilitator). | 135 women started the intervention, but only 110 finished it. They were eligible if they were 10-28 weeks pregnant, 16 years or older, in prenatal care, and Spanish or English-speaking. | Feasibility and fidelity were measured by patient retention and length, number and adherence to content; Pre and post-intervention BMI; Gestational gain weight. | Compared to usual care, fewer normal-weight women in the intervention exceeded the Institute of Medicine’s recommendations. Likewise, retention rate was very high (81%). | **Peripheral** – Delivery – Cultural examples and themes  **Peripheral** – Delivery – Therapy framework – Provider-client relationship |
| 1. Gonyea, López & Velásquez, 2016 | To test the effectiveness of a culturally-sensitive cognitive behavioral (CBT) group intervention in supporting Latino families’ ability to manage the disease’s neuropsychiatric symptoms and improve caregiver well-being | The 2 manualized interventions (CBT vs Control [Psychoeducation]) had the same structure: 5 weekly 90-minute group sessions, followed by telephone coaching at 3, 6, 9 and 12 weeks post-intervention. | 67 caregivers were assigned to the CBT experimental condition or the psychoeducational (PED) control condition, and interviewed at baseline, post-group, and 3 months follow-up. | Center for Epidemiological Studies-Depression scale; Neuropsychiatric Inventory-Distress scale; Neuropsychiatric Inventory-Severity scale; Revised Scale for Caregiving Self-Efficacy; State Anxiety Inventory-State | Compared with the PED participants, CBT participants reported lower neuropsychiatric symptoms in their relative, less caregiver distress about neuropsychiatric symptoms, a greater sense of caregiver self-efficacy, and less depressive symptoms over time. | **Peripheral –** Delivery – Materials and semantics; Cultural examples and themes  **Peripheral –** Delivery – Therapy framework – Provider-Client relationship |
| 1. Hinton, Hofmann, Rivera, Otto & Pollack, 2011 | To compare a culturally adapted CBT to applied muscle relaxation (AMR) in the treatment of Latino patients with PTSD. | The treatment was delivered in groups of six participants. Both treatments were manualized, and offered across 14 weekly sessions, with each session lasting an hour. | 24 Latino patients who were considered to be treatment resistant for PSTD. | PTSD checklist; Anxiety subscale of the symptom checklist; Nervios scale; Emotion regulation scale | In both treatment conditions, patients improved on all measures, however, the experimental condition had a greater effect. | **Core** – Modification  **Peripheral** – Engagement – Psychoeducation  **Peripheral** - Delivery – Cultural examples and themes |
| 1. Holden, Shain, Miller, Piper, Perdue, Thurman & Korte, 2008 | To evaluate the impact of depression on a CBT-based intervention, and its efficacy at 6 month, 12 months, and 0 to 12 month cumulative follow-up about high-risk behaviour and clinically confirmed reinfection. | The behavioural-cognitive intervention aims to reduce sexual risk behaviour and associated STI reinfections among Mexican and African American women. | 477 English-speaking women (149 black and 328 Mexican-American) aged 14 to 45, who had a current non-viral STI. | Reinfection with chlamydia and/or gonorrhoea; sexual risk behaviours reported by participants during interviews. | The intervention was equally successful in reducing reinfection and high-risk behaviours among depressed and non-depressed participants. | **Peripheral** – Engagement – Psychoeducation  **Peripheral** – Delivery – Cultural examples and themes |
| 1. Kanter, Santiago-Rivera, Rusch, Busch & West, 2010 | To explore the feasibility and initial effectiveness of behavioural activation for Latinos (BAL) in a community mental health setting. | BA consists on activating clients to obtain and maintain stable sources of positive reinforcement. 12 BAL sessions over 20 weeks were delivered to participants. | 10 adults (18 or older) with a formal diagnose of depression. Although men and women were recruited, the sample consisted of all women. 40 years of age in average, mostly from Mexico (60%) and Puerto Rico (30%). | Primary care evaluation of mental disorders; Pan Hispanic familismo scale; Treatment adherence checklist; Beck depression inventory; Hamilton’s depression inventory. | The majority of the participants responded to BAL and approximately half achieved remission. Across clients, a mean of 7.7 sessions were completed over a mean of 12.4 weeks. Therapists reported engaging in a mean of 3.24 BA techniques per session (of 4 possible techniques) | **Peripheral** – Delivery –Materials and semantics  **Peripheral** – Delivery - Cultural examples and themes  **Peripheral** – Delivery - Therapy framework – Session structure  **Peripheral** – Delivery - Therapy framework – Provider –client relationship  **Peripheral** – Delivery - Therapy framework – Person / place |
| 1. Le, Perry & Stuart, 2011 | To evaluate the efficacy of a CBT intervention to prevent perinatal depression in high-risk Latinas. | Eight weekly, 2-hour long CBT psycho-educational group sessions to prevent perinatal depression. Participants also received three individual booster sessions at 6 weeks, 4 and 12 months postpartum. | 217 Latina women participated in the study. | Centre for epidemiological studies depression scale; Beck depression inventory; Mood screener. | Women in the intervention group had lower depressive symptoms than women in the usual care group immediately after participating in the intervention. However, the intervention did not reduce depressive symptoms during the postpartum period. | **Peripheral** – Engagement - Psychoeducation  **Peripheral** – Delivery – Therapy framework – Provider-client relationship |
| 1. Mauldon, Melkus & Cagganello, 2006 | To test the feasibility, acceptability, and efficacy of a culturally appropriate, Spanish-language cognitive-behavioural diabetes intervention for Hispanic Americans with type 2 diabetes. | Weekly, 3 hour-long, cognitive-behavioural educational sessions conducted in Spanish in a health centre. | 17 Spanish-speaking patients with type-2 diabetes were enrolled, between the ages of 21 and 65 years old. | Physiologic measures (HbA1c, body mass index and lipids);  Diabetes mellitus-related health belief instrument; Diabetes knowledge questionnaire; *Cuestionario sobre sus problemas con la diabetes* / Problem areas in diabetes; Language-based acculturation scale. | Over the 6 months of the study, most of the participants showed an increase in knowledge scores, improvement in lipid profiles, and reduction in HbA1c levels. Excellent acceptance for the intervention, although women fared better than men in the study. | **Peripheral** – Engagement – Psychoeducation  **Peripheral** – Delivery – Materials and semantics  **Peripheral** – Delivery – Cultural examples and themes |
| 1. Miranda, Azocar, Organista, Dwyet & Areane, 2003 | To determine if adding clinical case management to traditional CBT for depression would reduce dropout and improve outcomes for ethnically diverse, impoverished outpatients. | Cognitive-behavioural treatment in a group format lasting for 12 weekly sessions.  The case management intervention took place over a six-month period and assessed patient’s particular needs and goals. | 199 participants were included on the study. Thirty-eight percent of them were Spanish-speakers. | Structured clinical interview for DSM-V; Beck depression inventory; Social adjustment scale.  Translated versions of the measures were used when necessary. | The patients in the experimental condition had lower dropout rates than those in control condition. The improvement was greater for patients whose first language was Spanish. | **Peripheral** – Delivery – Materials and semantics  **Peripheral** – Delivery – Therapy framework – Provider-client relationship |
| 1. Penedo, Traeger, Dahn, Molton, Gonzalez, Schneiderman & Antoni, 2007 | To evaluate the efficacy of a cognitive behavioural-based intervention on quality of life (including sexual functioning). | Ten-week cognitive-behavioural stress management intervention for prostate cancer (Penedo et al., 2000). Groups in the experimental condition met once per week, and each session lasted two hours. | 93 Hispanic men, age 50 or older, who were monolingual Spanish speakers and who had undergone either surgery or radiation therapy for prostate cancer. | Functional assessment of cancer therapy -General module; expanded  Prostate cancer index composite. | Regarding quality of life, participants showed significant improvements in total, physical, and emotional well-being, as well as in sexual functioning. | **Peripheral** – Engagement – Access/Entry  **Peripheral** – Delivery – Materials and semantics  **Peripheral** – Delivery – Cultural examples and themes  Peripheral – Delivery – Therapy framework – Session structure |
| 1. Perez Foster, 2007 | To investigate the feasibility of treating depression in two socioeconomically burdened groups of women seeking services in community settings. | Manualized CBT for depression delivered in a group format (six participants per group), women only, and conducted for 16 weeks. Control group consisted of a supportive/exploratory group. | 91 women seeking treatment for depressive complaints at a homeless shelter program and a municipal psychiatric clinic for Latino patients. | Beck depression inventory; Centre for epidemiological studies - Depression scale; Duke health profile. | Both treatment conditions were equally effective in decreasing depressive symptoms up to 4 months after treatment. Improvements in self-reported physical health. No significant differences between conditions were found. | **Peripheral** – Delivery – Materials and semantics  **Peripheral** – Delivery – Therapy framework – Person/Place |
| 1. Pina, Silverman, Fuentes, Kurtines & Weems, 2003 | To examine treatment response and maintenance to exposure-based CBT for  Hispanic/Latino relative to European-American youths with phobic and anxiety disorders. | Ten to twelve group sessions were conducted by trained therapists. Manuals were used, and the therapy was administered primarily in English. | Data was collected from a total of 131 youths (46% girls) and their parents. The ages ranged between 6 and 16 years of age. Sixty percent of the participants were European-American, and the 40% were  Hispanic/Latino. | Anxiety disorders interview schedules for children; Revised children’s manifest anxiety scale (and the parents’ version); Child behaviour checklist. | The intervention was equally effective for Hispanic/Latino  youths as with European-  Americans. | **Peripheral** – Delivery – Therapy framework – Provider-client relationship |
| 1. Pina, Zerr, Villalta & Gonzales, 2012 | To examine the effects of a program with varying degrees of parent involvement on Hispanic/Latino and Caucasian children with anxiety. | The conditions were: Child only condition; Child plus parent condition. Each condition lasted 12 weeks and was manualized and culturally sensitive. | 88 youths were randomized to one of the two conditions. Forty percent of the participants were Caucasian, and sixty percent were Hispanic/  Latino. Only 73 participants completed the interventions. | Anxiety disorders interview schedule for DSM-IV (Child and parent version); Revised children’s manifest anxiety scale; Children’s depression inventory. | Child anxiety symptoms improved significantly on both conditions, although additional gains were found for children in the child plus parent condition. Program effects did not vary by Latino ethnicity or  Spanish language use in the intervention. | **Unclear** – Authors claim to ‘emphasize core therapeutic components  (e.g. systematic and gradual exposures) and the use of culturally responsive implementation strategies. No further details are given. |
| **Non-adapted CBT for Latinos in the United States** | | | | | | |
| 1. Gil, Wagner & Tubman, 2004 | To examine the effects of an alcohol and other drug use intervention among African-American, Mexican-American and foreign Hispanic juvenile offenders. | Brief motivational, cognitive behavioural intervention. Participants were assigned randomly to the individual format, the family-involved format, choice of one of these two, or a waiting list control condition. | 2013 juvenile offenders referred for treatment (14 to 19 years old). Ninety-seven of them completed the treatment. | Time-line follow-back  Interview; Problem recognition questionnaire; Williams’ perceptions of discrimination measure; Ethnic mistrust measure; Ethnic orientation and pride measure; Acculturation for Hispanics measure; Acculturation stress questionnaire. | There were significant reductions in alcohol and marijuana use for all ethnic groups from baseline to post-intervention. | N/A |
| 1. Marchand, Ng, Rohde & Stice, 2010 | To test whether a brief indicated cognitive-behavioural depression prevention program produced similar effects for Asian American, Latino, and European American adolescents with elevated depressive symptoms. | The experimental group consisted of four weekly 1 hour-long sessions utilizing cognitive and behavioural procedures to reduce negative cognitions and increase pleasant activities. Groups were composed of 6-10 participants. Control group was wait-list. | 167 students aged 14 to 24 from diverse ethnic backgrounds: European American (n=98), Latino (n=32), or Asian-American / Pacific Islander (n=37). | Beck Depression Inventory; Adapted version of the Schedule for affective disorders and schizophrenia for school-age children; Beck depression inventory II. | Depressive symptom reductions were significantly greater for intervention than control participants. The intervention was similarly efficacious for Asian American, Latino and European American adolescents. | N/A |
| 1. Melnyk, Jacobson, Kelly, O'Haver, Small & Mays, 2009 | To evaluate the preliminary efficacy of an educational, cognitive and behavioural intervention (COPE TEEN) on Hispanic adolescents’ healthy lifestyle choices, as well as mental and physical health outcomes. | Fifteen manualized sessions delivered  2 to 3 days per week, during the teen’s health class. Control group received instructions in health topics that were not contained in the intervention program. | 19 adolescents (mean age = 15.5 years old) attending an urban, predominantly Hispanic high school. | Healthy lifestyle beliefs scale; Nutrition knowledge; Healthy lifestyle choices scale; Beck youth inventory – II; Anthropometric measures & laboratory work. | The program was well received by Hispanic adolescents, and had a positive effect on depression and anxiety symptoms, as well as in healthy lifestyle choices. | N/A |

**Quality of the included papers**

After reviewing the full-text and ensuring that the studies were relevant for the purposes of the review, the quality of each paper was assessed by the researcher. The data extraction tool utilised to assess the quality of the papers was the Critical Appraisal Skills Programme parameters (CASP, 2017 – see appendix 1.1). A score was assigned to each question of the CASP (see Appendix 1.2), giving a possible range of 11-37. The scores were divided into tertile groups based on lower (27-29), medium (30-31) or higher (≥32) CASP scores, thus classifying the papers as low, medium or high quality. The CASP scores for each paper included in the review can be found in Appendix 1.2.

The 22 papers excluded at the “screened by quality” stage (see Figure 2.1) were removed due to not having a clearly focused aim (first criterion on the CASP quality rating system), or for having a relatively poor quality score (26 points or less on the CASP evaluation). This poor quality might indicate that these studies could be methodologically weak or underpowered to make assumptions about their results. Therefore, these studies were excluded from further consideration, which resulted in the 60 papers included in this review. Appendix 1.3 shows the 22 excluded papers.

In order to determine the validity of the quality ratings, a second quality assessment was conducted by an external reviewer, based on a proportion of the papers. Twelve of the 60 remaining papers (20%) were selected randomly, using a random number list generated in Excel. These papers were then evaluated by the external reviewer, also utilising the CASP assessment tool (Appendix 1.4). Inter-rater reliability was calculated to determine the agreement on the quality scores provided by both the main researcher and the external examiner. Intraclass correlation resulted in an average coefficient of 0.784, and the percentage of agreement resulted on an agreement of 92%. Both of these scores indicate a strong inter-rater agreement.

**Results**

**Characteristics of the studies included in the review**

From the 60 papers included in the review, 68.3% included adult populations, 20% included adolescents, 5% children, and 6.7% elderly populations. Twenty-one studies were randomized controlled trials, whereas 49 were uncontrolled effectiveness studies. Twenty-two papers were conducted in the USA, 15 in Mexico, nine in Brazil, four in Chile, four in Colombia, four in Puerto Rico, one in Argentina, and one in Costa Rica. Regarding the methodological quality of the reviewed papers, 43% were considered as having a high quality, 43% as medium quality, and 14% low quality.

**Narrative summary of findings**

A second data extraction tool was created by the researcher (Table 2.3), to detail the outcomes of the studies that were included in the review. These outcomes included whether the intervention was statistically significant, the available effect sizes, retention rates, and quality scores. The nature of adaptations was mainly peripheral (Chu & Leino, 2017).

**Table 2.3. Summary of the main outcomes**

| **Reference** | **Was the adaptation effective?**  **(p-value)** | **Effect size**  **(d)** | **Retention rate** | **Score on quality rating** |
| --- | --- | --- | --- | --- |
| **Adapted CBT in Latin America** | | | | |
| 1. Cabiya et al., 2008 | 0.04 | 0.29 for depression scores (treatment vs control) | 54% | High  (33) |
| 1. De la Rosa Gomez & Cardenas Lopez, 2012 | 0.02 | 1.25 for depression scores | 75% virtual reality  53% imagination | High  (35) |
| 1. Díaz-Martínez et al., 2011 | 0.07 | Not known | 82% for CBT group | Medium  (30) |
| 1. Rossello & Jimenez-Chafey, 2006 | <0.05 | 1.23 for anxiety scores\* | 55% | Medium  (31) |
| 1. Rossello & Bernal, 1999 | <0.01 | CBT vs ITP= 0.35  CBT vs WL= 0.75\* | CBT = 84%  IPT = 83%  WL = 78% | High  (32) |
| 1. Rossello et al., 2011 | <0.0001 | 0.83 for suicidal ideation scores\* | 95% | Medium  (31) |
| **Non-adapted CBT in Latin American countries** | | | | |
| 1. Aguilera-Sosa et al., 2009 | <0.01 on BMI pre-post intervention | 1.19\* | Not known | Medium  (31) |
| 1. Alcázar-Olán et al., (2018) | Yes, for participants with high session attendance (8 or more sessions – all outcomes <0.05) | 0.62 on average for main outcomes (medium)\* | 66% | Low  (28) |
| 1. Arrivillaga Quintero et al., 2007 | 0.031 | 0.68 for systolic blood pressure pre-post treatment\* | 88% for the experimental group | High  (34) |
| 1. Becerra Galvez et al., 2016 | <0.05 for anxiety on both measures (pre-post intervention) | 1.2 for anxiety outcomes\* | Not known | Medium  (31) |
| 1. Botero Garcia, 2005 | <0.05 on main outcome (PSTD severity) | 1.4 on average for number of symptoms, severity and depression\* | 100% | Low  (29) |
| 1. Caceres-Ortiz et al., 2011 | <0.001 | 1.98 for PSTD symptoms (Hedges’ g. equivalent to 1.9 Cohen’s *d*) | 100% | Medium  (31) |
| 1. Castro et al., 2012 | 0.034 in comparison with control | -0.44\* | Not known | Medium  (31) |
| 1. Contreras et al., 2006 | <0.05 for all the outcome measures | 0.64 on average | Not known | High  (34) |
| 1. Cordioli et al., 2002 | <0.001 for Y-BOCS global | 1.75 | 93% | Medium  (31) |
| 1. Cruz-Almanza et al., 2006 | <0.01 for self-esteem and coping after follow-up 1 | 1.3\* | 83% | High  (35) |
| 1. De Souza et al., 2013 | <0.05 | 0.96 on average for anxiety measures | 71% | Medium  (30) |
| 1. Duchesne et al., 2007 | <0.01 for all outcomes (pre-post) | 2.7 for binge eating frequency\* | Not known | Medium  (31) |
| 1. Escoto Ponce de León et al., 2010 | Not known | -1.93 for body image dissatisfaction scores\* | 100% | High  (35) |
| 1. Furlan, 2013 | <0.05 for most of the outcome measures | 0.44 on average (Cliff’s delta, equivalent to *d*=0.7) | 50% | Medium  (30) |
| 1. Garduno et al., 2010 | <0.05 | Not known | Not known | Low  (28) |
| 1. Gil-Bernal & Hernandez Guzman, 2009 | <0.05 for both of the intervention groups | -0.52 for the group on which parents participated | Not known | High  (34) |
| 1. Gomez et al., 2009 | <0.0001 | 2.16 for OCD symptoms\* | 83% | Medium  (31) |
| 1. Gonzalez Fragoso et al., 2012 | 0.05 for sentiment expression and depression on 2nd and 3rd follow-ups, respectively | Not known | Not known | Low  (28) |
| 1. Gonzalez Garcia et al., 2015 | 0.014 for anxiety and depression | 1.5 | 100% | Medium  (30) |
| 1. Guerra Vio et al., 2009 | 0.08 for self-care | 1.01 for self-care pre-post intervention\* | 100% | Medium  (30) |
| 1. Habigzang et al., 2016 | ≤0.001 | 0.55 on average between all measures | Not known | Low  (27) |
| 1. Habigzang et al., (2018) | Yes, for all outcome variables (p ≤ 0.001) except PSTD. | 1.06 on average for significant outcomes (no PSTD) | 100% | High  (32) |
| 1. Meyer et al., 2010 | <0.01 | 5.9 on average pre-post intervention\* | 100% for experimental group  90% for control | High  (37) |
| 1. Montero Pardo et al., 2012 | 0.033 for burden pre-post intervention | 0.51 | Not known | Medium  (30) |
| 1. Pegado et al., (2018) | Yes (p=0.01) | 0.52 for restraint at follow-up (intervention vs control)\* | 91% | High  (33) |
| 1. Perez Baquero et al., 2014 | <0.001 | Not known | 100% | Low  (28) |
| 1. Reyes Jarquin & Gonzalez-Celis Rangel, 2016 | <0.001 for physical and psychological wear | 2.50 | Not known | Medium  (31) |
| 1. Riveros et al., 2005 | <0.01 | Not known | 100% | Low  (28) |
| 1. Tapia et al., 2014 | <0.001 pre-post intervention for experimental group. No differences between groups. | 2.9 for salivation perception\* | 90% | Medium  (30) |
| 1. Vergara Lope Tristan & Gonzalez-Celis Rangel, 2009 | <0.05 for all outcomes right after the intervention, non-significant on follow-ups | Not known | Intervention group= 58%  Control= 76% | Low  (27) |
| 1. Villalobos Perez et al., 2005 | <0.001 | 4.87 for depression scores\* | 66% | Low  (29) |
| 1. Zimmer et al., 2007 | <0.05 for global assessment and mini-mental state | Not known | 85% for experimental group  83% for control | High  (34) |
| **Adapted CBT for Latinos in the United States** | | | | |
| 1. Alegria et al., 2014 | <0.05 for both adapted interventions | 0.55 on average for both adapted interventions, pre-post treatment | 66% for both adapted interventions | High  (33) |
| 1. Burrow-Sanchez & Wrona, 2012 | Not known | 0.53 pre-post intervention\* | 82% | Medium  (32) |
| 1. Cachelin et al., 2014 | <0.001 for binge eating frequency | 0.70 pre-post treatment | 64% | Medium  (30) |
| 1. Dwight-Johnson et al., 2011 | 0.003 for depression at 6-month follow-up | -4.18 between control and intervention\* | 84% | High  (37) |
| 1. Evans-Hudnall et al., 2014 | <0.05 for tobacco use, alcohol use, and medication adherence. | 0.13 for exercise (minutes) between control and intervention\* | 90% | Medium  (31) |
| 1. Feldman et al., (2016) | Yes (<0.001) | 1.07 for panic disorder severity symptoms (large) | 59% | High  (34) |
| 1. Gallagher-Thompson et al., 2008 | <0.05 for all the outcome measures (depression, stress and bother) | 0.36 on average for depression and perceived stress for Hispanics on experimental group\* | 85% | High  (34) |
| 1. Gesell et al., 2015 | 0.036 for IOM recommended weight gain in normal-weight  women | Not known | 81% | Medium  (32) |
| 1. Gonyea et al., (2016) | Yes (p < .001) for all outcome measures except for anxiety | 0.19 on average for main outcomes (small)\* | 94% | High  (33) |
| 1. Hinton et al., 2011 | <0.01 for all outcome measures | 1.4 on average between interventions | 100% | High  (35) |
| 1. Holden et al., 2008 | 0.03 for reinfection rate at 12-month follow up | Not known | Not known | High  (33) |
| 1. Kanter et al., 2010 | <0.01 for depression on both measures | 1.62 on average | 30% | Medium  (30) |
| 1. Le et al., 2011 | 0.03 for depression right after intervention | -0.28 between control and intervention | 68% | High  (35) |
| 1. Mauldon et al., 2006 | 0.003 for diabetes knowledge | 1.8 pre-post intervention\* | 94% | Medium  (30) |
| 1. Miranda et al., 2003 | 0.04 for Spanish speaking participants | Not known | 76% | High  (32) |
| 1. Penedo et al., 2007 | < 0.001 for quality of life (intervention vs control) | Not known | 77% | High  (34) |
| 1. Perez Foster, 2007 | <0.001 from baseline, post-test and 4-month follow-up. | Not known | 100% | Low  (28) |
| 1. Pina et al., 2003 | < 0.01 for manifest anxiety | 0.19 for Hispanics/Latinos pre-post treatment | Not known | Medium  (30) |
| 1. Pina et al., 2012 | <0.0001 for total anxiety on both experimental conditions | 3.9 pre-post intervention for both experimental conditions\* | 77% | High  (34) |
| **Non-adapted CBT for Latinos in the United States** | | | | |
| 1. Gil et al., 2004 | Not known | Not known | Not known | Low  (27) |
| 1. Marchand et al., 2010 | <0.001 for depression | 0.92 on average for each assessment (post, 1-month follow-up and 6-month follow-up) | Not known | High  (35) |
| 1. Melnyk et al., 2009 | <0.10 only for anxiety and healthy life choices (significance was established at <0.10) | 0.45 on average for all the outcome measures, pre-post treatment | 89% | High  (34) |

\*Effect size (*d*) was not explicitly reported in these studies. Therefore, it was calculated by the researchers utilising the provided means and standard deviations

*Adapted CBT in Latin America.* Half of the papers of this group involved peripheral cultural adaptations, specifically in the delivery domain. The remainder had unspecified cultural adaptations. Five of the six studies that formed this group had significant positive outcomes, meaning that the interventions had beneficial effects for the patients. Except for one study, the effect sizes were all moderate and medium, which indicates a considerable effect of the therapy. All of the studies retained more than 50% of the patients (three of them retained more than 80%), showing a relatively high level of acceptability. The papers ranged between medium and high quality.

*Non-adapted CBT in Latin American countries.* Except for one paper, all the 32 studies resulted in significant improvements for the patients. Many studies had effect sizes above *d*=1.00, again indicating a large effect of the intervention. Most of the studies retained more of the 75% of the patients. There were a few papers of low and high quality – most were of medium quality.

*Adapted CBT for Latinos in the United States.* Most of the cultural adaptations were peripheral, implemented in all of the delivery domains. A handful of studies included engagement adaptations, and only three of them had cultural adaptations at a core level. Only one of the papers had an unspecified type of cultural adaptation. All the 19 studies had significant and positive outcomes. The effect sizes (*d*) varied widely, ranging from 0.13 to 4.18. Most of the studies retained more than 75% of patients. The majority of the studies were rated as being of high quality, a handful of studies were medium quality, and only one study was rated as low quality.

*Non-adapted CBT for Latinos in the United States.* There were only three such studies. One of the studies did not disclose whether the results of the intervention were statistically significant, and did not provide the effect size or retention rate. The remaining studies reported in statistically significant outcomes. However, it should be noted that one of the studies established the level of significance at 0.1. The effect sizes in these papers were medium and large. It was possible to derive the retention rate for only one of the studies, which was 89%. Two studies were rated as being of high quality, and one was rated as being low quality.

**Quantitative comparison between groups**

*Effect sizes, retention and quality scores.* Given the low number of studies regarding non-adapted CBT in non-Latin American countries (*N* = 3), this group was omitted from subsequent consideration and quantitative analyses. There were no substantial differences between the groups in terms of effect sizes, retention rates or quality scores (see Table 2.4). However, it is worth noting that the trend was for non-adapted therapy in Latin America to be superior to the adapted versions in effect size and retention rate. Thus, the overall finding was unexpected – adapted CBT for the Latin American groups did not appear to enhance therapy outcome.

**Table 2.4. Quantitative comparison between the groups of analysed papers**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Latin America** | | | | **United States** | | | |
|  | **Adapted**  **(n=6)** | | **Non-adapted**  **(n=32)** | | **Adapted**  **(n=19)** | | **Non-adapted**  **(n=3)** | |
|  | ***M*** | ***SD*** | ***M*** | ***SD*** | ***M*** | ***SD*** | ***M*** | ***SD*** |
| Effect size (d) | 0.822 | 0.433 | 1.618 | 1.358 | 1.189 | 1.264 | 0.685 | 0.332 |
| Retention rate (%) | 72.33 | 17.025 | 86.00 | 16.470 | 79.50 | 17.123 | 89.00 | - |
| Quality scorea | 31.83 | 1.835 | 31.23 | 2.473 | 32.10 | 2.404 | 31.00 | 4.359 |

aPossible scores range from 11 to 37

To determine whether the number of effective interventions differed among the groups, a chi-squared test was implemented comparing the frequency of significant and non-significant P-values between the categories. There were five studies with significant outcomes and one non-significant in the group of adapted therapy in Latin America; twenty-nine papers from the non-adapted therapy in Latin America resulted in significant outcomes, while only one was non-significant; and finally, all of the 19 studies from the adapted therapy in the USA had significant outcomes. There was no significant difference between the groups in the proportion of significant interventions (*X2* = 4.084, *df* = 4, *p* = 0.395).

*Association of the quality of the studies with outcome variables.* To determine whether the quality of the studies was related to effect sizes and retention rates (as suggested by Ost, 2014), Pearson’s correlations were used. No significant correlation was found between the quality scores and effect sizes (*r* = 0.246, *p* = 0.103), or between quality scores and retention rates (*r* = 0.049, *p* = 0.753).

**Discussion**

**Summary of key findings**

The main goal of this review was to evaluate the current evidence regarding the effectiveness of both regular and culturally-adapted CBT in different locations, in order to determine whether cultural adaptations of CBT result in better outcomes for patients, as is commonly assumed (Organista & Munoz, 1996; Sue et al., 2009). The example addressed was the use of adaptations to CBT for Latin American patients, in Latin American vs Western clinical settings. The type of therapy adaptation was also assessed. The findings of this study indicate that, contrary to our hypotheses, there were no differences between the different sets of studies in terms of effectiveness, retention rates or methodological quality. This could indicate that CBT is effective by itself, regardless of the adaptations. The majority of the cultural adaptations made to the therapy were peripheral or unspecified, rather than core adaptations (Chu & Leino, 2017).

**Relationship with the existing literature**

One of the most commonly cited studies on cultural adaptations of therapy was carried out by Griner & Smith (2006). Their meta-analysis found an average size effect of *d*=0.45 for culturally-adapted therapy for Latinos in the United States, in comparison to non-adapted therapy. Similarly, Huey & Polo (2008) reported an average effect size of *d*=0.47 for culturally-adapted therapy for Latino youths in the United States. While these studies indicate that cultural adaptations can be effective, it is important to note that these reviews included a wide range of therapies, not only CBT. Benish, Quintana, & Wampold (2011) carried out a meta-analysis of culturally-adapted interventions. The average effect size for the primary outcomes was *d*=0.32. Likewise, Hall et al. (2012) reported a medium effect size (*g*=0.52) on their meta-analysis for “culturally responsive interventions” over non-adapted versions. Besides including several types of therapy, these two studies did not report the specific effect sizes for Latino participants. Therefore, the results of these studies reveal that cultural adaptations might be helpful, but our research indicates that this is not the case specifically for CBT with Latin American patients.

Adapting a therapy is commonly based on the premise that the relevant patients have characteristics that prevent them from getting full benefits from that therapy in its original form. However, there is an alternative perspective – that such adaptations of evidence-based therapies represent a form of “broken leg exception” (Meehl, 1957), where therapists assume that their patients are “unique”, due to their having a specific characteristic (in this case, being from a different culture). Meyer et al., (2014) acknowledge this possibility in the content of their “Broken Leg Exceptions Scale”, suggesting that clinicians might exempt patients from an ethnic minority from undertaking exposure therapy. The resulting issue is that we are not aware of what are necessary adaptations and what are “broken leg exceptions”, and further research is needed to determine the differences between the two.

**Clinical implications**

Creating adaptations to CBT is time-consuming, and requires clinicians to learn multiple versions of the same method. As adaptation results in better outcomes in some settings (e.g., Griner & Smith, 2006), then the necessary research is well-justified in those psychological interventions. However, in our efforts to follow recommendations (American Psychological Association, 2003; Bernal et al., 2009; Miranda et al., 2003; Organista & Munoz, 1996; Sue et al., 2009) that we should be inclusive, we might sometimes be investing our time and effort unproductively, at least in the delivery of CBT.

The current literature does not allow us to say that there is no potential benefit of adapting CBT, but peripheral adaptations have not yet been shown to be effective. Future research needs to consider whether core adaptations have greater impact (Chu & Leino, 2017) or whether adaptations in general are effective for other non-Western populations, before one can recommend adaptations to CBT as being worth the effort invested. It will be important that adaptations should be clearly defined, so that they are replicable and comparable. Of course, therapy protocols need to be used flexibly with individual patients (Wilson, 1996). However, that should be done without assuming that such adaptations should be made on the basis of ethnicity per se.

**Limitations**

This review has a number of strengths and limitations. Firstly, it is limited by the small number of papers from non-adapted CBT in Western cultures. Also, the included studies addressed a wide range of disorders, potentially reducing comparability. This heterogeneity of studies, along with the unbalanced amount of papers in the groups, was the reason why the chosen design was a systematic review and not a meta-analysis.

The tool chosen to evaluate the quality of the studies included in the review (CASP) might have influenced the findings. The CASP version utilised for this study was the Randomised Controlled Trial one, even when not all the reviewed studies had this design. The researchers chose this tool given its conciseness and clearness, and adapted it to include both effectiveness and efficacy studies. However, future studies should consider other quality assessment tools, such as the Quality Assessment Tool for Quantitative Studies (EPHPP – Effective Public Health Practice Project, 1998), or the Downs and Black Checklist (1998).

The study did not consider ‘grey literature’ (resources published outside academic papers), which could have resulted in a publication bias. However, grey literature often includes less rigorous methodological procedures, meaning that its inclusion on this review could have made the results less reliable. It should be noted that the study was not pre-registered in PROSPERO. This step was omitted given that, when the study was designed and approved by the ethics committee, this was not normal practice. However, it is clear that this is good practice for future reviews.

Other aspects to consider rely on the fact that Latin America and the United States might be not so culturally different from each other. The geographical closeness, as well as the influence of immigration and media, might reduce the ‘cultural distance’ between these regions. Therefore, a similar review including papers from other cultures might indicate whether cultural adaptations of therapy are more effective in different locations, and considering other individual therapies. Likewise, a further issue to consider in such studies is the degree to which the individual patient is acculturated to the local norms.

One might question whether the group of studies labelled as “regular CBT delivered in Latin America” should be considered “regular”, since the cultural context is already different, the providers are immersed in it, and the materials are translated. This might suggest that some adaptations have been already made to the therapy, even if they are not explicitly stated. However, even if that were the case, such adaptations would only be superficial and based on the therapist’s own judgment. It should be also stressed that “translation” and “validation” are non-equivalent processes. Therefore, it is unlikely that such adaptations modify CBT enough to consider it “culturally-adapted”.

In terms of strengths, this study included Hispanic databases and included non-English language studies. Furthermore, the nature of adaptations was considered, and the quality of the papers was taken into account and assessed. This approach provides a novel and comprehensive approach to the topic, where Latin American studies are often disregarded, and the type of adaptation is mostly ignored.

**Conclusion**

The evidence to date does not support cultural adaptations of CBT for Latin American populations, in terms of effectiveness or acceptability/retention rates. Therapists might be better encouraged to focus their efforts on improving the way they deliver CBT through training and supervision, rather than focusing on culturally adapting the therapy.

**Prelude to Chapter III**

Researchers, clinicians and associations place great emphasis on considering the patient’s culture while delivering psychological therapies. However, after assessing the evidence regarding culturally-adapted CBT for Latin American patients on Chapter II, no differences in outcomes were found between culturally-adapted and non-adapted CBT. The patients’ cultural background might not be the only one that matters. There is little research about how clinicians from different cultural settings deliver CBT. As exposed in the introduction of this thesis (Chapter I), therapists’ own cultural backgrounds might shape their therapy delivery style, and influence the decisions they make while delivering CBT. Therefore, the study presented on the next Chapter assessed the differences in CBT delivery between British and Latin American clinicians.

**Chapter III**

**Therapist drift in cognitive behavioural therapy for eating disorders: Initial evidence from Latin American clinicians and similarities with British clinicians**

**Abstract**

**Background:** Although numerous studies have indicated that key techniques of CBT are being underused by clinicians, this topic of therapist ‘drift’ is still unexplored in developing countries. The aim of this study was to obtain initial evidence regarding therapist drift in Latin American clinical settings, and to compare the results with the ones obtained from British clinicians. A second aim was to determine what additional factors might influence such drift. **Method:** A cross-sectional, mixed study was implemented to explore how often CBT techniques for eating disorders were used by clinicians from Latin America and the United Kingdom. They completed a survey about the frequency of use of CBT techniques, along other psychological measures. **Results:** UK clinicians were more likely to use eating disorder-specific techniques than Latin American clinicians (e.g. weighing the patient; introducing regular eating). In contrast, Latin American clinicians were more likely to use the least supported CBT techniques (e.g. relaxation; letting the patients talk about whatever was on their mind). Clinicians’ extraversion and openness explained some of these differences. **Discussion:** Differences were found in the delivery of CBT for eating disorders among the studied groups, with greater evidence of therapist drift among Latin American clinicians.

**Background**

CBT is one of the most utilized therapies for the treatment of several psychological disorders, given its high empirical support (Butler, Chapman, Forman, & Beck, 2006; Feng et al., 2012; Hofmann & Smits, 2008). It has proved to be particularly fruitful in the treatment of eating disorders (Dalle Grave, Calugi, Conti, Doll, & Fairburn, 2013; Spielmans et al., 2013). However, numerous studies have found that this therapy is delivered inappropriately, since clinicians tend to underuse manuals and protocols (Mulkens, De Vos, De Graaff, & Waller, 2018; Tobin, Banker, Weisberg, & Bowers, 2007; Waller et al., 2013), and do not deliver key techniques that are an essential part of therapy (Waller et al., 2012). Previous findings from different therapies have indicated that this ‘therapist drift’ seem to be related to clinician characteristics such as therapists’ age, training or anxiety (DiGiorgio, Glass, & Arnkoff, 2010; Kosmerly et al., 2015; Waller et al., 2013). It is necessary to further investigate therapist drift, given that the clinician characteristics that underpin it have the potential to impact patients’ therapy outcomes (Baldwin & Imel, 2013; Waller & Turner, 2016; Wampold, Baldwin, Holtforth, & Imel, 2017).

Therapist drift is a topic that, to date, has not been studied in Latin America. There are several reasons to believe that this phenomenon would be particularly common in this location. In contrast to more developed countries (such as the UK), there are no organizations that mandatorily supervise and regulate clinicians’ practice in many Latin American countries. Such lack of regulation could mean that therapists are less likely to maintain their practice through training and supervision. Furthermore, it is common for individuals with very modest or no knowledge of CBT to practice as therapists in Latin America, sometimes without having an academic background in psychology or mental health (Martinez-Taboas, 2014). This lack of training or qualifications is likely to impair the delivery of CBT, particularly because historically psychoanalysis has been the predominant training modality in psychology in Latin America (Sanchez-Sosa & Valderrama Iturbide, 2001). Finally, access to high quality mental health services is limited for the general population in those countries, due in part to the lack of highly trained health care professionals, and the tendency for those who practice psychotherapies to fail to use evidence-based treatments.

One might hope that clinicians who lack core training, accreditation and supervision would be aware of their limited ability to deliver evidence-based therapies. However, there are reasons to suspect that this is not the case, and that clinicians drift partly because they are unaware of their limitations (Waller & Turner, 2016). Previous studies have found that clinicians strongly overestimate their own skills and patient outcomes (Parker & Waller, 2015; Walfish, McAlister, O’Donnell, & Lambert, 2012), meaning that they do not realize their limitations. However, the extent of such overestimation it is not yet known in developing countries, and whether it influences the delivery of evidence-based treatments (such as CBT) in those countries.

Even if there were equivalent levels of training and access across countries, there are also cultural differences that might be expected to result in different patterns of therapy delivery across countries (Hofstede et al., 2010). For example, cross-cultural studies have shown that Mexican individuals are likely to have personality profiles that differ from individuals from other countries (Cruz Martinez, Rivera Aragon, Diaz Loving, & Taracena Ruiz, 2013). For example, Mexican individuals have been shown to have more extraverted and collectivist personality traits than are found in the UK population (Hofstede et. al., 2010; Lara Cantú & Suzan-Reed, 1988). Likewise, Mexican people have shown to have greater desire to be accepted by others than those from more developed countries (Lara Cantú, 1990). It could be argued that these traits might make therapists less likely to impose some of the more challenging elements of CBT on their patients (Waller & Turner, 2016). However, this hypothesis remains untested. Although a great amount of literature recommends addressing culture as an important part of the therapy, its focus has been on the patient’s side (e.g. adapting therapy to accommodate culturally diverse patients). In contrast, therapists’ own culture and the way it could influence therapy delivery is still virtually unexplored.

In summary, therapist drift is a phenomenon that can occur in different contexts, but that is especially likely in Latin America, both because of organizational issues (e.g., lack of quality mental health services) and given the therapists’ own cultural biases (e.g., higher desire by Latin American therapists to be liked by their patients, leading them to deliver a less demanding therapy). Therefore, the main aim of the present study is to obtain initial evidence of therapist drift in Latin America, exploring how often CBT techniques for eating disorders are used, and to compare these results to those obtained from a UK sample. We focused on eating disorders given that this is an area with a known problem of therapist drift, and one of the most researched in this area. We hypothesized that Latin American therapists would show a higher drift than UK clinicians. Secondarily, we aim to determine what factors predict therapist drift in each location (e.g. age, experience, received supervision, training, self-assessment, anxiety, academic background, social desirability, personality). It is predicted that Latin American clinicians will show a greater association between therapist drift and psychological factors (e.g. anxiety, social desirability) and organizational factors (training, supervision, experience) than UK clinicians.

**Method**

**Ethical considerations**

This study was reviewed and approved by the University of Sheffield’s Department of Psychology Ethics Committee (see appendix 2.1). Informed consent was obtained from the participants prior to the initiation of the study (see appendices 2.3.1 and 2.3.2).

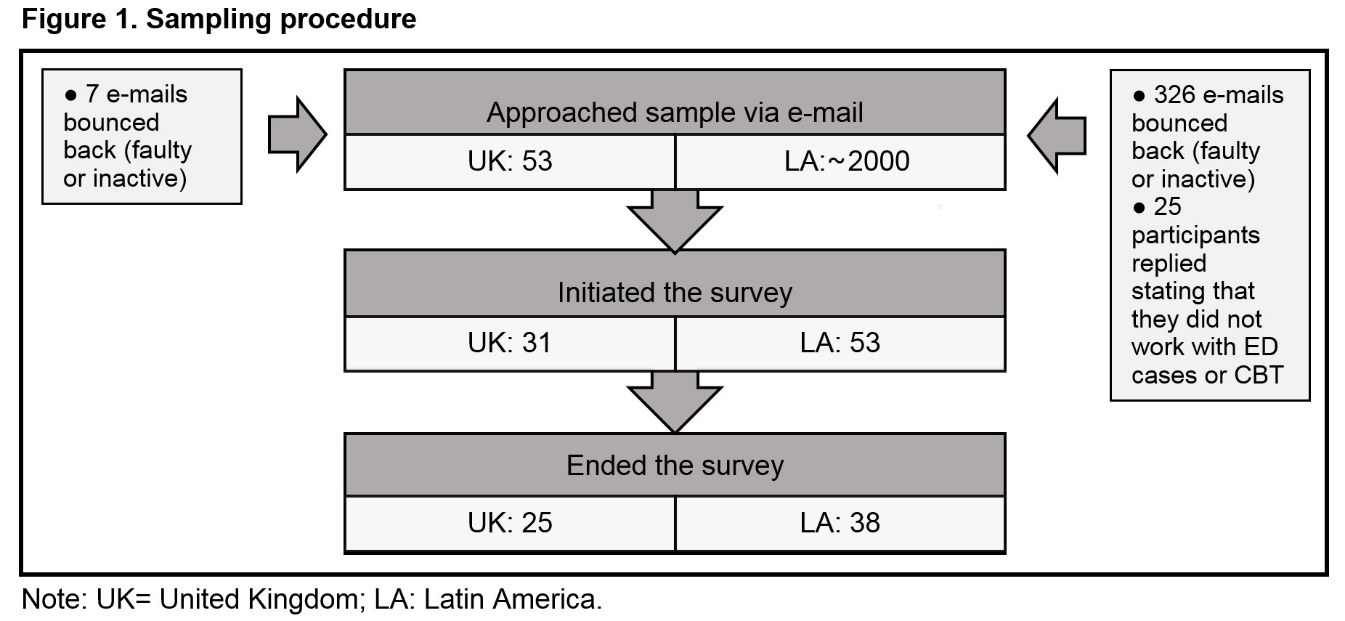
**Design**

This was a cross-sectional mixed study, with correlational and comparative elements.

**Participants**

Participants were approached via email (see appendices 2.2.1 and 2.2.2), and they were asked to forward the survey to their colleagues (snowball sampling method). Therefore, the exact number of approached participants is unknown. Figure 3.1 shows a more detailed description of the sample collection. Most of the e-mails from the Latin American sample were obtained using lists of members of different psychological associations (e.g. Instituto Mexicano de Psicoterapia Cognitivo Conductual, Asociacion de Psicología de Puerto Rico, Colegio de Psicólogos de Magallanes) and Universities (e.g. Universidad de Guanajuato, Universidad de la Frontera, Universidad Autonoma Metropolitana) from the participant countries. The rest of the participants were the authors’ professional contacts and members of the British Association for Behavioural and Cognitive Psychotherapies mailing list.

**Figure 3.1. Sample collection process**



Note: UK=United Kingdom; LA=Latin America

**Measures and procedure**

Participants completed an online Qualtrics survey (see appendices 2.4.1 and 2.4.2). It included questions about the frequency of use of therapy techniques when working with eating disorders (rated on a seven-point Likert scale, ranging from “Never” to “Always”). The techniques included in the survey were mainly techniques commonly used in evidence-based CBT for eating disorders and general CBT, and were based on Cowdrey and Waller’s (2015) research (see Tables 3.2 and 3.3 for details of the techniques measured). The survey also collected information about participant’s age, experience, supervision received, training, and academic background. The clinicians also self-rated their level of skill and patient outcomes relative to other therapists (Parker & Waller, 2015).

Participants completed the following standardised measures to determine their psychological characteristics (the UK sample completed the English versions, and the Latin American sample completed the translated and validated Spanish versions):

*Cognitive-Somatic Anxiety Questionnaire* (CSAQ; Schwartz, Davidson, & Goleman, 1978 – see appendix 5.1.1). The CSAQ is a measure of anxiety, evaluating cognitive and emotional responses to perceived threats. It consists of 14 statements, ranked from “not at all” to “a lot”. It has been translated into Mexican Spanish and validated in that form (Zanatta Colin, Bonilla Muñoz, & Trejo González, 2003 – see appendix 5.1.2). Exploratory factor analysis showed two factors (cognitive and somatic anxiety), explaining 50.2% of the variance. Reliability coefficients for the subscales are acceptable (Cronbach’s alpha = 0.83 for cognitive anxiety and 0.80 for somatic anxiety).

*Ten-Item Personality Inventory* (TIPI; Gosling, Rentfrow, & Swann, 2003 – see appendix 5.2.1). The TIPI is a brief measure of the personality characteristics within the five-factor model (extraversion, agreeableness, conscientiousness, emotional stability, and openness to experience). Its Spanish adaptation (Renau, Oberst, Gosling, Rusiñol, & Chamarro, 2013 – see appendix 5.2.2) has acceptable test-retest correlations and a significant convergent validity with the longer NEO-PI-R (Costa & McCrae, 1992). It also has strong inter-rater reliability and correlates well with participant’s self-assessment ratings of their personality types.

*Marlowe-Crowne Social Desirability Scale* (MC-SDS; Crowne & Marlowe, 1960 – see appendix 5.3.1). The MC-SDS evaluates a person’s need to give a favourable image of the self and the need for social approval. In its original version, the participant responds “true” or “false” to a series of 33 statements about themselves. It has been tested with Mexican population (Lara Cantú & Suzan-Reed, 1988 – see appendix 5.3.2), where an exploratory factor analysis did not reveal any meaningful distinct factors, suggesting that the scale measures a single construct of social desirability. The Kuder-Richardson reliability coefficient for dichotomous variables was 0.78 for the complete scale. For the purposes of this study, a shortened version of the scale was used (Reynolds, 1982; form C), which consists of 13 of the original items, and which also has strong validity and reliability.

**Data analysis**

A sample size carried out with G\*power indicated that, with a medium effect size (*d* = .50), an alpha of .05, and power of .80, 51 participants would be needed per group. All analyses were conducted using SPSS (version 22). Sample characteristics were reported as means and standard deviations. The comparison of the frequency of use of specific techniques between groups was conducted using independent samples *t*-tests (correcting for unequal variance, where necessary). The association of drift and personality characteristics was tested using correlation analyses. Lastly, analysis of covariance (ANCOVA) was used to determine the variables that predicted the use of techniques. A *p*-value of 0.05 was taken as significant for all analyses (including Bonferroni corrections where necessary), and the hypothesis testing was one-tailed. Since missing data were not replaced, sample size varied across analyses.

**Results**

**Sample characteristics**

The sample consisted of 75 clinicians (60% Latin American, 40% British) who delivered CBT for eating disorders in psychological health settings (e.g. clinics, hospitals, private settings). The mean age of the participants was 38.3 years (*SD*=9.23), with no significant differences between groups (*t*=0.06, *p*=0.956). Most of the sample (63.1%) consisted of psychologists, while the remainder included dietitians, nurses and occupational therapists. Thirteen (17.5%) participants were male and 61 (82.5%) were female, with no differences in gender proportions between regions (*X2*=0.21, *p*=0.65).

Table 3.1 shows that there were no significant differences between clinicians from different regions in organizational factors such as experience, training, workload or supervision. However, there was a difference in the use of manuals, which were utilised more by UK clinicians.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Table 3.1. Sample’s organizational characteristics** | | | | | | | | | | | | | |
| **Dimensional characteristics** | | | | | | | | | | | | | |
|  | | LatAm | | | | | UK | | | | | *t* | *p* |
| *N* | *M* | | | *(SD)* | *N* | *M* | | | *(SD)* |
| Experience as therapist (years) | | 44 | 13.1 | | | (10.2) | 30 | 15.0 | | | (9.92) | 0.77 | *NS* |
| Experience with CBT (years) | | 43 | 10.2 | | | (8.20) | 30 | 9.87 | | | (6.38) | 0.19 | *NS* |
| Years since completing formal training in CBT | | 27 | 8.89 | | | (8.52) | 21 | 7.41 | | | (5.58) | 0.69 | *NS* |
| Experience treating eating disorders (years) | | 40 | 8.16 | | | (7.34) | 30 | 9.70 | | | (6.02) | 0.94 | *NS* |
| Eating disorder cases treated weekly | | 40 | 2.43 | | | (1.48) | 30 | 2.87 | | | (1.48) | 1.25 | *NS* |
| Hours of supervision received weekly | | 40 | 1.65 | | | (0.77) | 30 | 1.57 | | | (0.50) | 0.55 | *NS* |
| **Categorical characteristics** | | | | | | | | | | | | | |
|  | | LatAm | | | | | UK | | | | | *x2* | *p* |
|  | | Yes | | No | | | Yes | | No | | |
| Formal training in CBT | | 29 | | 15 | | | 21 | | 9 | | | 0.136 | *NS* |
| Use of manuals | | 10 | | 26 | | | 17 | | 11 | | | 7.005 | 0.008 |
|  |  | LatAM | | | | | UK | | | | | All | |
|  |  | n | | | % | | n | | | % | | n | % |
| Frequency of attendance at conferences/refresher courses | Every 1 - 6 months | 7 | | | 13.2 | | 2 | | | 6.5 | | 9 | 10.7 |
| Every 6 months - 1 year | 14 | | | 26.4 | | 15 | | | 48.4 | | 29 | 34.5 |
| Every 1 - 3 years | 8 | | | 15.1 | | 7 | | | 22.6 | | 15 | 17.9 |
| Every 3 - 5 years | 3 | | | 5.7 | | 2 | | | 6.5 | | 5 | 6.0 |
| Less often than every 5 years | 3 | | | 5.7 | | 2 | | | 6.5 | | 5 | 6.0 |
| Never | 5 | | | 9.4 | | 2 | | | 6.5 | | 7 | 8.3 |

Note: LatAm=Latin America; UK=United Kingdom; *NS*=Non-significant

**Use of specific techniques**

*CBT techniques for eating disorders.* Table 3.2 shows the level of use of specific techniques for the eating disorders reported by clinicians from the two groups. There were significant differences for a variety of the techniques. The UK clinicians were more likely to use ‘introduction of regular meals’, ‘behavioural experiments’, ‘other exposure work’, ‘monitoring physical risk’, and ‘weighing the patient’. In contrast, Latin American therapists were more likely to use ‘pre-therapy motivation work’.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Table 3.2. Clinicians’ use of ED-specific techniques** | | | | | | | | | |
| Technique | LatAm | | | UK | | | *t* | *p* | *d* |
| *N* | *M* | *(SD)* | *N* | *M* | *(SD)* |
| Introducing regular eating | 39 | 5.03 | (2.10) | 29 | 6.66 | (0.67) | 4.55 | 0.001\* | 1.04 |
| Cognitive restructuring | 38 | 5.74 | (1.57) | 29 | 6.00 | (1.23) | 0.75 | *NS* | 0.18 |
| Behavioral experiments | 38 | 4.63 | (1.98) | 29 | 6.03 | (1.27) | 3.53 | 0.001\* | 0.84 |
| Body image exposure work | 38 | 4.58 | (1.88) | 29 | 4.45 | (1.72) | 0.29 | *NS* | -0.07 |
| Other exposure work | 38 | 3.84 | (1.81) | 29 | 4.76 | (1.88) | 2.02 | 0.049 | 0.49 |
| Monitoring physical risk | 38 | 5.29 | (2.07) | 29 | 6.76 | (0.64) | 4.13 | 0.001\* | 0.95 |
| Pre-therapy motivational enhancement | 38 | 5.68 | (1.65) | 29 | 4.72 | (2.10) | 2.03 | 0.048 | -0.50 |
| Weighing the patient | 38 | 3.55 | (2.53) | 29 | 6.55 | (0.83) | 6.84 | 0.001\* | 1.59 |
| Focusing on the therapeutic alliance | 38 | 6.39 | (1.26) | 29 | 6.07 | (1.36) | 1.01 | *NS* | -0.24 |
| Monitoring changes in behaviours, cognitions and emotions | 38 | 6.34 | (1.36) | 29 | 6.76 | (0.58) | 1.70 | *NS* | 0.40 |
| **Cronbach’s Alpha: LatAm=0.890; UK=0.709; All=0.849** | | | | | | | | | |

Note: LatAm=Latin America; UK=United Kingdom; *NS*=Non-significant; \*Significant after Bonferroni correction

*General CBT techniques.* Table 3.3 shows the clinicians’ level of use of more general CBT techniques (including some that are not evidence-based). UK therapists were more likely to use ‘asking the patients to record their thoughts’, ‘give patients homework’, ‘monitoring progress’, and ‘setting an agenda each session’. In contrast, Latin American clinicians were more likely to ‘explore the patient’s patterns of relating to people’, ‘look at problems besides eating disorders’, ‘use relaxation exercises’, and ‘encourage the patient to talk about whatever was on their mind’.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Table 3.3 Clinicians’ use of general techniques** | | | | | | | | | |
| Technique | LatAm | | | UK | | | *t* | *p* | *d* |
| *N* | *M* | *(SD)* | *N* | *M* | *(SD)* |
| Drawing a diagram for the patient explaining the problem, which includes the link between thoughts, feeling and behaviours | 36 | 5.11 | (2.12) | 28 | 5.82 | (1.44) | 1.52 | *NS* | 0.25 |
| Drawing a diagram that shows the patient's patterns in relating to people | 36 | 3.64 | (1.9) | 28 | 3.32 | (1.72) | 0.67 | *NS* | -0.17 |
| Mindfulness techniques | 36 | 3.50 | (1.44) | 28 | 3.39 | (1.52) | 0.29 | *NS* | -0.07 |
| Coping the present and the future | 36 | 5.33 | (1.53) | 28 | 5.29 | (1.36) | 0.13 | *NS* | -0.02 |
| Exploring the patient's childhood and past | 36 | 4.50 | (1.83) | 28 | 4.32 | (1.54) | 0.42 | *NS* | -0.10 |
| Spending time looking at links between beliefs, thoughts and feelings | 36 | 5.89 | (1.35) | 28 | 6.18 | (1.28) | 0.87 | *NS* | 0.22 |
| Exploring the patient's patterns of relating to people | 36 | 5.47 | (1.58) | 28 | 3.86 | (1.58) | 4.06 | 0.001\* | -1.28 |
| Letting the patient lead the content of the session | 36 | 3.39 | (1.38) | 28 | 3.21 | (1.17) | 0.54 | *NS* | -0.14 |
| Asking patients to keep records of their thoughts | 36 | 4.69 | (1.74) | 28 | 5.64 | (1.42) | 2.40 | 0.019 | 0.59 |
| Looking at other problems besides eating difficulties | 36 | 5.64 | (1.53) | 28 | 4.18 | (1.34) | 4.00 | 0.001\* | -1.01 |
| Relaxation exercises | 36 | 3.94 | (1.71) | 28 | 2.64 | (1.31) | 3.34 | 0.001\* | -0.85 |
| Talking about childhood or past experiences | 36 | 3.69 | (1.79) | 28 | 3.82 | (1.47) | 0.31 | *NS* | 0.07 |
| Changing the meaning attached to thoughts | 36 | 5.14 | (1.79) | 28 | 5.32 | (1.61) | 0.42 | *NS* | 0.10 |
| Giving the patient tasks / homework to do between sessions | 36 | 5.72 | (1.45) | 28 | 6.54 | (0.84) | 2.82 | 0.007 | 0.69 |
| Asking the patient to complete monitoring surveys and / or questionnaires regularly | 36 | 3.58 | (1.93) | 28 | 5.46 | (1.64) | 4.12 | 0.001\* | 1.04 |
| Spending sessions talking about whatever is on the patient's mind | 36 | 3.56 | (1.56) | 28 | 2.21 | (1.07) | 4.08 | 0.001\* | -1.00 |
| Setting an agenda at the beginning of each session | 36 | 4.00 | (2.27) | 28 | 6.04 | (1.21) | 4.62 | 0.001\* | 1.12 |
| **Cronbach’s alpha: LatAm=0.817; UK=0.721; All=0.762** | | | | | | | | | |

Note: LatAm=Latin America; UK=United Kingdom; *NS*=Non-significant; \*Significant after Bonferroni correction

**The role of clinicians’ characteristics in explaining the use of techniques**

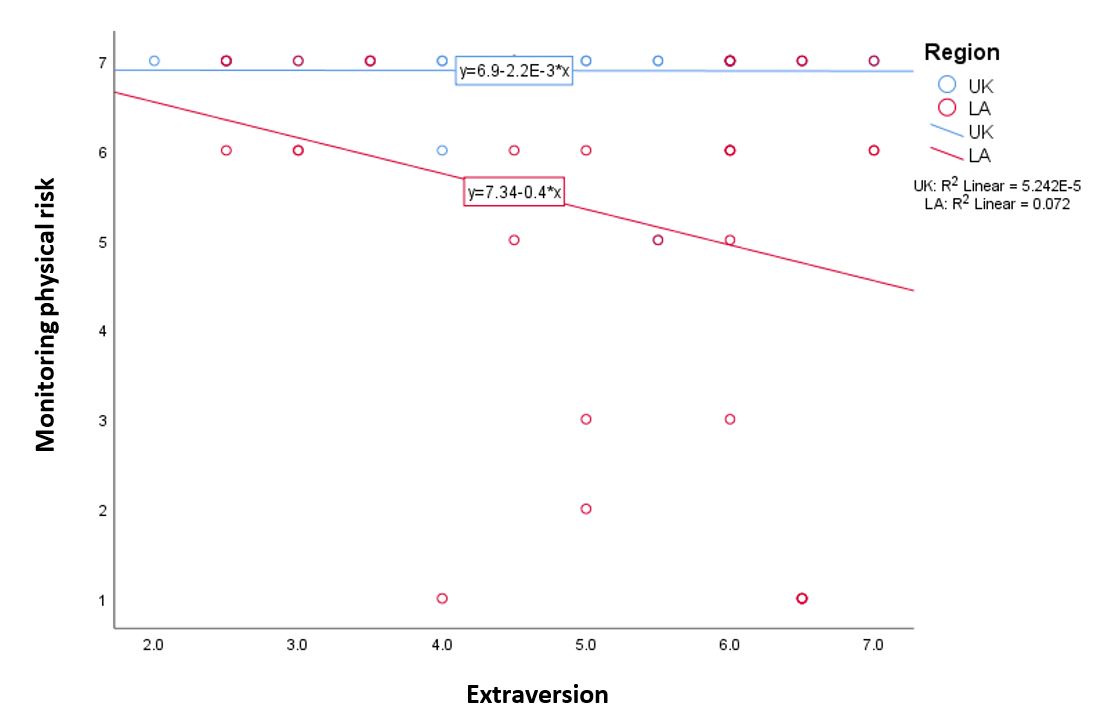
Analyses of covariance (ANCOVA) were implemented to determine which psychological variables predicted the use of specific techniques (see Table 3.4). In each case, the psychological variables (personality, social desirability, anxiety) were entered as covariates, so that if the original significant difference became non-significant or was reduced in significance, it could be concluded that any significant covariate had explained that difference between the samples

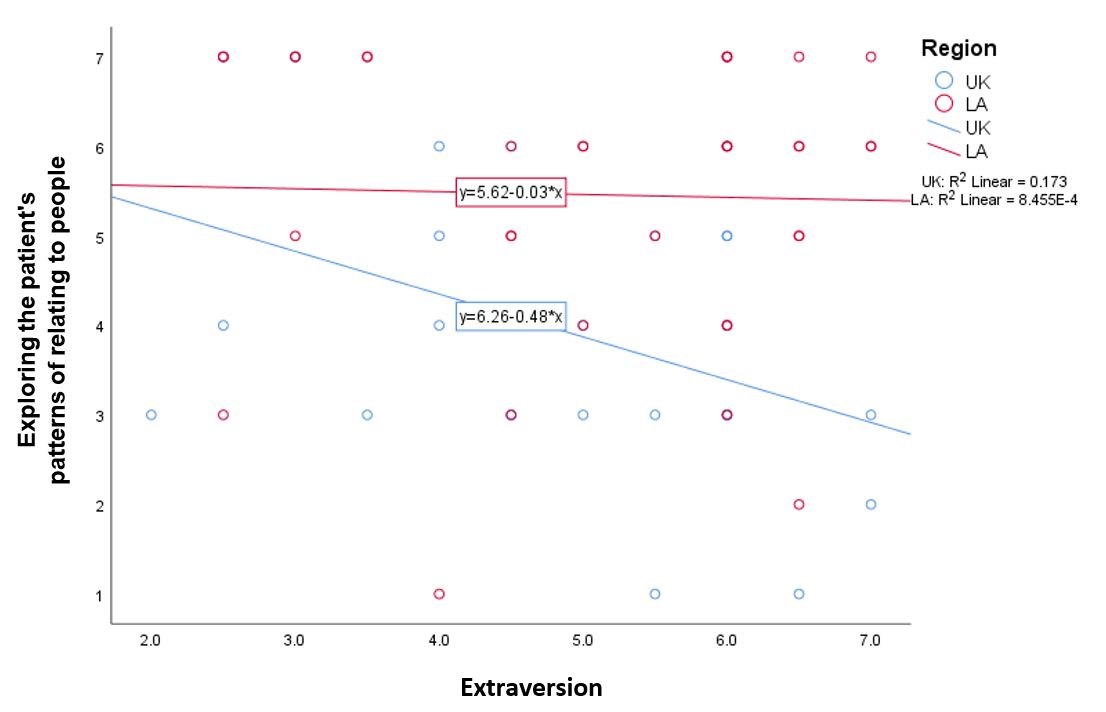
|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Table 3.4. Clinicians’ characteristics that explain Latin America / UK differences in technique use** | | | | | | | | | |
| Technique | LatAm | | | UK | | | *F* | *p* | *Significant covariates* |
| *N* | *M* | *(SD)* | *N* | *M* | *(SD)* |
| **ED-specific techniques** | | | | | | | | | |
| Introducing regular eating | 39 | 5.03 | (2.10) | 29 | 6.66 | (0.67) | 1.895 | *NS* | - |
| Behavioral experiments | 38 | 4.63 | (1.98) | 29 | 6.03 | (1.27) | 1.358 | *NS* | - |
| Other exposure work | 38 | 3.84 | (1.81) | 29 | 4.76 | (1.88) | 2.561 | 0.017 | Conscien-tiousness |
| Monitoring physical risk | 38 | 5.29 | (2.07) | 29 | 6.76 | (0.64) | 2.673 | 0.013 | Extraver-sion (R) |
| Pre-therapy motivational enhancement | 38 | 5.68 | (1.65) | 29 | 4.72 | (2.10) | 2.407 | 0.024 | - |
| Weighing the patient | 38 | 3.55 | (2.53) | 29 | 6.55 | (0.83) | 4.367 | 0.001 | - |
| **General techniques** | | | | | | | | | |
| Exploring the patient's patterns of relating to people | 36 | 5.47 | (1.58) | 28 | 3.86 | (1.58) | 2.795 | 0.010 | Extraver-sion (R) |
| Asking patients to keep records of their thoughts | 36 | 4.69 | (1.74) | 28 | 5.64 | (1.42) | 1.252 | *NS* | - |
| Looking at other problems besides eating difficulties | 36 | 5.64 | (1.53) | 28 | 4.18 | (1.34) | 4.239 | 0.001 | Extraver-sion, Social desirability (R) |
| Relaxation exercises | 36 | 3.94 | (1.71) | 28 | 2.64 | (1.31) | 2.611 | 0.015 | Emotional stability (R) |
| Giving the patient tasks / homework to do between sessions | 36 | 5.72 | (1.45) | 28 | 6.54 | (0.84) | 1.919 | *NS* | Extraver-sion, open-ness to experience |
| Asking the patient to complete monitoring surveys and / or questionnaires regularly | 36 | 3.58 | (1.93) | 28 | 5.46 | (1.64) | 2.494 | 0.019 | - |
| Spending sessions talking about whatever is on the patient's mind | 36 | 3.56 | (1.56) | 28 | 2.21 | (1.07) | 3.345 | 0.003 | Agreeable-ness (R) |
| Setting an agenda at the beginning of each session | 36 | 4.00 | (2.27) | 28 | 6.04 | (1.21) | 4.283 | 0.001 | ExtraversionOpenness to expe-rience (R) |

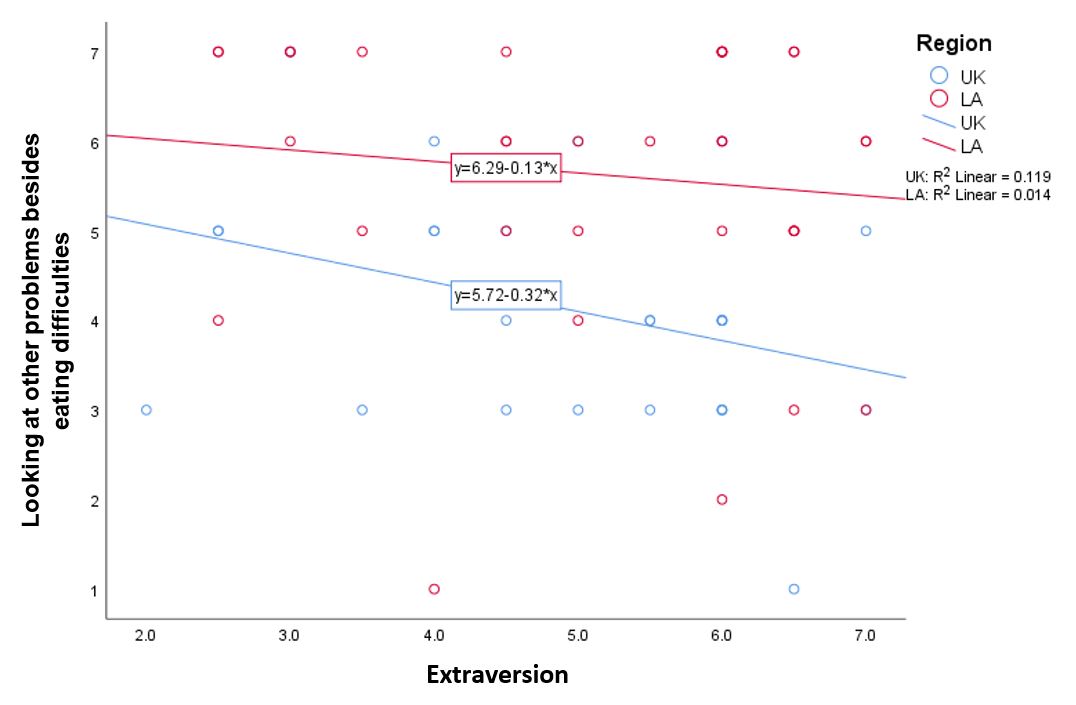
Note: LatAm=Latin America; UK=United Kingdom; *NS*=Non-significant; (R)=Covariate significance different according to therapists’ location

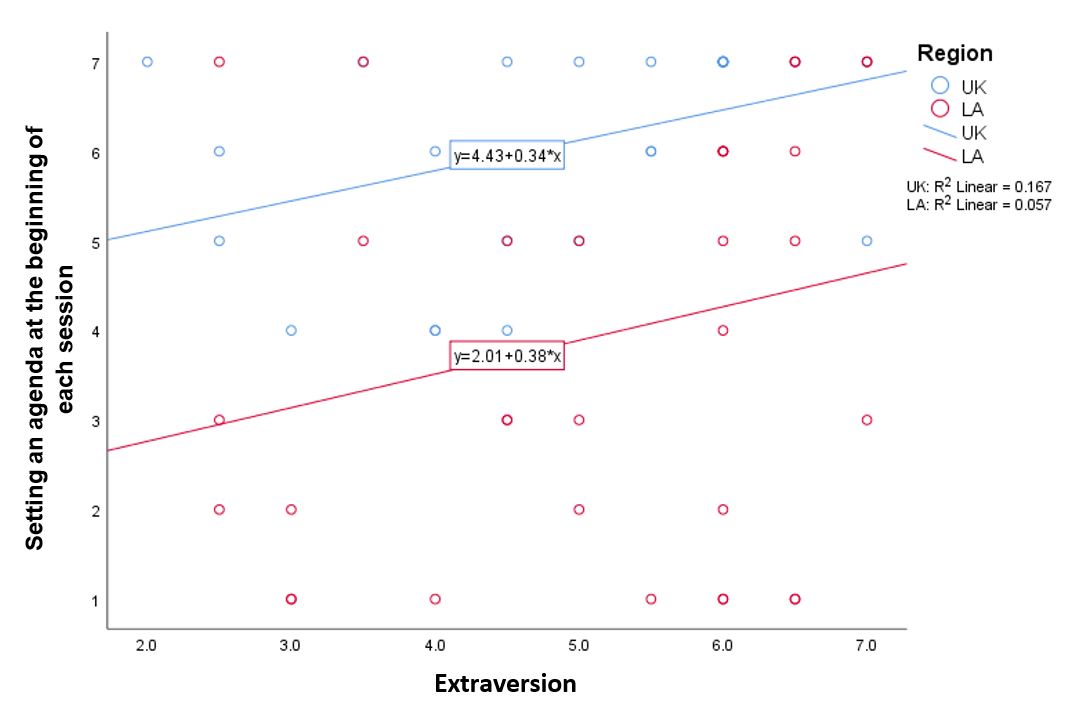
Among other personality variables, therapist extraversion was the most common, predicting the use of techniques such as: ‘monitoring physical risk’, ‘explore the patient’s patterns of relating to people’, ‘looking at problems other than eating difficulties’, and ‘setting an agenda each session’, and ‘giving the patient homework’. Scatter plots were generated to determine the direction of extraversion’s effect in technique use (Figures 3.2 a-d).

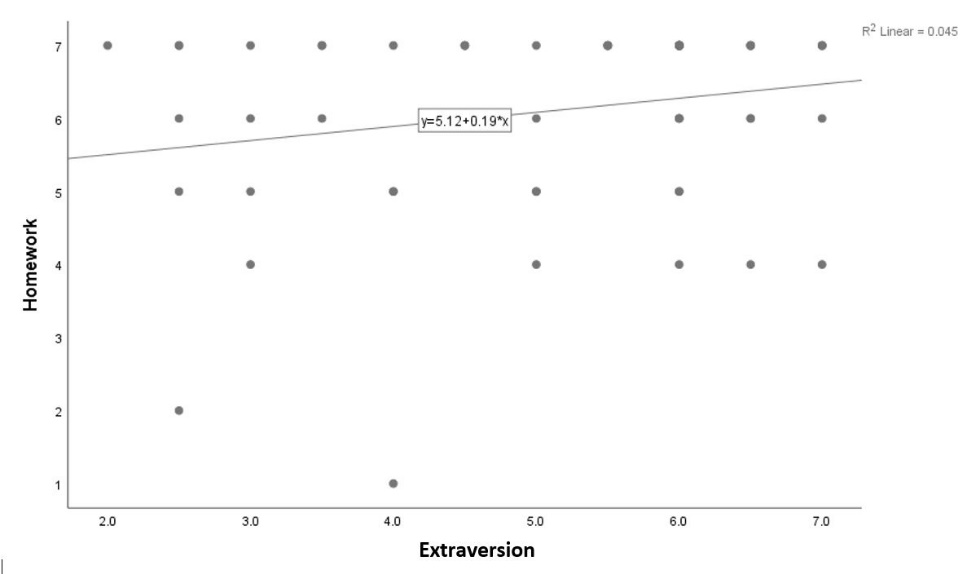
**Figures 3.2 a-d. Patterns of technique use according to therapists’ extraversion**

**a.** 

**b.** 

**c.** 

**d.** 

**e.** 

**Cultural differences in self-assessment of clinical skills**

The two groups of clinicians had similar patterns of estimation of the number of patients who recover, improve, remain the same or deteriorate. However, there was a difference in therapists’ self-assessment of their own skills compared to their peers. In both groups, the mean was above the 50% that one would expect. However, Latin American clinicians rated their skills as even higher than those of the UK therapists (73.7 vs 62.1, respectively, *p*=0.002). Therefore, it is possible that both groups of therapists believe that they do not need to improve because they are already doing a good job, but that this tendency is greater in the Latin American group.

**Discussion**

This study aimed to determine how widely core CBT techniques for the treatment of eating disorders are used by clinicians of different cultural backgrounds – specifically, Latin America and the United Kingdom. In line with our hypotheses, UK clinicians were more likely to use a wider range of CBT techniques, particularly, techniques specific for the eating disorders (introduction of regular meals; behavioural experiments; exposure work; monitoring physical risk; weighing the patient), while Latin American therapists were more likely to use pre-therapy motivation work. UK therapists were also more likely to use a range of general CBT techniques (thought records; homework; monitor progress; agenda-setting). In contrast, Latin American clinicians were more likely to use methods that are unsupported in CBT for eating disorders (e.g. relaxation; encourage the patient to talk about whatever was on their mind).

Given the similarity of the groups in terms of experience, age, training, supervision and workload, there is a strong indication that the differences in therapy delivery might be due cultural aspects. These cultural differences can also be reflected in the type of techniques that were delivered more often by the groups: In contrast with the UK sample, the Latin American group was less likely to implement the most challenging techniques (e.g. exposure work). Latin American clinicians showed a greater preference for techniques such as ‘talking about whatever is on the patient’s mind’, or ‘looking at other issues besides eating disorders’ – techniques that could be considered less anxiety-inducing. Such technique choices by the Latin American group might be an indication of the agreeable, non-confrontational style acquired by their cultural traits.

Our findings relate closely to previous research, showing that Latin American therapists tend to underuse several CBT techniques, as do therapists from developed countries (see DiGiorgio et al., 2010; Mulkens et. al., 2018; Kosmerly et al., 2015; Waller et al., 2012). However, the results show a greater level of therapist drift in Latin America, which appears to be related to specific aspects of culture. The literature suggests that culture is a factor that should influence therapy delivery (see Benish, Quintana, & Wampold, 2011; Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009; Organista & Muñoz, 1996). While this conclusion usually relates to the patient’s culture (e.g. the need for therapies to be adapted), these findings show that the therapist’s own culture also matters. The findings also support Hofstede et al.’s (2010) theory relating to cultural differences, since the intergroup differences were consistent with Hofstede’s conclusions about the nature of UK and Latin American cultural differences, and the likely effect on their behaviour.

Clinicians’ personality explained some of the differences in therapy implementation. Extraversion played an important role in our study, since it predicted the use of several techniques – in particular, ‘monitoring physical risk’, ‘exploring patient’s patterns of relating to people’, ‘looking other problems besides eating disorders’, ‘giving homework to the patient’, and ‘setting an agenda each session’. Therapist openness to experience also predicted the use of several techniques (‘coping in the present and in the future’, ‘setting an agenda each session’, and giving ‘homework between sessions to the patient’). Since both extraversion and openness to experience are traits that reflect an inclination for a variety of activities instead of a strict routine, clinicians with high levels of these traits might be more willing to utilize a more diverse range of techniques (regardless of whether those techniques are empirically supported or not).

As found in similar studies (Parker & Waller, 2015; Walfish et al., 2012), self-assessment was higher than could be justified for participants from both cultural backgrounds. However, it was considerably higher in the Latin American sample. This difference might imply that Latin American therapists believe that they already have a very positive skill base, and therefore do not see it as important to maintain and develop their skills through ongoing training and supervision. This pattern might explain some of their focus on non-evidence-based approaches in CBT for eating disorders.

**Clinical Implications**

In clinical terms, supervision and training are usually recommended as means of promoting better therapy competence and delivery (e.g., Fairburn & Cooper, 2011). Appropriate dissemination of manualized protocols is recommended in Latin America. Since most of literature on the material is in English, this can create a language barrier, which necessitates adaptations. However, the level of therapist drift in developed cultures should also be remembered (e.g., Waller, 2016), indicating that better dissemination and implementation is not something that should be regarded as a problem only for developing countries. Regardless of their cultural background, clinicians should be encouraged to keep in mind that the patients’ wellbeing is the most important factor within the therapeutic process. Questioning whether the patient is getting better should be the frame of reference when delivering therapies, whatever the therapy or the disorder.

**Limitations**

This study has some limitations – particularly the reduced sample size, associated with the low response rate common in online surveys. The low response might also be a product of the limited group who were being sought (clinicians working with CBT for the eating disorders). This group of clinicians might be particularly hard to recruit in Latin America, where the acceptance and implementation of CBT is relatively recent, and where the prevalence of eating disorders appears to be lower than in developed countries (Soh & Walter, 2013). Other potential recruitment techniques would have been in-situ questionnaire administrations, which might have provided a more personalised approach for clinicians, potentially enhancing participation. However, as this is the first such study including Latin American clinicians, its findings could set the basis for further, similar studies with larger samples.

Further studies involving a more extensive amount of countries are recommended, in order to explore the various patterns of therapist drift across different cultural settings. Future research should also inquire more extensively about the therapist’s reasons to choose the techniques that they deliver and the ones that they dismiss, and whether they attribute their decisions to culture-specific reasons. Regarding self-assessment, it is possible that the recorded responses come from clinicians whose performance is indeed above average, perhaps reflecting the confidence of highly competent clinicians who agree to participate in surveys and questionnaires. Future studies should explore whether therapists who rate themselves as above average achieve better patient outcomes.

It is necessary to mention that the informed consent forms for the participants contained the names of both of the main researchers, being one of them a well-known expert in the eating disorders field. This could have been a potential source of bias, causing that the participants overstated their responses (e.g. exaggerated their technique use and/or self-assessment). The measure utilised in this study can be considered a single-item scale, since one single item is used to evaluate the frequency of use of one particular technique. Single item scales have been criticised in the past, given that their internal consistency reliability cannot be estimated (Wanous & Reichers, 1996; Loo, 2002). Therefore, future studies should evaluate the frequency of use of techniques with a multi-item instrument.

It is worth noting that the techniques included in this study were grouped *a priori* as ‘General techniques’ and ‘ED-specific techniques’. *A posteriori* factor analyses revealed a different factor structure, which could be conceptualised as ‘*behavioural-cognitive*’ and ‘*cognitive-behavioural*’, according to the techniques’ focus (see Table 3.5). The results of this factor analysis were obtained by combining the groups of clinicians (LatAm and UK). When carried out with the separate samples, the KMO measure of sample adequacy coefficient was small, indicating an insufficient number of participants to obtain a reliable factor structure (KMO < 0.5 for both groups of clinicians). Future studies are encouraged to classify the techniques according to the factor structure suggested by a factor analysis.

**Table 3.5. *A posteriori* factor analysis for the techniques included in this study**

|  |  |  |
| --- | --- | --- |
|  | Factor 1 | Factor 2 |
| Behavioural experiments | **0.872** | 0.113 |
| Monitoring physical risk | **0.795** | 0.086 |
| Other exposure work | **0.782** | 0.16 |
| Weighing the patient on each session | **0.751** | -0.183 |
| Monitoring surveys | **0.705** | -0.17 |
| Cognitive restructuring | **0.669** | 0.294 |
| Body image exposure work | **0.652** | 0.255 |
| Introduction of regular eating | **0.638** | -0.076 |
| Set an agenda each session | **0.586** | -0.214 |
| Homework | **0.584** | 0.097 |
| Drawing a diagram linking thoughts, feelings and behaviours | **0.566** | -0.176 |
| Record thoughts | **0.561** | 0.071 |
| Changing the meaning attached to thoughts | **0.521** | 0.5 |
| Monitoring the change in behaviours, cognitions and emotions | **0.506** | 0.484 |
| Coping in the present and the future | **0.495** | 0.207 |
| Drawing a diagram about the patients’ patterns of relating to other people | 0.238 | 0.205 |
| Exploring the patients’ patterns of relating to other people | -0.022 | **0.785** |
| Looking at other problems besides eating difficulties | -0.286 | **0.779** |
| Therapeutic alliance | 0.229 | **0.615** |
| Talk about whatever is on the patients’ mind | -0.305 | **0.596** |
| The patient leads the content of the session | 0.037 | **0.551** |
| Explore the patients’ childhood and past | -0.075 | **0.551** |
| Look at the link between beliefs, thoughts and feelings | 0.458 | **0.524** |
| Talk about the patients’ childhood and past | -0.031 | **0.514** |
| Relaxation | 0.152 | **0.497** |
| Pre-therapy motivation work | 0.057 | **0.484** |
| Mindfulness | 0.281 | **0.446** |
| Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization. Rotation converged in 3 iterations | | |

**Conclusion**

Therapist drift is a phenomenon that occurs in different locations, in ways that could reflect cultural influences and differences. Cultural theories can be a useful tool to understand the level and patterns of drift, with personality differences across the cultures being important. Cultural adaptations to therapy should be considered where possible and useful, but those adaptations might need to include changes to therapists’ behaviours, as much as to the content of the therapy. Therapist training and supervision are likely to be important when planning therapy choice and implementation.

**Prelude to Chapter IV**

After finding different patterns of therapist drift in different cultural settings (Chapter III), the next study assessed what additional variables might affect therapy delivery. In particular, the study aimed to assess how patient characteristics such as mood and gender influence CBT delivery. An experimental, vignette-based approach was used. The influence of some clinicians’ characteristics (e.g. anxiety, personality, firmness, empathy) on therapy delivery was also considered. In order to address possible cultural differences in CBT delivery, Mexican and British clinicians were included in the study.

**Chapter IV**

**Do patients’ mood and gender affect the way we deliver CBT? An experimental, vignette-based study of the relevance of patient and clinician characteristics**

**Abstract**

**Background:** Clinicians often fail to deliver the best psychological treatments available. Such flaws in delivery can be related to both clinicians’ and patients’ characteristics. Research on this topic has relied on surveys of the use of the techniques. Furthermore, little is known of this therapist ‘drift’ outside highly developed countries. Therefore, the aim of this study was to test experimentally whether patients’ and clinicians’ characteristics influenced CBT delivery. Possible cultural differences were assessed comparing Mexican and British clinicians’ responses. **Method:** An experimental, vignette-based study evaluated clinicians’ likelihood of utilizing several CBT techniques by manipulating patients’ mood and gender. **Results:** Anxious patients were the most likely to receive the techniques, especially exposure and other behavioural techniques. Therapists delivered more techniques to male patients, while angry and calm female patients were the least likely to receive the techniques. Therapists were more likely to deliver talking techniques to females. Mexican clinicians delivered fewer techniques overall, but UK clinicians delivered more techniques to male patients. Some clinicians’ characteristics (firmness and empathy) had an effect on therapy delivery. **Conclusion:** These findings suggest that clinicians treat their patients differently, either consciously or inadvertently. These differences are likely to be related to clinicians’ concerns and gender stereotypes about their patients.

**Background**

Clinicians often fail to deliver the best psychological treatments available, despite having all the necessary tools to implement them correctly (Waller, 2009). Clinicians are more likely to underuse or omit certain techniques according to their patients’ characteristics, for example, their patients’ diagnosis (DiGiorgio et al., 2010) or anxiety level (Meyer et al., 2014). Other reasons behind this therapist ‘drift’ have been investigated, and some clinicians’ characteristics play a significant role in therapy delivery (Cowdrey & Waller, 2015; DiGiorgio et al., 2010; Kosmerly et al., 2015). Such factors include clinicians’ age, anxiety and experience (Waller et al., 2012; Wisniewski, Hernandez Hernandez, & Waller, 2018). However, most of these studies have relied on surveys of the use of the techniques, involving correlational designs. There is a need for experimental confirmation of how patients’ and therapists’ characteristics influence therapy delivery.

While the understanding of therapist drift has grown considerably in recent years, such research has been largely in countries such as the United Kingdom and the United States. Little is known of therapist drift in non-Western countries. At a general level, cross-cultural research has found marked differences between Anglo/European nations and other parts of the world (Hofstede et al., 2010), with those cultural differences being closely linked to personality traits (Hofstede & McCrae, 2004). Given these cultural differences, it is possible that the research into therapist ‘drift’ will not generalise to other cultures. Therefore, this study examines therapist drift outside of ‘Western’ cultures, using the specific example of Mexico. Mexico has a combination of traits that differentiate it from European/Caucasian countries (e.g. greater respect of hierarchies; greater avoidance of uncertainty; lower individualism – Hofstede et al., 2010). Those characteristics might mean that Mexican therapists are less likely to impose some of the more ‘demanding’ elements of therapy on their patients.

Such avoidance might be especially likely if the patients show characteristics that clinicians could perceive as ‘challenging’ or ‘vulnerable’ (e.g. a patient behaving in an anxious or angry way). Furthermore, males and females are treated differently in other health settings (Bernstein & Kane, 1981; Foss & Sundby, 2003), with healthcare staff often attributing traits like fragility or emotionality to female patients. Such clinician attribution could be an important limitation to how we deliver psychological therapies to female patients, and the pattern of clinician attribution might also vary with cultural normative characteristics.

In summary, therapist drift has previously been associated with several therapist characteristics (e.g., therapists’ age, experience or anxiety level). However, it is still unclear whether factors such as the patient’s gender and emotional state influence the techniques clinicians use in therapy. Furthermore, it is unknown whether the patterns of technique use differ in different cultural settings. Therefore, the aim of this experimental study is to determine whether patients’ characteristics (gender, anxiety and anger) and clinician characteristics (age, experience, personality, anxiety, firmness, and empathy) influence the way clinicians deliver therapy, and to assess possible cultural differences (comparing Mexico and the UK). The study will consider the delivery of cognitive-behavioural therapy (CBT), given its broad empirical support and clear protocols and procedures (Beck, 2011; DiMauro, Domingues, Fernandez, & Tolin, 2013; Wootton, Bragdon, Steinman, & Tolin, 2015). Given the tendency for Mexicans to focus on being agreeable and to avoid confrontation (Hofstede et al., 2010), it is hypothesised that clinicians from Mexico will deliver fewer of the most ‘demanding’ CBT techniques, particularly if their patients are female and/or exhibit anxiety or anger. In contrast, it is hypothesized that UK clinicians will not show this pattern to the same degree.

**Method**

**Ethical considerations**

This research was approved by the University of Sheffield's Department of Psychology Research Ethics Committee (see appendix 3.1). Informed consent was obtained from participants prior their participation on this study (see appendices 3.3.1 and 3.3.2).

**Design**

This was an experimental, vignette-based study that evaluated clinicians’ likelihood of utilizing several CBT techniques, by manipulating patient’s mood and gender in a series of six fictional vignettes. The within-subject variables were patient’s mood (anxious, angry, calm) and gender (male, female), whereas the between-subject variable was clinician’s country of origin (UK or Mexico).

**Participants**

The sample included two groups of clinicians – one from Mexico and other from the UK – who stated that they used CBT with their patients. A sample size calculation (G\*power) showed that, with a medium effect size, a power of 0.80, and a significance level of .05, 30 participants would be needed per group. Both groups of clinicians were primarily approached via e-mail (see appendices 3.2.1 and 2.2.2). Clinicians from the UK were contacted through the BABCP contact list, and were also asked to re-send the survey to their colleagues (snowball sampling). Besides e-mail, the Mexican sample was contacted through different methods, such as social media, websites of universities and psychological associations, through the researcher’s professional contacts, and by asking the participants to re-send the survey to their colleagues. To enhance participation, the Mexican sample was offered the possibility of entering a draw for one of five Amazon gift cards after completing the survey. The draw was carried out upon sample completion, and the winners were picked by generating a random number list in Excel.

**Measures and procedure**

The participants completed an online questionnaire created on Qualtrics (see appendices 3.4.1 and 3.4.2). Initially, they provided information regarding their age, gender, profession, theoretical orientation, training, experience, caseload, and supervision. The core part of the survey consisted of a series of six vignettes that depicted a fictional therapy session with the following types of patients: A female patient showing anxiety signs; a male patient showing anxiety signs; an angry female patient; an angry male patient; a control (calm) female patient; and a control (calm) male patient (Table 4.1).

|  |  |
| --- | --- |
| **Table 4.1. Vignettes presented to the participants** | |
| Patient | Vignette |
| Anxious female | Gloria is a 27-year-old woman. She describes herself as a very shy, introverted person, and has been struggling in her new job. She says that she feels very intimidated by her boss, and that she’s afraid of being judged by her colleagues, so she tends to avoid everyone as much as possible. Gloria recognizes that this will eventually damage her career, so she looks for psychological support. While in therapy, she is clearly nervous, stating that she is afraid of ‘opening up to a complete stranger’. As her therapist, you decide that cognitive-behavioural therapy would suit Gloria’s situation. How likely is it that you would use each of the following techniques as part of that approach? |
| Angry female | Clara is a 20-year-old psychology student. She was referred to therapy after recently threatening to kill herself when she failed one of her course modules. Clara shows up in therapy, where she complains that she doesn’t need therapy, and that she knows as much about psychology as any therapist. She starts to behave more aggressively, raising her voice and cursing. You decide that a cognitive-behavioural approach would be suitable for Clara’s situation. How likely is that you will use the following techniques with her? |
| Calm female | Sara is a 40-year-old patient, who seeks therapy after the loss of her father. She acknowledges that she is going through a very difficult time, and that she needs additional help to go through it. Sara attends therapy punctually, and seems very interested and willing to work in order to get better. As her therapist, you chose a cognitive behavioural approach to treat her. How likely is that you will implement each of these techniques with Sara? |
| Anxious male | Daniel is 25-year-old men with severe claustrophobia. He recently started working in an office that he describes as being ‘too small’, and says that he can ‘barely breathe when he’s there’. Daniel doesn’t want to lose this job, so he looks for psychological help. While in therapy, Daniel is extremely nervous. He says he has 'always been like this’, and that it will be ‘impossible’ for him to get better. As Daniel’s therapist, you decide that a cognitive-behavioural approach would suit his needs. How likely is it that you would use each of the following techniques as part of the therapy? |
| Angry male | Gabriel is 26-year-old men who recently started working as a police officer. Some weeks ago, one of his co-workers was shot and killed. Since then, Gabriel has experienced several panic attacks. One of those panic attacks occurred during working hours in the presence of his boss, who required him to get psychological help. Gabriel is clearly angry. He is reluctant to speak, and states that he doesn’t want to be in therapy. He believes that therapy is a waste of his time, and that the panic attacks will eventually go away on their own. As Gabriel's therapist, you decide that a cognitive-behavioural approach would suit his needs. How likely is it that you would use the following techniques as part of the approach? |
| Calm male | Alan is 30 years old, and has been unable to hold a job for the last year. He says that some days he feels very active and motivated, but suddenly he starts feeling depressed and miserable, and doesn’t want to go to work. He recognizes that he has a problem and that he has to do something about it, or things could get worse. Alan attends therapy, where he shows his willingness to cooperate, and seems very involved in the process. As Alan’s therapist, you decide that you’ll treat him using a cognitive-behavioural approach. How likely is that you will use the following techniques with Alan? |

On each vignette, the participants indicated the likelihood of utilizing a list of techniques commonly utilized in CBT with their patients (Table 4.2 – Cowdrey & Waller, 2015; Westbrook, Kennerley, & Kirk, 2007). These techniques were later grouped into three main categories: Talking-based techniques; Change-oriented-based techniques; and exposure (Levita, Salas Duhne, Girling, & Waller, 2016) for the subsequent analyses (Table 4.2). Therapists rated the likelihood of utilizing these techniques on a seven-point Likert scale, ranging from “Extremely unlikely” (1) to “Extremely likely” (7).

|  |  |
| --- | --- |
| **Table 4.2. Techniques commonly used in CBT listed in the survey** | |
| Technique | Group to which it belongs |
| 1. Mindfulness techniques | Talking-based techniques |
| 1. Exploring the patients’ childhood and past |
| 1. Spending time looking at the link between beliefs, thoughts and feelings |
| 1. Exploring the patients’ patterns of relating to people |
| 1. Changing the meaning attached to thoughts |
| 1. Spending sessions talking about whatever is on the patients’ mind |
| 1. Setting an agenda at the beginning of each session |
| 1. Remain silent |
| 1. Cognitive restructuring |
| 1. Motivational work |
| 1. Psychoeducation |
| 1. Socratic questioning |
| Cronbach’s alpha=0.936 | |
| 1. Asking patients to keep records of their thoughts | Change-oriented-based techniques |
| 1. Relaxation exercises |
| 1. Behavioural activation |
| 1. Addressing therapy interfering behaviours |
| 1. Diary keeping |
| 1. Behavioural experiments |
| Cronbach’s alpha=0.899 | |
| 1. Exposure | |
| Cronbach’s alpha=0.772 | |

The questionnaire also included the following measures to determine the clinicians’ psychological characteristics:

*Cognitive-Somatic Anxiety Questionnaire* (CSAQ; Schwartz et al., 1978 – see appendix 5.1.1). The psychometric characteristics of the CSAQ and its validated version for Mexican populations are described on page 89 of this thesis.

*Ten-Item Personality Inventory* (TIPI; Gosling et al., 2003 – see appendix 5.2.1). The psychometric characteristics of the TIPI and its Spanish adaptation are described on page 89 of this thesis.

*Firmness and Empathy Questionnaire* (FEQ; McAdam Freud & Waller, in preparation [see appendices 5.4.1 and 5.4.2]). The FEQ consists of 16 statements – eight for firmness and eight for empathy. Exploratory factor analyses showed two factors (firmness and empathy), which together explained 37.2% of the variance. Cronbach’s alpha for the Empathy scale was .810, and for the Firmness scale 0.623. Since this is a novel measure, no validation or adaptation studies have been conducted to date.

**Data analysis**

The main analysis was carried out utilizing a repeated measures ANCOVA. The within-subject variables were patient’s mood (anxious, angry, calm), patient’s gender (male, female), and the type of techniques utilized (talking-based, change-oriented-based, exposure). The between-subjects factor was clinician’s country of origin (Mexico or the UK). Clinicians’ characteristics (age, experience, anxiety, personality, and firmness/empathy) were used as covariates to assess whether they predicted technique usage. A *p*-value of 0.05 was taken as significant for all analyses, and the hypotheses tests were one-tailed. Missing data were not substituted, resulting in slight differences in N across analyses.

**Results**

**Sample characteristics**

Table 4.3 shows a descriptive summary of the participants’ characteristics, and the comparison between the Mexican and British groups. The sample consisted of 128 therapists – 59.4% were from the UK and 40.6% from Mexico. *t*-tests showed that participants from the UK were significantly older than the Mexican participants, as well as more experienced as CBT clinicians and as therapists in general. In both groups, the proportion of female participants was higher than men. The Mexican group was formed almost entirely of psychologists, whereas the British sample was formed of professionals from a wider range of professional backgrounds. In both groups, most of the clinicians had a theoretical orientation based on CBT or a similar approach, and most of them declared themselves to have received formal training in CBT interventions. The British participants had a larger caseload than the Mexican sample. Both of the groups treated almost all of their patients with CBT, and both received about the same amount of supervision hours.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Table 4.3. Sample’s demographic and professional characteristics** | | | | | | | | |
| Numeric variables | | | | | | | | |
|  | | Total | UK | | Mexico | | *t* | *P* |
| Age (years) | | M=45.08 (SD=13.44) | M=52.49 (SD=9.99) | | M=36.67 (SD=10.44) | | 9.569 | .001 |
| Experience as therapist (years) | | M=16.19 (SD=12.04) | M=21.046 (SD=11.26) | | M=9.09 (SD=9.38) | | 6.515 | .001 |
| Experience with CBT (years) | | M=11.68 (SD=9.18) | M=14.243 (SD=8.66) | | M=7.88 (SD=8.69) | | 4.048 | .001 |
| Categorical variables | | | | | | | | |
|  | | Total | | UK | | Mexico | | |
| Gender | Male | 40 (31.3%) | | 26 (34.2%) | | 14 (26.9%) | | |
| Female | 88 (68.7%) | | 50 (65.8%) | | 38 (73.1%) | | |
| Profession | Psychologist | 74 (57.8%) | | 23 (30.3%) | | 51 (98.1%) | | |
| Nurse (Psychiatric, mental health, others) | 18 (14.1%) | | 18 (23.7%) | | - | | |
| CBT Therapist | 12 (9.4%) | | 12 (15.8%) | | - | | |
| Occupational therapist | 5 (3.9%) | | 5 (6.6%) | | - | | |
| Counselling | 4 (3.1%) | | 4 (5.3%) | | - | | |
| Social worker | 3 (2.3%) | | 3 (3.9%) | | - | | |
| Mental health practitioner | 2 (1.6%) | | 2 (2.6%) | | - | | |
| Other | 10 (7.8%) | | 9 (11.8%) | | 1 (1.9%) | | |
| Theoretical orientation | CBT and related | 104 (81.3%) | | 62 (81.6%) | | 42 (80.8%) | | |
| Other | 19 (14.8%) | | 9 (11.8%) | | 10 (19.2%) | | |
| Did not respond | 5 (3.9%) | | 5 (6.6%) | | - | | |
| Formal training in CBT | Yes | 122 (95.3%) | | 75 (98.7%) | | 47 (90.4%) | | |
| No | 5 (4.7%) | | 1 (1.3%) | | 5 (9.6%) | | |
| Patients treated per week | <1 | 5 (3.9%) | | - | | 5 (9.6%) | | |
| 1-5 | 30 (23.4%) | | 10 (13.2%) | | 20 (38.5%) | | |
| 6-10 | 28 (21.9%) | | 18 (23.7%) | | 10 (19.2%) | | |
| 11-15 | 23 (18%) | | 16 (21.1%) | | 7 (13.5%) | | |
| 15-20 | 22 (17.2%) | | 18 (23.7%) | | 4 (7.7%) | | |
| >20 | 20 (15.6%) | | 14 (18.4%) | | 6 (11.5%) | | |
| Patients treated with CBT (%) | 0-10 | 3 (2.3%) | | - | | 3 (5.8%) | | |
| 11-20 | 2 (1.6%) | | 1 (1.3%) | | 1 (1.9%) | | |
| 21-30 | 6 (4.7%) | | 1 (1.3%) | | 5 (9.6%) | | |
| 31-40 | 2 (1.6%) | | 1 (1.3%) | | 1 (1.9%) | | |
| 41-50 | 2 (1.6%) | | - | | 2 (3.8%) | | |
| 51-60 | 6 (4.7%) | | 4 (5.3%) | | 2 (3.8%) | | |
| 61-70 | 10 (7.8%) | | 4 (5.3%) | | 6 (11.5%) | | |
| 71-80 | 10 (7.8%) | | 6 (7.9%) | | 4 (7.7%) | | |
| 81-90 | 35 (27.3%) | | 7 (9.2%) | | 28 (53.8%) | | |
| 91-100 | 52 (40.6%) | | 52 (68.4%) | | - | | |
| Hours of supervision per week | <1 | 95 (74.2%) | | 65 (85.5%) | | 30 (57.7%) | | |
| 1-2 | 29 (22.7%) | | 11 (14.5%) | | 18 (34.6%) | | |
| >3 | 4 (3.1%) | | - | | 4 (7.7%) | | |

Table 4.4 shows the mean scores obtained by participants in the different psychological measures they completed, and the differences between clinicians from different countries. As can be seen, there were several significant differences in personality traits between the two groups of clinicians.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Table 4.4. Sample characteristics on psychometric measures (divided by country)** | | | | | | |
| Psychological measures | Country | *N* | *M* | *SD* | *t* | *p* |
| Extraversion | UK | 49 | 4.408 | 1.467 | 0.891 | *NS* |
| Mex | 27 | 4.148 | 1.054 |
| Agreeableness | UK | 49 | 6.030 | 0.868 | 4.320 | 0.001 |
| Mex | 27 | 5.092 | 0.971 |
| Conscientiousness | UK | 49 | 5.653 | 1.100 | 0.984 | *NS* |
| Mex | 27 | 5.388 | 1.154 |
| Emotional Stability | UK | 49 | 5.306 | 0.993 | 1.468 | *NS* |
| Mex | 27 | 4.962 | 0.939 |
| Openness | UK | 49 | 5.602 | 0.999 | 1.632 | *NS* |
| Mex | 27 | 5.185 | 1.177 |
| Cognitive Anxiety | UK | 49 | 1.568 | 0.546 | 2.069 | 0.042 |
| Mex | 27 | 1.862 | 0.669 |
| Somatic Anxiety | UK | 48 | 1.380 | 0.430 | 0.894 | *NS* |
| Mex | 27 | 1.296 | 0.316 |
| Empathy | UK | 49 | 6.040 | 0.656 | 2.435 | 0.017 |
| Mex | 27 | 5.638 | 0.743 |
| Firmness | UK | 49 | 4.782 | 0.848 | 5.008 | 0.001 |
| Mex | 27 | 5.716 | 0.626 |

Note: UK=United Kingdom; Mex=Mexico; *NS*=Non-significant

**Overall use of techniques**

The mean scores and standard deviations for technique usage across conditions are shown in Table 4.5. Among the possible combinations of patient mood, patient gender, type of technique utilized, and therapist’s country of origin, there were 36 different combinations (Table 4.5). Although most techniques were reported to be used routinely (none were reported less than half the time), differences were found in their usage across conditions.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Table 4.5. Mean levels of reported use of therapy techniques by patient gender, patient mood type and therapist’s country of origin** | | | | | |
| Country | Mood | Gender | Type of technique | M | SD |
| UK | Anxious | Male | Exposure | 6.755 | .722 |
| Talking-based | 5.392 | .637 |
| Change-oriented-based | 5.850 | .714 |
| Female | Exposure | 6.510 | 1.043 |
| Talking-based | 5.577 | .554 |
| Change-oriented-based | 5.605 | .821 |
| Angry | Male | Exposure | 6.040 | 1.554 |
| Talking-based | 5.222 | 1.034 |
| Change-oriented-based | 5.534 | 1.112 |
| Female | Exposure | 4.408 | 1.903 |
| Talking-based | 5.527 | .964 |
| Change-oriented-based | 5.534 | 1.113 |
| Calm | Male | Exposure | 4.775 | 1.971 |
| Talking-based | 5.488 | .582 |
| Change-oriented-based | 5.857 | .537 |
| Female | Exposure | 4.102 | 1.734 |
| Talking-based | 5.290 | .888 |
| Change-oriented-based | 4.996 | 1.091 |
| Mexico | Anxious | Male | Exposure | 5.925 | 1.899 |
| Talking-based | 4.646 | .887 |
| Change-oriented-based | 5.339 | .790 |
| Female | Exposure | 6.296 | 1.409 |
| Talking-based | 5.008 | .707 |
| Change-oriented-based | 5.425 | .860 |
| Angry | Male | Exposure | 5.148 | 2.196 |
| Talking-based | 4.743 | .794 |
| Change-oriented-based | 5.123 | .933 |
| Female | Exposure | 4.000 | 1.640 |
| Talking-based | 4.945 | .654 |
| Change-oriented-based | 4.913 | .968 |
| Calm | Male | Exposure | 4.296 | 1.937 |
| Talking-based | 5.014 | .817 |
| Change-oriented-based | 5.240 | .882 |
| Female | Exposure | 4.111 | 1.671 |
| Talking-based | 4.925 | .709 |
| Change-oriented-based | 4.950 | 1.173 |

Note: 1=Extremely unlikely; 7=Extremely likely

**Impact of patients’ characteristics in the use of CBT techniques**

The results in Table 4.5 were examined using a 3 (mood) x 2 (gender) x 3 (type of technique) x 2 (country) ANOVA, with repeated measures on the first three factors. The dependent variable was the likelihood of utilizing each technique. The analysis revealed several significant main effects and interactions between technique usage and the patients’ mood, patients’ gender, and clinicians’ country of origin (Table 4.6). The significant effects will be considered below, developing from the main effects to the interaction terms.

|  |  |  |  |
| --- | --- | --- | --- |
| **Table 4.6. 3x2x3x2 ANOVA comparing technique use by patients’ mood and gender, and by clinicians’ country of origin** | | | |
|  | *f* | *p* | *η2* |
| Mood | 42.677 | .001 | .366 |
| Mood \* Country | .990 | *NS* | .013 |
| Gender | 20.146 | .001 | .214 |
| Gender \* Country | 6.722 | .011 | .083 |
| Technique | 2.508 | *NS* | .033 |
| Technique \* Country | .235 | *NS* | .003 |
| Mood \* Gender | 9.412 | .001 | .113 |
| Mood \* Gender \* Country | 1.056 | *NS* | .014 |
| Mood \* Technique | 62.518 | .001 | .458 |
| Mood \* Technique \* Country | .577 | *NS* | .008 |
| Gender \* Technique | 26.439 | .001 | .263 |
| Gender \* Technique \* Country | 2.912 | *NS* | .038 |
| Mood \* Gender \* Technique | 14.695 | .001 | .166 |
| Mood \* Gender \* Technique \* Country | .670 | *NS* | .009 |

Note: *NS*=Non-significant

*Impact of the patients’ mood in the use of CBT techniques.* As can be seen in Table 4.6, the overall pattern of technique usage showed that therapists were likely to deliver more techniques for anxious patients in comparison to angry or calm patients (Figure 4.1). The most utilized techniques for anxious patients were exposure and other behavioural techniques. (Figure 4.2). There was also an effect of patient’s mood on technique delivery – the use of exposure substantially decreased with calm patients (male or female), and with angry female patients (Figure 4.3).

*Impact of patients’ gender in the use of CBT techniques.* Table 4.6 shows a significant difference in technique usage according to patients’ gender – therapists were more likely to deliver the techniques to male patients than to female patients (Figure 4.4). When the patient was female, angry and calm patients were likely to receive fewer techniques than anxious patients (Figure 4.5). Female patients were likely to receive more talking and behavioral techniques than men (Figure 4.6).

*Impact of therapists’ country of origin in therapy delivery.*Results in Table 4.6 indicate thatMexican clinicians were less likely to deliver the techniques than British clinicians to all patients overall (Figure 4.7). However, Mexican clinicians delivered roughly the same amount of techniques to male and female patients. In contrast, British clinicians delivered more exposure and other behavioural techniques to male patients (Figure 4.8).

**Impact of clinicians’ characteristics on technique usage**

An ANCOVA was used to test whether clinician characteristics might explain some of the previously significant main effects and interactions (excluding country of origin as a factor). The ANOVA was repeated with clinicians’ age, experience, personality and firmness/empathy used as covariates. As can be seen in Table 4.7, none of the previously significant main interaction effects remained significant or approached significance. Firmness and Empathy showed several significant effects as covariates. No other potential covariates were significant.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Table 4.7. ANCOVA showing the results of the significant interactions of covariates** | | | | | | |
|  | Main | | Empathy | | Firmness | |
|  | *f* | *P* | *f* | *p* | *f* | *p* |
| Mood | 1.837 | *NS* | 4.295 | .015 | .814 | *NS* |
| Gender | 1.322 | *NS* | .984 | *NS* | 5.391 | .023 |
| Mood \* Gender | 2.053 | *NS* | .984 | *NS* | .986 | *NS* |
| Mood \* Technique | 1.795 | *NS* | 4.619 | .001 | .666 | *NS* |
| Gender \* Technique | .137 | *NS* | 2.955 | *NS* | 2.966 | *NS* |
| Mood \* Gender \* Technique | 1.889 | *NS* | 3.284 | .012 | .228 | *NS* |

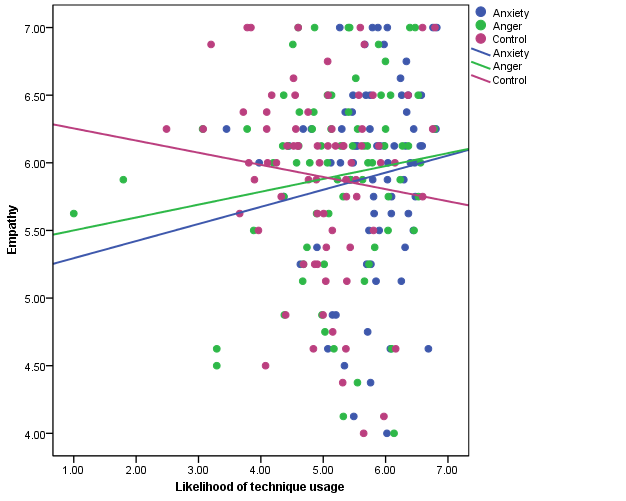
Note: *NS*=Non-significant

As Table 4.7 indicates, two of the previous interactions (Mood by Gender and Gender by Technique) were not explained by any of the covariates. However, the participants’ level of Empathy was significant in three effects, being associated with the loss of the significant ANOVA effects for Mood, Mood by Technique and Gender by Technique. In contrast, the covariate of Firmness accounted for the loss of the main effect of gender.

*The influence of clinicians’ empathy and firmness on technique usage.* Scatter plots were generated to illustrate how the pattern of covariate effects in Table 4.7 (clinicians’ empathy and firmness) affected technique usage. The results are presented below.

The role of clinicians’ empathy. As can be observed in Figure 4.9, higher levels of clinician empathy were associated with a higher likelihood of implementing CBT techniques when treating anxious or angry patients. In contrast, high levels of clinicians’ empathy indicated being less likely to deliver the techniques to calm patients. Thus, clinicians who are more empathic are more likely to offer highly emotional patients a larger number of CBT techniques.

**Figure 4.9. The impact of clinicians’ empathy on technique usage, according to the patients’ mood**



Developing the finding in Figure 4.9, Figure 4.10 shows the interactions of Empathy with Mood and the types of technique used. The most salient feature is that high levels of empathy are associated with a higher likelihood of delivering behavioral techniques to angry and anxious patients, and more talking techniques to control patients. In contrast, higher levels of clinician empathy indicated a decrease in the likelihood of utilizing exposure with calm patients. To summarise, clinicians who are more empathic are more likely to use talking techniques with patients who have low emotional arousal, but behavioural techniques with those who have high emotional arousal.

**Figure 4.10. The impact of clinician empathy on technique usage according to the different types of techniques utilized with the different patient moods**

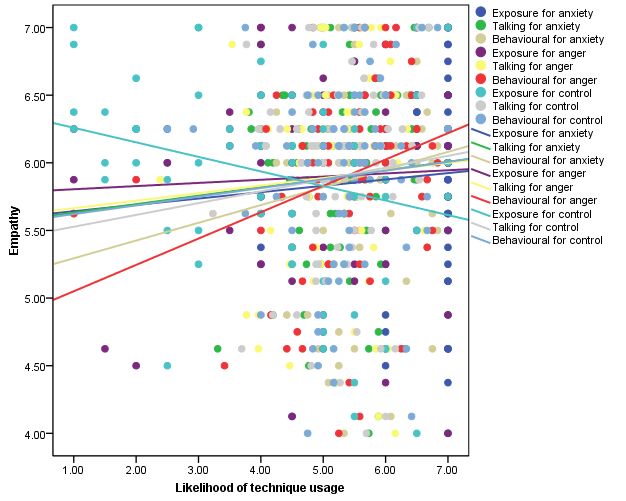
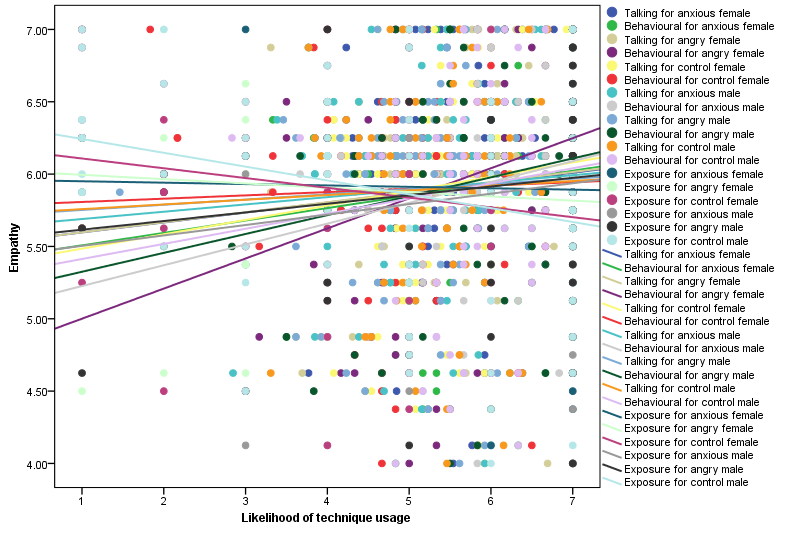


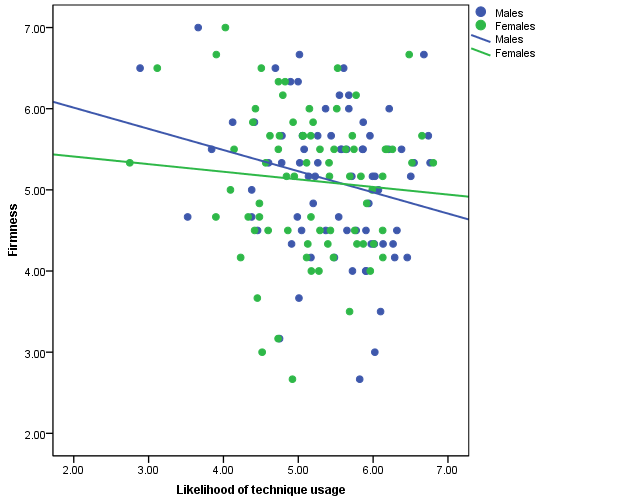
Figure 4.11 shows the relationship of Empathy with the interaction of Mood by Gender by Technique. The effect indicates that more empathic clinicians are less likely to deliver exposure to calm patients, both male and female. In contrast, more empathic clinicians were more likely to deliver behavioural techniques to angry patients (both male and female), and to anxious males. In short, this pattern shows again that empathic clinicians tend to use more behavioural techniques with highly emotional patients, and focus less on exposure if the patient is calm, regardless of patients’ gender.

**Figure 4.11. Differences across the all the possible combinations of mood, gender and therapist’s country of origin**



The role of clinician firmness on technique usage. Figure 4.12 shows that high levels of clinician firmness are associated with delivering fewer techniques to patients of both genders. However, this relationship was more marked for male patients. In short, firmer clinicians tend to focus on a smaller range of techniques for their patients, and more so if the patient is male.

**Figure 4.12. Impact of clinicians’ firmness on technique usage according to patients’ gender**



**Discussion**

The main goal of this study was to determine whether patients’ characteristics (gender and mood) influenced the way clinicians from different countries delivered therapy. A series of fictional vignettes were presented to a sample of Mexican and British clinicians who reported delivering CBT. Those vignettes depicted clinical situations in which they had to treat a patient, male or female, behaving in an anxious, angry, or calm (control) way. They indicated the likelihood of utilizing a number of techniques commonly used in CBT with that specific patient. A second goal was to investigate whether clinicians’ own characteristics influenced the way they deliver therapy.

Regarding the first goal, both patient and therapist characteristics were related to technique usage. Contrary to previous findings (Meyer et al., 2014), anxious patients were the most likely to receive more techniques, especially exposure. However, exposure was underused with calm patients overall, but this was more marked with angry females. Regarding gender, therapists were likely to deliver more techniques to male patients, while angry and calm female patients were the least likely to receive the techniques. Finally, therapists were likely to deliver more talking techniques to females than to males. Considering clinician’s country of origin, and in line with our hypothesis, Mexican clinicians were less likely to deliver the techniques overall than UK clinicians. This level of use was also influenced by patients’ gender. Mexican clinicians delivered roughly the same amount of techniques to males and females, whereas UK clinicians delivered more techniques to men.

Concerning our second goal, clinicians’ characteristics, particularly firmness and empathy, also affected therapy delivery. Empathic clinicians were likely to deliver more techniques to angry and anxious patients, but fewer to calm patients. Empathic clinicians were also more likely to utilize talking techniques with calm patients, and behavioural techniques with emotionally aroused patients. Furthermore, empathic clinicians were less likely to utilize exposure if the patient was calm. Finally, firm clinicians delivered fewer techniques to patients of both genders, but particularly so for male patients.

These outcomes suggest that clinicians treat patients differently, either consciously or inadvertently. For example, it is possible that clinicians deliver fewer techniques to angry patients due to a concern that they will make them even more upset or distressed. This concern appears to be even stronger when the angry patient is female, possibly reflecting a stereotype that females are less resilient. Unexpectedly, this patient gender bias was stronger in British clinicians than among Mexican clinicians, with British clinicians delivering more techniques to men than women. This finding is at odds with previous findings on cross-cultural research (Hofstede et al., 2010) which indicated that Mexican society holds more traditional differential views on gender roles than Anglo/European countries such as the UK.

Clinicians’ empathy and firmness also influenced their intended behaviour. Empathic clinicians were more likely to deliver more techniques to patients who could be considered as ‘challenging’ (angry or anxious). This pattern could imply that empathic clinicians are more willing to use a wider range of techniques. Alternatively, it could indicate that the more empathic clinicians were less focused than evidence-based protocols would suggest. Empathic clinicians also utilized more passive techniques with calm patients (e.g. more talking and less exposure), which could be an indicative of empathic clinicians’ ability to assess their patients’ emotional responses and plan the therapy accordingly. In contrast, firmness was associated with a lower likelihood of technique usage with male patients. This pattern could suggest that firm clinicians prefer to use a smaller but targeted range of techniques, especially with male patients.

Our findings have some similarities with existing literature. In line with previous studies (Kosmerly et al., 2015; Waller et al., 2012; Wisniewski et al., 2018), we found that some CBT techniques are underused. However, this occurred to a lesser extent in our study, as most of the techniques were likely or very likely to be utilized by the clinicians. This difference might relate to the use of a vignette-based study, which is likely to result in greater reported likelihood of using techniques than studies indicate in everyday practice (e.g. Simpson-Southward, Waller & Hardy 2016). There is also some evidence regarding the differences in technique usage by clinicians from different cultures. For example, Costa, Terraciano and McCrae (2001) found that gender differences were more pronounced in European and American cultures, where traditional gender roles are usually minimized. These findings could indicate a cultural shift, given current globalization and technological advances, potentially making Hofstede et al.’s (2010) conclusions outdated.

**Limitations**

This research has a number of limitations, such as the smaller size of the Mexican sample, and the differences in profession, age, experience and supervision. More homogeneous samples should be sought in future research. The case vignettes utilised in this study were not piloted or tested for face validity or reliability. Future studies where CBT experts review the vignettes are encouraged, as well as the administration of the vignettes to a small group of participants to ensure that the content of the vignettes is relevant for its purposes.

The use of an online questionnaire also has drawbacks, as it might overestimate the use of therapeutic methods. Similarly, the case vignettes might not depict accurately the intended clinical setting. Therefore, more direct observational methods of therapeutic competence and adherence should be conducted in future. However, the value of experimental methods is important in this field, and should be encouraged in this field of research. The techniques included in this study were grouped based on previous research (Levita et al., 2016). Technique grouping based on factor analyses or similar methods might be more reliable. Finally, this study has compared clinicians from only two countries. Research into therapist drift should be extended to a range of other countries, to determine the generalisability of these findings.

**Clinical implications**

These findings suggest that clinicians should be flexible while delivering CBT (as protocols indicate), but not excessively or inappropriately so. The therapy should not be changed to a degree where it loses its fundamental components, especially if these changes are based on our own personal biases. If adjustments to CBT are going to be made, these should be tested to prove that they work rather than being assumed to be effective. This recommendation applies particularly when the adjustments to therapy are related to our own levels of firmness and empathy, as we cannot be certain that such personal biases are leading us into clinically useful flexibility or into unhelpful drift away from protocols and effective treatment.

**Conclusion**

Therapist drift is a phenomenon that occurs in different cultural settings, and it can be elicited by the some of our patients’ characteristics, such as their gender and their emotional state. The results of this study indicate that female patients, as well as angry patients overall, are more likely to receive a narrower range of CBT components. Furthermore, some therapist factors such as their levels of firmness and empathy can affect the range of techniques they use. Clinicians are encouraged to be mindful of these possible biases, and to take actions to try to minimise them.

**Prelude to Chapter V**

The studies in the last three Chapters focused on either the conscious or unconscious decisions that clinicians take while delivering therapy. These decisions are reflected in the techniques they choose to use or to omit with their patients. So far, the results of these studies have indicated that clinicians modify therapy either because it is recommended to them (e.g. culturally-adapted interventions – Chapter II), because they have a culture-related therapy delivery style (e.g. relational-focused interventions are preferred by Latin American clinicians – Chapter III), or because they hold some biases towards some of their patients (e.g. the patient is female; the patient is angry – Chapter IV). Clinicians are likely to believe that these therapy modifications are on their patients’ best interests. However, the patients’ own opinions are often disregarded while making these modifications.

The aim of the final study of this thesis was to evaluate the patients’ opinions regarding some CBT techniques. The patients’ responses were then compared to the ones provided by a sample of clinicians. To assess the role of cultural background on this study, we included a multi-cultural sample of patients, and we analysed the results according to their cultural groups. Additionally, therapists were asked to indicate the importance of individual CBT techniques with patients from different ethnicities.

**Chapter V**

**A comparison between patients’ and clinicians’ opinions about the importance of CBT techniques – The role of patients’ cultural background**

**Abstract**

**Background:** The aim of this study was to explore the opinions about the important aspects of CBT according to both patients’ and clinicians’ perspectives. It also aimed to determine whether other factors (such as the patients’ cultural background and clinicians’ anxiety) could play a role in such preferences. **Method:** Two groups of participants were approached – a group of CBT clinicians and a group of CBT patients. An online survey with a list of several techniques commonly used in CBT was developed for each group, who indicated the importance they attributed to the techniques. Participants also completed other psychological measures. **Results:** Clinicians valued all *Change-oriented* techniques and several *Interpersonal engagement* techniques more than the patients. Clinicians considered all the techniques equally important regardless of the patients’ ethnicity. Anxious clinicians attributed a lower importance to ‘behavioural experiments’ and ‘exposure’. Non-Anglo/European patients had a higher preference for Change-oriented techniques compared to Anglo/European patients. Westernised/acculturated patients from non-Anglo/European origins considered a wider range of techniques to be important. **Conclusion:** Planning the therapy in collaboration with the patient and discussing the rationale for the techniques used is encouraged. Clinicians are also encouraged to consider acculturation before modifying CBT, as acculturated patients might consider this less necessary.

**Background**

CBT has shown positive results for the treatment of several psychological disorders (Butler, Chapman, Forman, & Beck, 2006; Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012). It has proven to be particularly effective for disorders such as depression (Cuijpers et al., 2013; Ekers, Richards, & Gilbody, 2008) and anxiety (Hofmann & Smits, 2008; Norton & Price, 2007). Its positive results are maintained in specific populations such as children, adolescents (Compton et al., 2004; Klein, Jacobs, & Reinecke, 2007) and elderly patients (Pinquart & Sörensen, 2001; Satre, Knight, & David, 2006). It is also effective in group (Johnsen & Thimm, 2018; Petrocelli, 2002) and computer-based formats (Andrews, Cuijpers, Craske, McEvoy, & Titov, 2010; Hedman, Ljótsson, & Lindefors, 2012).

Of course, CBT is not always effective. Compared to other disorders, CBT has smaller effects for schizophrenia (Jauhar et al., 2014) and for some symptoms of bipolar disorder (Ye et al., 2016). The effectiveness of CBT can be also compromised by some clinician-related factors. Clinicians tend to underuse or omit some of the most demanding techniques of CBT (e.g. behavioural techniques such as exposure), consciously or inadvertently (Waller, 2009; Waller & Turner, 2016). Such omissions are often made under the belief that the patients are exceptional cases, who would not benefit from treatment as recommended by the protocols (Meyer et al., 2014). This phenomenon of omitting techniques, also known as therapist drift (Waller, 2009) can be exacerbated if the clinician is anxious (Deacon & Farrell, 2013), or if they perceive their client as ‘fragile’ or ‘vulnerable’ (Meyer et al., 2014).

In addition to these limitations to CBT’s effectiveness for some disorders and as delivered by some clinicians, there is the possibility that cultural factors might be relevant. In particular, some concerns have been raised about the generalizability of CBT’s effectiveness, given its Anglo/European origins (Arnett, 2008; Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009). To address this, researchers and clinicians have recommended adapting therapy for patients from different cultural settings (American Psychological Association, 2003; Hinton & Patel, 2017). Besides modifications in therapy engagement and treatment delivery, such recommendations can also involve the addition, modification or omission of therapy components (Chu & Leino, 2017). However, there is a possibility that such adaptations can be over-used. For example, some therapists have stated that they are more likely to exclude culturally-diverse patients from CBT techniques such as exposure (Meyer et al., 2014), despite a lack of evidence to support that exclusion. Therefore, by trying to be culturally sensitive, clinicians might be engaging in practices that increase therapist drift and compromise therapy effectiveness.

Furthermore, it is possible that the adjustments that therapists make to therapy are not the ones that the patient would want or need, as there is limited evidence that the patient’s own preferences or values are considered when making such changes. We cannot assume that the patients will benefit from certain therapy modifications just because they belong to a certain cultural group. In particular, the patient’s level of acculturation needs to be considered when planning changes to therapy protocols – the patient who has adapted to a host culture over many years might have very different needs to the one who recently arrived from another culture. Such acculturation – the changes that occur in an individual due to constant interaction with culturally dissimilar people and contexts (Schwartz, Unger, Zamboanga, & Szapocznik, 2011) – might make these cultural modifications of therapy less necessary.

In summary, CBT’s effectiveness can be affected by the decisions that clinicians make while planning and delivering therapy. These decisions might be on the basis of their own judgement, due to unconscious factors such as their level of anxiety, or the result of recommendations by researchers and organizations (e.g. cultural adaptations). However, patients might consider these therapy modifications unecesary, and might have different opinions regarding what is important in therapy. Therefore, there is a need to explore the level of agreement about the important aspects of CBT according to both the patients’ and the clinicians’ perspectives, and to address how cultural background plays a role in such preferences. It is hypothesized that patients and clinicians will have different opinions about what elements of CBT are more and less important, and that there will also be such differences between Anglo/European and non-Anglo/European patients.

This research had the following aims:

1. To compare the importance that patients and clinicians attribute to specific CBT techniques.
2. To compare the importance given by therapists to specific CBT techniques for patients from their same ethnicity, and for patients from a different ethnicity than theirs.
3. To assess whether therapists’ anxiety predicts the importance they attribute to specific CBT techniques.
4. To compare the perceived importance that patients from different cultural backgrounds attribute to specific CBT techniques.
5. To determine whether the level of acculturation in non-Anglo/European patients predicts the importance they attribute to specific CBT techniques.

**Method**

**Ethical considerations**

This research was reviewed and approved by the University of Sheffield’s Department of Psychology Ethics Committee (see appendix 4.1). Informed consent was obtained from the participant prior the start of the study (see appendices 4.3.1 and 4.3.2).

**Design**

This was a cross-sectional mixed study, with correlational and comparative elements.

**Participants**

To achieve the aims of this study, two groups of participants were approached by e-mail (see appendices 4.2.1 and 4.2.2) – a group of CBT clinicians, and a group of CBT patients. A sample size calculation (G\*power) showed that, with a medium effect size (0.5), a power of 0.80, and a significance level of .05, 64 participants would be needed for each group. CBT clinicians were contacted via the British Association for Behavioural and Cognitive Psychotherapies (BABCP) contact list. They were asked to confirm that they were CBT practitioners (including training and accreditation status), and that they were delivering CBT in their professional setting. CBT patients were contacted via the University of Sheffield’s volunteer mailing lists, and by utilizing the services of a company that provides targeted responders. All participants were also asked to forward the survey to any other potential participants. Patients were offered monetary compensation for their participation. The characteristics of the groups are presented in the Results section.

**Measures and procedure**

A Qualtrics online survey was developed for each group (see appendices 4.4.1 and 4.4.2). Both surveys collected basic demographic information (age, gender, country of origin, ethnicity). Clinicians were also asked questions regarding their experience, theoretical orientation, caseload, and supervision received. The core part of the survey consisted of a list of several techniques commonly utilized in CBT (Cowdrey & Waller, 2015; Westbrook et al., 2007). Patients and therapists were asked to indicate the importance they attributed to each technique from a range to 1 to 7, where 1 was “unimportant” and 7 was “very important”.

In addition, patients who identified themselves as having a non-Anglo/European origin completed a measure of acculturation. The Vancouver Index of Acculturation (VIA; Ryder, Alden, & Paulhus, 2000 – see appendix 5.5) is a 20-item measure that distinguishes two forms of acculturation – the acquisition of new (mainstream) cultural tendencies, and the loss of old (heritage) cultural tendencies. The VIA showed adequate internal consistency (Cronbach’s alpha = 0.79 for the Heritage subscale, and 0.75 for the Mainstream subscale.

Finally, all therapists also completed the short version of the Intolerance of Uncertainty (IUS-12; Carleton, Norton, & Asmundson, 2007 – see appendix 5.6), which measures the individual’s response to uncertain situations. Responses are given on a Likert scale from one (not at all characteristic of me) to five (entirely characteristic of me). It has a strong internal consistency (Cronbach’s alpha = 0.91) and a high convergent validity with the original 27-item version (*r*=0.96). Confirmatory factor analysis demonstrates that it yields two scales – prospective anxiety (anxiety over not knowing what is going to happen if one acts) and inhibitory anxiety (avoidance of action due to not knowing the outcome).

**Data analysis**

The statistical analyses were carried out with SPSS v.22. Initially, principal components analysis was used to determine whether the therapy techniques formed meaningful factors. To address the first aim – comparing patients’ and clinicians’ technique preference, a *t*-test for independent samples was implemented. For the second aim, a paired *t*-test was used to determine whether clinicians attributed different levels of importance to the techniques according to their patient’s ethnic background. The third aim was addressed with a correlation analysis (Pearson’s *r*), to determine whether clinicians’ anxiety predicted technique preference. The fourth aim was addressed with a *t*-test for independent samples, comparing the importance that patients attributed to the techniques according to their cultural background (Anglo/European vs non-Anglo/European, following Hofstede et al.’s [2010] classification). Finally, the fifth aim was addressed with a correlational analysis (Pearson’s *r*), to determine whether patients’ technique preference was associated with their level of acculturation. A *p-*value of 0.05 was taken as significant for all analyses, and the hypothesis testing was two-tailed.

**Results**

**Sample characteristics**

*Patients.* As can be seen in Table 5.1, the patient sample consisted of 167 participants living in the UK, who indicated that they were currently receiving CBT or had received it in the past. Their mean age was 32.2 years old, and 70% of the patients were female. Most of the patients were born in the UK (82.6%), and the ones who were born elsewhere had a mean of 11.3 years living in the UK. The majority of the participants were students (76%). Most of the participants either had finished the treatment or were still under treatment (83.9%), and the remainder (16.1%) had started the treatment but had ended it early. More than half of the sample identified themselves as being from a White/Caucasian ethnicity (55.1%), followed by black/African descent (11.4%) and South Asian (7.8%). The participants were also asked to indicate the country of their cultural heritage. Following Hofstede’s classification (Hofstede et al., 2010), the sample was divided in two groups for the subsequent analyses - Northern/Western Europe and Anglo origin (‘Anglo/European’; 52.6%), and Non-Anglo/European (47.4%) origin.

*Therapists.* As Table 5.1 indicates, the therapist sample consisted of 83 participants living in the UK, who stated that they delivered or had delivered CBT to their patients. Therapists’ mean age was 53.6 years old, and most were women (74.7%). They had a mean of 22 years of experience as clinicians, and their mean duration of experience with CBT was 13.4 years. Most of the therapists received less than one hour of supervision per week (86.7%), and the rest received 1-2 hours of weekly supervision. Nearly all the clinicians identified their ethnicity as White/Caucasian (95.2%).

|  |  |  |
| --- | --- | --- |
| **Table 5.1. Sample characteristics** | | |
| Patients (n=167) | | |
|  | | n (%) |
| Country of origin | UK | 138 (82.6%) |
| Other | 29 (17.4%) |
| Gender | Female | 117 (70.1%) |
| Male | 45 (26.9%) |
| Non-binary | 5 (3%) |
| Student status | Undergraduate | 65 (38.9%) |
| Postgraduate | 62 (37.1%) |
| Non-student / Other | 40 (24%) |
| Ethnicity | White/Caucasian | 92 (55.1%) |
| Black/African descent | 19 (11.4%) |
| South Asian | 13 (7.8%) |
| East Asian | 7 (4.2%) |
| Middle Eastern | 3 (1.8%) |
| Hispanic | 6 (3.6%) |
| Mixed | 27 (16.2%) |
| Treatment completion | Yes | 125 (74.9%) |
| No | 26 (15.6%) |
| Continue in treatment | 15 (9%) |
| Therapists (n=83) | | |
|  | | N (%) |
| Gender | Females | 62 (74.7%) |
| Males | 21 (25.3%) |
| Ethnicity | White/Caucasian | 79 (95.2%) |
| Other | 4 (4.8%) |
| Supervision received | Less than 1 hour per week | 72 (86.7%) |
| 1-2 hours per week | 11 (13.3%) |

**Do techniques cluster in homogeneous groups?**

To reduce the quantity of techniques for the subsequent analyses, a principal component factor analysis with Varimax rotation was implemented. Eighteen techniques were initially included in the analysis, and after fixating the factor loading cut-off point to 0.4, and removing one item for lacking face validity, 16 techniques were classified in three meaningful factors (Table 5.2). This underlying factor structure explained 45.43% of the variance. Factor 1 included active techniques on which the main goal is to achieve a behavioural change in the patient, therefore, it was named ‘Change-oriented’. Factor 2 included more conversational techniques, hence, it was identified as ‘Interpersonal engagement’. Finally, Factor 3 included methods commonly utilized to reduce the patients’ emotional arousal. Therefore, it was named ‘Calming’.

**Table 5.2. Technique reduction with factor analysis**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Factors** | | |
|  | **Change-oriented** | **Interpersonal engagement** | **Calming** |
| Homework | **0.750** | -0.033 | 0.008 |
| Behavioural experiments | **0.747** | 0.059 | 0.055 |
| Agenda setting | **0.702** | 0.126 | 0.159 |
| Exposure | **0.640** | 0.244 | 0.133 |
| Behavioural activation | **0.578** | 0.012 | 0.162 |
| Goal setting | **0.533** | 0.101 | 0.327 |
| Surveys | **0.468** | 0.056 | 0.247 |
| Changing the meaning attached to thoughts | **0.409** | 0.255 | -0.213 |
| Exploring patterns in relating to others | 0.025 | **0.772** | 0.192 |
| Exploring childhood and past | 0.060 | **0.759** | 0.217 |
| Other problems | -0.101 | **0.685** | 0.335 |
| Alliance | 0.359 | **0.461** | -0.252 |
| Motivation | 0.470 | **0.445** | 0.170 |
| Psychoeducation | 0.315 | **0.412** | -0.031 |
| Mindfulness | 0.179 | 0.040 | **0.760** |
| Relaxation | 0.146 | 0.136 | **0.738** |
| Cronbach’s alpha | 0.795 | 0.729 | 0.723 |

Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser normalization. The rotation converged in 9 iterations.

**Patients’ and therapists’ opinions regarding the importance of CBT techniques**

Patients and therapists had different opinions regarding the importance of several CBT techniques (Table 5.3). Clinicians considered nearly all the Change-oriented techniques to be more important than the patients. The effect sizes of these differences ranged from medium to very high, which indicates a large discrepancy in patients’ and clinicians’ opinions. Clinicians also attributed greater importance to several Interpersonal engagement techniques, specifically: ‘alliance’, ‘motivation’ and ‘psychoeducation’. The effect sizes in this category ranged from medium to high. There was no significant difference in patients’ and clinicians’ opinions regarding the Calming factor overall. However, ‘relaxation’ was preferred by the patients.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Table 5.3. Comparison between patients’ and therapists’ opinions regarding the importance of CBT techniques** | | | | | | | |
|  | Patient | | Therapist | | *t* | *p* | *d* |
| *M* | *SD* | *M* | *SD* |
| **Change-oriented** | **4.735** | **0.983** | **5.808** | **0.847** | **8.487** | **<.001** | **1.16** |
| Homework | 4.683 | 1.793 | 6.319 | 1.052 | 9.063 | <.001 | 1.11 |
| Behavioural experiments | 4.096 | 1.718 | 5.970 | 1.243 | 9.836 | <.001 | 1.24 |
| Agenda setting | 4.174 | 1.732 | 5.723 | 1.552 | 6.888 | <.001 | 0.94 |
| Exposure | 4.988 | 1.686 | 6.325 | 0.932 | 8.066 | <.001 | 0.98 |
| Behavioural activation | 5.269 | 1.498 | 6.157 | 1.217 | 5.015 | <.001 | 0.65 |
| Goal setting | 4.838 | 1.658 | 5.518 | 1.733 | 3.007 | .003 | 0.40 |
| Surveys | 4.012 | 1.639 | 4.458 | 1.762 | 1.975 | .049 | 0.26 |
| Changing the meaning attached to thoughts | 5.826 | 1.362 | 5.994 | 1.464 | 0.894 | *NS* | - |
| **Interpersonal engagement** | **5.152** | **1.032** | **5.516** | **0.879** | **2.748** | **0.006** | **0.37** |
| Exploring patterns in relating to others | 5.114 | 1.561 | 5.181 | 1.503 | 0.505 | *NS* | - |
| Exploring childhood and past | 4.431 | 1.940 | 4.548 | 1.607 | 0.371 | *NS* | - |
| Other problems | 4.784 | 1.753 | 4.398 | 1.468 | 1.730 | *NS* | - |
| Alliance | 6.096 | 1.257 | 6.873 | 0.397 | 7.294 | <.001 | 0.83 |
| Motivation | 4.766 | 1.682 | 5.669 | 1.250 | 4.770 | <.001 | 0.60 |
| Psychoeducation | 5.725 | 1.360 | 6.428 | 1.036 | 4.536 | <.001 | 0.58 |
| **Calming** | **4.676** | **1.695** | **4.247** | **1.654** | **1.902** | ***NS*** | **-** |
| Relaxation | 4.886 | 1.841 | 4.199 | 1.947 | 2.727 | .007 | 0.36 |
| Mindfulness | 4.467 | 1.938 | 4.295 | 1.890 | 0.666 | *NS* | - |

Note: *NS*=Non-significant

**Importance of CBT techniques according to the patients’ ethnicity**

Clinicians did not differentiate technique importance according to their patient’s ethnicity (Table 5.4) – all were equally important for patients from their own ethnicity and for patients from a different ethnicity. The only exception was the individual technique ‘changing the meaning attached to thoughts’, which was regarded as less important for patients from a different ethnic background. However, the effect size for this difference was small.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Table 5.4. Therapists’ opinions regarding the importance of CBT techniques according to their patient’s ethnicity** | | | | | | | |
|  | Patient from same ethnicity | | Patient from different ethnicity | | *t* | *p* | *d* |
|  | *M* | *SD* | *M* | *SD* |
| **Change-oriented** | **5.845** | **0.824** | **5.771** | **0.967** | **1.084** | ***NS*** | **-** |
| Homework | 6.420 | 0.883 | 6.300 | 1.143 | 1.415 | *NS* | - |
| Behavioural experiments | 5.990 | 1.301 | 5.970 | 1.336 | 0.152 | *NS* | - |
| Agenda setting | 5.790 | 1.499 | 5.740 | 1.620 | 0.815 | *NS* | - |
| Exposure | 6.340 | 0.932 | 6.260 | 1.075 | 1.136 | *NS* | - |
| Behavioural activation | 6.200 | 1.255 | 6.140 | 1.363 | 0.587 | *NS* | - |
| Goal setting | 5.460 | 1.755 | 5.460 | 1.843 | 0.000 | *NS* | - |
| Surveys | 4.500 | 1.837 | 4.450 | 1.807 | 0.630 | *NS* | - |
| Changing the meaning attached to thoughts | 6.070 | 1.464 | 5.840 | 1.658 | 2.360 | 0.021 | 0.14 |
| **Interpersonal engagement** | **5.493** | **0.881** | **5.519** | **0.916** | **1.062** | ***NS*** | **-** |
| Exploring patterns in relating to others | 5.210 | 1.508 | 5.210 | 1.552 | 0.000 | *NS* | - |
| Exploring childhood and past | 4.500 | 1.621 | 4.540 | 1.645 | 0.773 | *NS* | - |
| Other problems | 4.370 | 1.552 | 4.450 | 1.518 | 1.062 | *NS* | - |
| Alliance | 6.870 | 0.411 | 6.880 | 0.399 | 1.000 | *NS* | - |
| Motivation | 5.610 | 1.297 | 5.670 | 1.300 | 1.092 | *NS* | - |
| Psychoeducation | 6.410 | 1.048 | 6.370 | 1.118 | 1.000 | *NS* | - |
| **Calming** | **4.203** | **1.675** | **4.269** | **1.740** | **0.890** | ***NS*** | **-** |
| Relaxation | 4.080 | 1.992 | 4.140 | 2.018 | 0.660 | *NS* | - |
| Mindfulness | 4.330 | 1.886 | 4.390 | 1.940 | 1.092 | *NS* | - |

Note: *NS*=Non-significant

**Clinicians’ anxiety and technique preference**

Clinicians’ anxiety was assessed to determine if it was associated with technique preference (Table 5.5). Therapists with high levels of prospective anxiety had a lower preference for ‘behavioural experiments’. Similarly, high levels of both prospective and inhibitory anxiety in clinicians were associated with a low preference for ‘exposure’.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Table 5.5. Correlation analysis between clinicians’ technique preference and anxiety level** | | | | |
|  | Prospective anxiety | | Inhibitory anxiety | |
| *r* | *p* | *r* | *p* |
| **Change-oriented** | **-0.015** | ***NS*** | **-0.059** | ***NS*** |
| Homework | 0.014 | *NS* | -0.085 | *NS* |
| Behavioural experiments | -0.250 | .026 | -0.220 | *NS* |
| Agenda setting | 0.162 | *NS* | 0.089 | *NS* |
| Exposure | -0.293 | .009 | -0.229 | .042 |
| Behavioural activation | 0.047 | *NS* | -0.083 | *NS* |
| Goal setting | 0.062 | *NS* | 0.111 | *NS* |
| Surveys | -0.074 | *NS* | -0.049 | *NS* |
| Changing the meaning attached to thoughts | 0.087 | *NS* | 0.113 | *NS* |
| **Interpersonal engagement** | **-0.088** | ***NS*** | **-0.046** | ***NS*** |
| Exploring the patterns in relating to others | -0.063 | *NS* | -0.084 | *NS* |
| Exploring childhood and past | 0.098 | *NS* | 0.117 | *NS* |
| Other problems | -0.218 | *NS* | -0.093 | *NS* |
| Alliance | 0.118 | *NS* | 0.155 | *NS* |
| Motivation | -0.186 | *NS* | -0.097 | *NS* |
| Psychoeducation | -0.064 | *NS* | -0.075 | *NS* |
| **Calming** | **-0.075** | ***NS*** | **-0.050** | ***NS*** |
| Relaxation | -0.005 | *NS* | -0.029 | *NS* |
| Mindfulness | -0.113 | *NS* | -0.074 | *NS* |

Note: *NS*=Non-significant

**Differences in patients’ opinions regarding the importance of CBT techniques according to their ethnicity**

Some differences were found regarding the importance attributed to some individual CBT techniques according to the patients’ cultural background (Table 5.6). Specifically, non-Anglo/European patients considered some Change-oriented techniques more important than Anglo/European patients. In contrast, Anglo/European patients considered ‘alliance’ more important than non-Anglo/Europeans. In summary, non-Anglo/Europeans considered a wider range of techniques to be more important than Anglo/Europeans.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Table 5.6. Patients’ opinions regarding the importance of CBT techniques according to their cultural background** | | | | | | | |
|  | Anglo/European | | Non-Anglo/European | | *t* | *p* | *d* |
|  | *M* | *SD* | *M* | *SD* |
| **Change-oriented** | **4.615** | **0.957** | **4.870** | **0.999** | **1.684** | ***NS*** | **-** |
| Homework | 4.818 | 1.752 | 4.532 | 1.838 | 1.031 | *NS* | - |
| Behavioural experiments | 3.977 | 1.781 | 4.228 | 1.648 | 0.940 | *NS* | - |
| Agenda setting | 3.864 | 1.762 | 4.519 | 1.639 | 2.479 | .014 | 0.38 |
| Exposure | 4.739 | 1.822 | 5.266 | 1.482 | 2.059 | .041 | 0.31 |
| Behavioural activation | 5.193 | 1.581 | 5.354 | 1.405 | 0.693 | *NS* | - |
| Goal setting | 4.636 | 1.736 | 5.063 | 1.547 | 1.670 | *NS* | - |
| Surveys | 3.750 | 1.510 | 4.304 | 1.734 | 2.205 | .029 | 0.34 |
| Changing the meaning attached to thoughts | 5.943 | 1.316 | 5.696 | 1.408 | 1.171 | *NS* | - |
| **Interpersonal engagement** | **5.170** | **0.972** | **5.132** | **1.101** | **0.234** | ***NS*** | **-** |
| Exploring patterns in relating to others | 5.182 | 1.565 | 5.038 | 1.564 | 0.593 | *NS* | - |
| Exploring childhood and past | 4.193 | 2.033 | 4.696 | 1.807 | 1.682 | *NS* | - |
| Other problems | 4.739 | 1.771 | 4.835 | 1.742 | 0.355 | *NS* | - |
| Alliance | 6.318 | 1.000 | 5.848 | 1.459 | 2.401 | .018 | 0.37 |
| Motivation | 4.773 | 1.672 | 4.759 | 1.703 | 0.051 | *NS* | - |
| Psychoeducation | 5.818 | 1.335 | 5.620 | 1.389 | 0.938 | *NS* | - |
| **Calming** | **4.511** | **1.728** | **4.860** | **1.648** | **1.333** | ***NS*** | - |
| Relaxation | 4.648 | 1.900 | 5.152 | 1.747 | 1.778 | *NS* | - |
| Mindfulness | 4.375 | 1.984 | 4.570 | 1.892 | 0.647 | *NS* | - |

Note: *NS*=Non-significant

**Patients’ technique preference and acculturation**

To assess whether acculturation was associated with technique preference in the non-Anglo/European sample, a correlation analysis was used (Table 5.7). In general, higher levels of acculturation (VIA Mainstream) were related to a preference for a wider range of individual techniques – particularly for Interpersonal engagement and Calming techniques.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Table 5.7. Correlation analysis between non-Anglo/European patients’ technique preference and acculturation level** | | | | |
|  | VIA Heritage | | VIA Mainstream | |
| *r* | *p* | *r* | *p* |
| **Change-oriented** | **0.138** | ***NS*** | **0.091** | ***NS*** |
| Homework | 0.121 | *NS* | 0.116 | *NS* |
| Behavioural experiments | -0.009 | *NS* | -0.062 | *NS* |
| Agenda setting | 0.184 | *NS* | 0.013 | *NS* |
| Exposure | -0.001 | *NS* | 0.117 | *NS* |
| Behavioural activation | 0.202 | *NS* | 0.124 | *NS* |
| Goal setting | 0.131 | *NS* | 0.021 | *NS* |
| Surveys | -0.064 | *NS* | 0.041 | *NS* |
| Changing the meaning attached to thoughts | 0.16 | *NS* | 0.105 | *NS* |
| **Interpersonal engagement** | **0.223** | ***NS*** | **0.200** | ***NS*** |
| Exploring patterns in relating to others | 0.216 | *NS* | 0.258 | .025 |
| Exploring childhood and past | 0.075 | *NS* | 0.068 | *NS* |
| Other problems | 0.214 | *NS* | 0.079 | *NS* |
| Alliance | 0.066 | *NS* | 0.110 | *NS* |
| Motivation | 0.192 | *NS* | 0.234 | 0.042 |
| Psychoeducation | 0.14 | *NS* | 0.066 | *NS* |
| **Calming** | **0.183** | ***NS*** | **0.021** | ***NS*** |
| Relaxation | 0.162 | *NS* | 0.323 | .004 |
| Mindfulness | 0.12 | *NS* | 0.162 | *NS* |

Note: VIA=Vancouver Index of Acculturation; *NS*=Non-significant

**Discussion**

The main aim of this study was to explore clinicians’ and patients’ opinions about the importance of several techniques commonly used in CBT, and to address how cultural and ethnic background play a role in their opinions. After an exploratory factor analysis, the techniques clustered into three categories – Change-oriented, Interpersonal engagement, and Calming techniques. This pattern is slightly different to that suggested by Levita et al., (2016). However, their groupings of techniques was ‘a priori’, whereas the present set are empirically derived, using an exploratory factor analysis.

In line with our hypotheses, clinicians and patients had different opinions regarding technique importance. Therapists valued nearly all Change-oriented techniques and several Interpersonal engagement techniques more than the patients. This difference might be related to the fact that, given their training, clinicians are more knowledgeable than the patients about the benefits of the techniques. The fact that clinicians valued some techniques more than the patients might reflect the clinicians having a paternalistic approach to therapy (Charles, Gafni, & Whelan, 1999). In the paternalistic approach, therapists believe that they can determine what is in the patient’s best interest, with little or no patient involvement (Emanuel & Emanuel, 1995). It should also be remembered that clinicians often over-estimate their performance (Parker & Waller, 2015; Walfish et al., 2012), which might mean that clinicians’ qualifications might not be a guarantee that their opinion is correct. The only technique that was preferred by the patients over the therapists was ‘relaxation’. Since ‘relaxation’ is a concept commonly utilized in contexts outside CBT, patients may be familiar with it, making them more likely to value it.

Another main finding was that clinicians give the same level of importance to nearly all the techniques, regardless of the patients’ ethnic background. This was an unexpected finding, given the large amount of literature recommending that clinicians should modify therapy to accommodate the presumed needs of ethnically diverse patients (American Psychological Association, 2003; Hinton & Patel, 2017; Soto, Smith, Griner, Rodríguez, & Bernal, 2018; Sue et al., 2009). It appears that, if clinicians are making any cultural modifications to CBT, they are not focusing on core modifications, but rather peripheral ones (Chu & Leino, 2017). Furthermore, previous research reported that they would not use some elements of CBT (e.g. exposure) with patients from ethnic minorities (Meyer et al., 2014), but such finding was not replicated here. All these findings are an indication that there is still no consensus about when and how to adapt therapy.

Therapists valued the techniques differently according to their level of anxiety. Most notably, highly anxious clinicians attributed a lower importance to ‘behavioural experiments’ and ‘exposure’ than less anxious clinicians. This finding is consistent with the existing literature (e.g. Levita et al., 2016; Meyer et al., 2014; Turner et al., 2014). The pattern indicates that anxious clinicians tend to avoid the most stress-inducing techniques of CBT, instead focusing on the less anxiety-inducing and challenging elements of therapy (e.g. talking techniques).

Non-Anglo/European patients had a higher preference for Change-oriented techniques than Anglo/Europeans. Cross-cultural studies have suggested that people from non-Anglo/European origins share characteristics such as collectivism and high uncertainty avoidance (Hofstede et al., 2013), which might have been expected to make them prefer the less challenging aspects of therapy (e.g. conversational or relational techniques). However, this was not the case in our study. There are several ways of interpreting this finding. First, it might be that the cultural theories are becoming less relevant, given the impact of social media and other technological advances. Second, it is possible that the age of the patients affected this result, since most of them were young university students. Young people are usually more prone to risk-taking (e.g. Feldstein & Washburn, 1980). Consequently, they may be more willing to cope with the challenging aspects of CBT, regardless of their ethnic background.

Finally, highly acculturated patients from non-Anglo/European origins considered a wider range of techniques to be important – particularly those from the Interpersonal engagement factor. High levels of acculturation in people from ethnic minorities has been linked to some positive aspects of therapy, such as help-seeking, stigma tolerance (Zhang & Dixon, 2003) and retention rates (Brocato, 2013). Our findings highlight the necessity of evaluating patients’ acculturation levels before considering making cultural adaptations to CBT.

**Limitations**

Our research has some limitations. The type and form of CBT received by the patients is not well known. For example, they could have engaged with self-help or on-line versions of CBT. Therefore, future research should screen the type of CBT received by patients more carefully. The patient sample was relatively small, and most of the participants were students. A larger, more diverse sample would allow for comparison of more clearly-defined cultural groups (Hofstede et al., 2010). Also, more robust conclusions could be reached if one were to utilize an experimental design or direct observation in clinical settings. Finally, the study should be extended to cover other forms of therapy besides CBT, to determine patterns of similarity or difference in the views of patients and therapists in those other approaches.

**Clinical implications**

Matching clinicians’ and patients’ perceptions about what elements of therapy are important is encouraged, as is discussing the rationale for the therapeutic techniques as treatment progresses. Without that openness, difference in their views about what is more or less helpful in therapy might result in a higher dropout risk. Patient participation in decision-making has yielded good results in psychotherapy (Mergl et al., 2011) and in other health settings (Guadagnoli & Ward, 1998). Finally, we should not automatically assume that a patient will need a culturally adapted version of CBT because of their ethnic background. Acculturated patients might consider such modifications less necessary.

**Conclusion**

Patients and clinicians differed in what they considered important in CBT – clinicians considered most of the techiques more important than their patients. These preferences were affected by both patients’ and clinicians’ cultural origins, but not always in the way cultural theories would have predicted. Clinicians are encouraged to have the openness to discuss with their patients the best way of addressing their cultural needs in therapy.

**Chapter VI**

**General discussion**

**Summary of aims**

The general aim of this thesis was to explore therapist drift – a phenomenon that occurs when clinicians do not deliver the best therapy available (Waller, 2009) – in the delivery of CBT in contexts outside the Anglo/European one. Since most of the research on therapist drift has come from these Anglo/European, highly developed countries, this investigation was based on the premise that therapist drift could manifest differently in different cultural settings. This assumption is grounded on the findings of several cross-cultural studies, where marked differences in some cultural dimensions have been found between Anglo/European countries and other parts of the world (e.g. Hofstede et al., 2010; Minkov, 2013). Those cultural dimensions include individualism, assertiveness, uncertainty avoidance, and respect for hierarchies. A study from Hofstede & McCrae (2004) linked these cultural dimensions to personality (e.g. uncertainty avoidance was predicted by high levels of neuroticism and low levels of agreeableness). Such links suggest that these cultural differences can also be observed at the individual level, in the form of personality traits.

Besides these cultural factors, this thesis also aimed to explore what additional variables could influence CBT delivery. A substantial amount of research regarding the factors that could affect therapist drift has been generated in recent years. Clinician-related variables such as anxiety (Meyer et al., 2014), experience (Wisniewski et al., 2018), age (Waller et al., 2012), and personality traits (Peters-Scheffer et al., 2013) have been previously linked to therapist drift. Some of these variables were explored in this thesis, along other patient-centred variables, such as the patients’ emotional state, gender, ethnicity, and preferences within the CBT delivery process. We also included variables related to therapy modifications – specifically, adapting CBT to accommodate patients from different cultural backgrounds.

**Summary of these findings in relation to the wider literature**

For the purposes of this thesis, a series of empirical studies were carried out to explore therapist drift in the delivery of CBT in Latin American countries. Those studies consisted of:

1. A systematic review regarding cultural adaptations of CBT for Latin American patients;
2. A comparative study assessing therapist drift in Latin America and the United Kingdom;
3. A vignette-based study evaluating the influence of patients’ mood and gender and clinicians’ country of origin on CBT delivery; and
4. A comparative study of clinicians’ and patients’ perceptions of the importance of CBT techniques (the sample of patients was multi-cultural, not only restricted to Latin American patients).

Overall, different patterns of drift were found between these cultural settings. The results from this thesis indicated that the factors that can influence CBT delivery in both Anglo/European countries and non-Anglo/European countries can be classified in three main categories: 1) Purposeful factors; 2) Implicit factors; and 3) Personal factors. Purposeful factors are the ones that accomplish a specific goal within the therapeutic process, and are implemented by clinicians in a deliberate way. An example of these purposeful factors is the adaptations made to CBT for specific populations (e.g. CBT modified for elderly patients, for children and adolescents, or for patients from ethnic minorities). Implicit factors are ones related to clinicians’ own preconceptions about their patients, often founded in biases and stereotypes. For example, a clinician might unconsciously conduct the therapy in a less demanding way with a patient who the clinician considers ‘fragile’ (e.g. a pregnant woman, a patient with comorbid depression). Finally, personal factors are those related to the clinicians’ personality traits. For example, clinicians with elevated uncertainty avoidance might be less likely to implement what they see as the most anxiety-inducing techniques with their patients. The nature of these factors is described in greater detail below.

***Purposeful factors that can affect CBT delivery.*** As briefly mentioned above, purposeful factors are the ones that serve a specific purpose within the therapy process. These factors are based on decisions that clinicians make deliberately. For example, clinicians might underuse, omit, or modify some elements of CBT because they explicitly believe that is for the patients’ own benefit.

A purposeful factor explored in this thesis was the use of cultural adaptations of CBT for patients from different cultural backgrounds. These cultural modifications of therapy are largely encouraged by researchers and professional associations (American Psychological Association, 2003; Organista & Muñoz, 1996), and clinicians might apply them believing they are in the patients’ best interests. However, the necessary development and training of clinicians in such adaptations is not without cost, so one needs to be able to demonstrate that such adaptations are justified by resulting in better outcomes. At least for CBT, this justification might not be present. The systematic review presented in Chapter II showed that culturally adapted CBT did not show any additional benefits compared to non-adapted CBT for Latin American patients. Therefore, while trying to follow these guidelines and recommendations, clinicians might be investing time and effort needlessly. Although several meta-analytic studies encourage adapting therapy for Latin American patients (e.g. Griner & Smith, 2006; Huey & Polo, 2008), none of these studies was focused in the particular case of CBT. Even when cultural adaptations might be beneficial for this population, this appears to be less necessary in the case of CBT. Therefore, it is necessary to acknowledge that guidelines and clinical recommendations regarding cultural adaptations of therapy are not always generalizable for all therapies, nor for all patients.

The papers analysed in the systematic review (Chapter II) also revealed that cultural adaptations of CBT vary widely in type and extent. Although most of the adaptations were peripheral (adaptations focused in the type of materials utilised and the way of engaging the patients), a considerable number of the adaptations were unspecified. This is worrisome, given that transparency is needed to identify which aspects of culturally-adapted interventions are the ones that improve therapy outcomes. These inconsistencies about when and how to culturally adapt CBT were also found in the fourth study presented in this thesis (Chapter V). The results of study 4 indicated that, when delivering CBT, clinicians considered all the CBT techniques equally important, regardless of the patients’ ethnicity. The lack of consensus about which elements to keep and which elements to culturally modify in therapy has been previously acknowledged (Soto et al., 2018), and continues to be an obstacle for the further development of culturally-adapted therapies.

Some efforts have been made to develop evidence-based approaches to culturally-modify therapy (e.g. Naeem et al., 2016; Rathod, Phiri, & Naeem, 2019). However, these approaches are far from being universally implemented, and have been tested for only some cultural groups. Although literature can be found about how to culturally-adapt therapy for Latin American patients, it has two major limitations: 1) these guidelines are based on anecdotal information and clinical judgement, and are not empirically-based (Naeem et al., 2016); and 2) the guidelines are not for the specific case of CBT for Latin American, but rather a guideline about how to be culturally sensitive in general. Most of the literature suffers from one or both of these limitations. Therefore, the lack of a clear, evidence-based approach regarding cultural adaptations of CBT for Latin American patients, along with the results of study one’s systematic review (Chapter II), makes these cultural modifications hard to justify at present.

The decisions that clinicians make on behalf of their patients and their influence in CBT delivery were also explored in the fourth study (Chapter V). In this study, patients’ and clinicians’ opinions regarding which techniques they considered important in CBT were compared. The results of this study indicated that clinicians considered almost all the techniques more important than the patients did. This disagreement among clinicians and patients can signify a risk for the therapeutic process, since it can result in patient dissatisfaction, and even treatment drop-out. Even when clinicians might consider that the decisions they take while delivering therapy are in the patients’ best interests, clinicians often overestimate their performance. This overestimation was evidenced in the second study of this thesis (Chapter III), and in other similar papers (e.g. Parker & Waller, 2015; Walfish et al., 2012). Performance overestimation might make clinicians believe that they are already competent enough, and thus make them less receptive to their patients’ needs and the relevant evidence.

***Implicit factors that can affect CBT delivery.*** Implicit factors are those related to clinicians’ own preconceptions about themselves and about their patients. These factors are not influential in a conscious way, but are rather ingrained in schemas, stereotypes and prejudices deeply rooted within the clinician’s psyche. These preconceptions might be an expression of their own cultural values. For example, exposure might be used less by clinicians from collectivistic societies, given its anxiety-inducing nature and how that could be seen as jeopardising for the patient-clinician relationship, which is more highly valued in these cultures. Similarly, clinicians working with depressed patients might inadvertently approach the treatment in a more cautious way, believing that depressed people are less resilient to the demands of CBT.

In this thesis, one of the implicit factors explored was how clinicians’ cultural values affected CBT delivery. In the second study (Chapter III), patterns of CBT delivery were explored among Latin American and British clinicians. Overall, British clinicians delivered a wider range of techniques than Latin American clinicians (this result was obtained again in the third study [Chapter IV]). In comparison to British clinicians, clinicians from Latin America preferred the less challenging techniques. This pattern might reflect the more agreeable, non-confrontational style of clinicians from Latin American cultures. Even though the literature extensively recommends taking the patient’s culture in consideration while planning therapy, the results presented in the second study (Chapter III) indicate that clinicians’ culture also matters. The way therapists’ own culture affects therapy delivery should be acknowledged by clinicians, as well as being further investigated by researchers.

The third study (Chapter IV) showed how clinicians’ own internal biases might affect CBT delivery. This vignette-based study evaluated the likelihood of Mexican and British clinicians utilizing several CBT techniques according to patients’ mood and gender. Overall, clinicians delivered fewer techniques to angry patients, especially if they were female. These findings demonstrate that clinicians might be falling into a gender stereotype, believing that female patients are less resilient to a more demanding style of therapy. This gender differentiation was more marked for British clinicians, who were more likely to deliver a wider range of techniques to male patients. One might have expected that such gender differentiation would be more noticeable in Mexican clinicians, given the low gender-egalitarianism found in Mexican society compared to the UK (Mac Giolla & Kajonius, 2018). However, this was not the case here. Similar results have been found previously. For example, Costa et al., (2001) found that gender differences in personality were more pronounced in European and American participants. Mac Giolla and Kajonius (2018) replicated this finding regarding sex differences in personality being larger in more gender-equal countries (e.g. Norway, Sweden or the Netherlands, compared to China, Malaysia or Japan).

Patients’ implicit factors also had an influence in CBT delivery. The results presented in the fourth study (Chapter V) revealed that non-Anglo/European patients had a higher preference for ‘Change-oriented’ techniques, in comparison to Anglo/European patients. However, this preference for Change oriented techniques was related to acculturation – high levels of acculturation predicted this preference for Change oriented techniques in non-Anglo/European patients. Given the potential stress-inducing nature of Change-oriented techniques, it was expected that most non-Anglo/European patients would prefer the Cognitive relational techniques. This hypothesis was made assuming that non-Anglo/European patients might consider Change oriented techniques not only intrinsically stress-inducing, but also culturally incompatible with their values. These findings indicate that patients from the same cultural background do not necessarily form a homogeneous group. The assumption that all people from a certain cultural group have the same opinions, needs and preferences might sometimes be founded in simple stereotypes rather than in reality.

***Personal factors that can affect CBT delivery.*** Personal factors are those related to clinicians’ own psychological characteristics. These might include factors such as clinicians’ personality traits, mood, or anxiety. Across all the studies presented in this thesis, several clinicians’ personal factors were related to CBT delivery. As presented in the second study (Chapter III), clinician personality needs to be considered. For example, more extraverted clinicians were more likely to use a wider and more mixed range of CBT techniques. This link of extraversion and technique preference has been found before in Mulkens et al.'s (2018) study, although their findings were specifically in the case of CBT for eating disorders. Openness to experience was also linked to the use of a wider range of CBT techniques. Openness predicted the use of several well supported techniques (e.g. coping in the present and in the future, homework, agenda setting). In contrast, Peters-Scheffer et al. (2013) found that low levels of openness to experience increased therapy adherence. However, this finding was for the treatment of autism in children, which might explain the difference in the outcomes.

Other personality traits linked to technique usage were firmness and empathy. Although the importance of these factors in the delivery of CBT has previously been acknowledged (Waller, Evans, & Stringer, 2012; Waller & Mountford, 2015), their combined influence has been little explored in an empirical way. The results obtained in the third study (Chapter IV) revealed that empathy could help clinicians to deliver CBT techniques, according to the patients’ emotional status. Highly empathetic clinicians delivered a more ‘dynamic’ intervention to emotionally aroused patients, using a wider range of techniques, particularly behavioural techniques and exposure. On the other hand, highly empathetic clinicians delivered a more calming intervention for less emotionally aroused patients, utilizing fewer techniques, with a focus on talking techniques. Empathy has been shown to improve therapy outcomes – a study from Burns & Nolen-Hoeksema (1992) showed that patients who were treated by highly empathetic clinicians had a greater improvement on their depression symptoms, compared to those who were treated by less empathetic clinicians. Therefore, empathy is a useful tool for both clinicians and patients – it helps clinicians to plan their therapy, and it promotes patients’ recovery. Firmness is a concept that has been less explored within the delivery of CBT. The results of the third study (Chapter IV) indicated that the firmer the clinicians, the fewer techniques they use, probably reflecting a stronger focus on core CBT methods. Although firmness can be useful for increasing therapy adherence, the consequences of being overly-firm in therapy are yet to be tested. Furthermore, the fact that clinicians are firmer with male than with female patients does not appear to have a valid justification.

Anxiety is a psychological factor that has been linked to the way clinicians deliver therapy in several studies (e.g. Levita et al., 2016; Meyer et al., 2014; Simpson-Southward et al., 2016). This link was once again confirmed by the results presented on the fourth study (Chapter V). Highly anxious clinicians were less likely to deliver techniques such as exposure and behavioural experiments to their patients. Given the stressful nature of the behavioural elements of CBT, clinicians might avoid these techniques as a safety behaviour – namely, the patient gets anxious with these techniques, and consequently, the therapist gets anxious too. To evade this anxiety, clinicians avoid behavioural techniques. However, even though avoiding the challenging elements of CBT might decrease both patients’ and clinicians’ anxiety on the short-run, the likely consequence is that the full benefits of CBT will not be delivered to the patient (Waller & Turner, 2016)

**Relationship of these findings to theory**

This thesis has five major theoretical implications, relating to: 1) the pertinence of making cultural adaptations; 2) the different patterns of therapist drift in different cultures; 3) the way in which patients’ characteristics affect the way clinicians deliver CBT; 4) the relevance of clinicians’ own characteristics in how they deliver CBT; and 5) the preferences of both patients and clinicians regarding CBT delivery. These theoretical implications are detailed below.

***Cultural adaptations of CBT.*** One of the most surprising findings of this thesis was the fact that culturally adapted CBT had the same outcomes as conventional, non-adapted CBT for Latin American patients. There are several potential reasons for this unexpected finding. One possible explanation is that the nature of CBT might be already compatible with Latin American patients’ preferences. Organista & Munoz (1996) have previously acknowledged the common areas between CBT characteristics and the preferences of Latin American patients. Citing Miranda (1976), Organista & Munoz state that Latin American patients usually look for quick symptom relief, guidance, and a problem-centred therapeutic approach. This pattern can be related to the hierarchical, uncertainty-avoidant, and short-term orientated values associated with Latin American cultures (Hofstede et al., 2010). The need for quick symptom relief and problem-centred treatment can be achieved with CBT, given that CBT has proven to have positive effects for many patients in fewer than 10 sessions (Delgadillo et al., 2014; Edinger, Wohlgemuth, Radtke, Coffman, & Carney, 2007; Waller et al., 2018). Similarly, CBT’s structured, manualized delivery might satisfy Latin American patients’ need for a guided, directive approach.

An additional possibility to consider is that Latin America might not be too culturally different from Anglo/European cultures. Even though Latin America does not belong to Hofstede’s et al. (2010) Anglo/European classification, it is undoubtedly a ‘westernised’ country. As a former Spanish colony, Latin America has been influenced by the ‘western culture’ for centuries, while maintaining its pre-Hispanic roots. This influence, along with factors such as the access to technological advances (e.g. internet, TV), migration, and the geographical closeness of Latin America to the United States, might have reduced this cultural distance even more in recent times, especially in younger generations. Nevertheless, cultural adaptations of CBT might be appropriate in some cases. Older patients, patients from ethnic minorities in vulnerable situations (e.g. irregular immigration status – Benuto & Leany, 2018), or patients from countries or ethnicities with a greater ‘cultural distance’ from the general ‘western’ values, might all benefit from these adaptations.

Besides following the recommendations regarding cultural adaptations of CBT, clinicians might tend to make these adaptations for other reasons. For example, Anglo/European clinicians might obtain a sense of security by classifying their ‘ethnically diverse’ patients under a label such as ‘Latino’, ‘Black’, ‘Asian’, etc. This way, by attributing certain characteristics to their patients, clinicians’ anxiety about what is different from them can be reduced. Another fact to consider is that a lot of emphasis is made on ‘adapting’ therapy for cultures outside the Anglo/European ones, but it appears to be less recommended the other way around. Techniques commonly used in CBT such as mindfulness – a technique rooted in the eastern tradition – has not had any sort of structured consideration of adaptation for Anglo/European patients. This disparity could reflect Anglo/European clinicians being reluctant to let other cultures implement ‘their’ therapy as it is, but believing that they can take elements of therapy originating elsewhere without considering any form of adaptation.

Distancing other cultures from the ‘mainstream’ Anglo/European one might be a deeply-rooted idea. It is not uncommon to see certain cultural groups mocked and stereotyped by people in other countries. This pattern can be interpreted as the need of societies to have a ‘scapegoat’ to claim superiority over. This perceived superiority can also be seen in other areas of human behaviour. For example, a study by Dupree and Fiske (2019) found that White liberals utilise a less sophisticated language when they address non-White ethnic minorities. This style of approach can be considered patronising, resulting in a stereotype where minorities are perceived as less capable of grasping complex vocabulary. Dupree and Fiske’s (2019) findings can be extrapolated to the case of culturally adapted CBT, where clinicians and researchers might believe that CBT is ‘too abstract’ for other cultures, and therefore it needs to be modified in a way that matches the other cultures’ perceived ‘limited’ capacities.

***Cultural differences in CBT delivery style between countries.*** Even though researchers and associations have emphasized the patients’ cultural background, the findings of this thesis indicated that clinicians’ cultural background might be even more relevant in CBT delivery. In comparison to British clinicians, Latin American clinicians utilised a more restricted range of techniques while delivering CBT to their eating-disordered patients. This pattern of therapy delivery by Latin American clinicians might reflect their collectivistic, uncertainty-avoidant nature. Due to the high value of harmonious interpersonal relationships in collectivistic societies, Latin American clinicians might be utilising fewer techniques in order to avoid distressing the patient and, therefore, endanger the relationship. Instead, Latin American clinicians might focus on the delivery of relational techniques (e.g. motivation work, talking about topics that are not related to the main reason for the consultation).

Clinicians’ cultural differences were also observed in their level of self-assessment, which was higher in Latin American clinicians. Even with this high value placed on personal relationships, Latin American societies are also high in power distance. Since power distance is about the respect to hierarchies in personal relationships, Latin American clinicians might view themselves as the ones who are ultimately in charge of the therapeutic process. With such a position in this hierarchy, clinicians might over-estimate their performance as a way of reassuring themselves about their competence, and thus reaffirming their position in this hierarchical relation. This combination of collectivism and respect for hierarchies in Latin American societies can result in the clinicians’ need to fulfil the role of a ‘benevolent figure of authority’ (Hofstede, 1980).

***The influence of patients’ mood and gender in CBT delivery.*** Another main theoretical contribution of this thesis is understanding the influence of patients’ emotional state and gender in the delivery of CBT. An example of this influence was the low use of exposure for calm and angry patients. There are alternative ways of interpreting this finding regarding calm patients and exposure: 1) clinicians might consider that, if the patient is calm, then their case is not too severe, and therefore the patient does not need an intensive intervention; or 2) clinicians want to keep the patient calm, avoiding a potentially stressful situation that could increase both patient’s emotional arousal and clinician’s anxiety. In the case of exposure use for angry patients, this technique was especially underused for females. Angry females might represent a particularly difficult patient for clinicians. Given their emotional arousal, angry female patients might be perceived as intimidating and hard to handle, and might make the clinician anxious. In parallel, clinicians might consider their angry female patients to be less resilient to a demanding intervention. Instead, clinicians might focus on delivering a style of CBT that emphasises talking techniques, in an attempt to calm the patient.

***The relevance of clinicians’ personality characteristics in CBT delivery.*** Another theoretical contribution of this thesis is the influence of clinician’s personality in CBT. An example of these variables was extraversion, which predicted the use of a wider range of techniques. An explanation for this finding is that, given the fact that extraverted individuals are usually less able to tolerate routine, the use of a wide range of techniques might satisfy clinicians’ need for variety and novelty.

Another personality factor that predicted a wider range of technique use was ‘openness to experience’. Open clinicians might have a higher need for novel, challenging experiences within therapy, which can be satisfied by having a wider range of techniques to choose from. Even though these personality characteristics might be seen as valuable for clinicians while delivering therapy, it is necessary to consider the risks of being overly-extraverted or overly-open while delivering therapy. Clinicians with high levels of extraversion or openness might be too flexible while delivering therapy, putting them at risk of utilizing methods with less empirical support (e.g. looking at other issues besides the referral problem).

Clinicians’ empathy and firmness also impacted CBT delivery. Empathetic clinicians utilised, arguably, the most appropriate techniques for the patients’ emotional state (e.g. talking more with their calm patients, doing more behavioural work with emotionally aroused patients). On the other hand, firmness was associated with the implementation of a more focused range of techniques. Although this focused approach can be interpreted as a targeted style of therapy, it could also reflect a degree of inflexibility on the part of clinicians. This firmness can be seen as a safety behaviour by clinicians, where they only utilise the techniques with which they already feel comfortable. Excessive firmness might also make clinicians reluctant to acknowledge their patients’ needs and opinions. This reluctance can also reflect a paternalistic approach to therapy (Emanuel & Emanuel, 1992), where clinicians take full control of the psychotherapeutic process, and disregard their patients’ needs.

The effects of clinicians’ anxiety in CBT delivery have been widely demonstrated. In this thesis, this effect was once more confirmed. Waller & Turner (2016) have previously discussed the reasons why clinicians’ anxiety affects therapy delivery. They refer to the concept of ‘uncertainty avoidance’, given that, while delivering CBT, neither the clinicians nor patients know for sure what is going to happen when implementing change. Beyond this uncertainty about the effects of change, clinicians might also be uncertain about how the process of CBT delivery might develop. Not knowing how the patient might react while delivering some techniques, especially the most challenging ones, might increase clinicians’ anxiety, and make them more prone to drift from evidence-based manuals and protocols.

***Differences in patients and clinicians’ opinions regarding the important aspects of CBT.*** The discrepancies in what clinicians and patients consider important within CBT also have theoretical implications. The fact that clinicians considered more techniques important than the patients might reflect their specialist knowledge, but might also be another indication of the tendency of therapists to adopt a paternalistic approach in therapy (Emanuel & Emanuel, 1992). This paternalistic approach might give clinicians a sense of control. However, this control is not always the best for the patient. CBT is a collaborative effort, where the role of the clinician is certainly important, but ultimately, is the patient who must do most of the work. Even when the use of a paternalistic approach can sometimes be useful (VandeCreek & Brace, 1991), its implementation must be well-justified, assessing the benefits and repercussions of this approach.

Another of the most salient theoretical contributions of this thesis was the fact that clinicians gave the same importance to CBT techniques regardless of the patients’ ethnic background. This pattern of responses can be seen from the perspective of social desirability. Clinicians might believe that prioritizing some techniques for a cultural group and not for the other could reflect discrimination, and therefore, they prefer to deliver therapy in a ‘colour-blind’ way. Another possibility (and potentially a more realistic one) is that clinicians genuinely ignore or are unaware of how to match the techniques to their patients’ cultural needs, reflecting a lack of cultural competency. Even though the results of this thesis indicated that cultural adaptations of CBT might not always be necessary, that does not mean that they are not necessary for any cultural group.

**Clinical implications**

The results of this thesis indicate that therapist drift is a phenomenon that occurs across different countries, and that there are several reasons behind such drift. In developing countries (e.g. Latin American countries), therapist drift might occur due to factors such as clinicians’ case overload (given the limited access to mental health services), poor training, lack of clinicians’ practice regulation, or the use of approaches with low empirical support. However, apart from these practicalities, therapist drift can also occur as a result of cultural factors.

The definition of ‘culture’ and what it involves can vary from the perspective of researchers, clinicians and patients. Therefore, the way in which we should address culture in therapy can also vary. It is necessary to avoid relying on our own personal judgements about what could be the best for the patients, given that our judgement is often based on biases and stereotypes. Clinicians should be encouraged to have a conversation with their patients, so they can identify and discuss together the best way of addressing any cultural needs. The use of acculturation assessment tools might also be helpful to better understand patients’ needs. The key issue is not assuming that all the patients from cultural settings different to the Anglo/European have the same values, behaviours, and preferences. As Owen et al. (2016) suggest, race or ethnicity may not be the most important aspect of the patients’ identity or relate to their referral reason. Therefore, it is necessary to let the patient choose which part of their identity is the one that can be addressed in therapy, in a way that helps to achieve their recovery.

Even when some of the results of this thesis indicated that patients and clinicians do not always fit within the cultural descriptions commonly attributed to them, some patients will want clinicians to put an extra effort to address their cultural needs. During the data collection of the fourth study of this thesis (Chapter V), a participant of African descent contacted the main researcher through e-mail. In this e-mail, the patient shared their negative experience regarding psychological treatments with White therapists. The patient said:

“I realised some time ago that it was impossible to continue with therapy because none of the White therapists I was seeing understood my cultural position, and, any time that I brought up the racism I had experienced and how it had impacted me, a strange phenomenon of defensiveness and gas-lighting occurred each and every time. My difficulties ended up being exacerbated and I was left with a pathological fear of White therapists, as I felt that I had to tell them what made them feel comfortable rather than what was going on for me […] I do not believe that any forms of therapy work for ethnic minorities in countries of European origin – not unless they are able to see an ethnic minority therapist and unfortunately, there are not too many of those in the UK”.

The prevalence of cases like the one presented above is unknown, but they certainly exist, and the importance of their experience is undeniable. Efforts must be made to find the way of giving patients with negative racial and cultural experiences the attention, empathy and understanding they need. A study by Owen et al. (2016) indicated that patients who rated their therapist as being more culturally humble had better therapy outcomes. Therefore, cultural sensitivity can be the difference between a successful and an unsuccessful intervention for some patients. Clinicians are encouraged to discuss these sorts of challenging cases in supervision, and, when possible, with colleagues and service users from diverse ethnicities. Clinicians are also advised to recognize how their own cultural values might affect their practice, given the common assumption that the patients’ culture is the only one that matters in therapy.

Beyond cultural modifications, clinicians who decide to modify CBT in the form of omission or underuse of techniques should be cautious. The versions of CBT that have shown the best results are those that are manual-based. Modified CBT must be tested, rather than assuming it will work. Although we should be flexible while delivering therapy and adapt it to the individual, the extent of these adaptations should not compromise therapy’s core components. Agreeing on ‘how many are too many’ modifications is a complex topic, which will always generate discussion. However, being attentive to the patients’ progress with constant monitoring, and being receptive to the patient’s feedback, can give us a good insight about the intervention’s effectiveness.

Clinicians are encouraged to improve their practice through training. Continued training will increase the likelihood of clinicians learning the therapy properly and in a way that is adaptive to a wider range of clinical presentations and contexts. That should provide more comprehensive and accurate treatment for their patients. Training should also stress the importance of clinicians talking to their patients before applying a culturally adapted therapy, given that different patients will have different cultural needs, and will want them addressed differently in therapy. We are not exempt from making errors while delivering therapy, but we should be willing to identify those errors, so we can improve our practice.

**Research implications**

This thesis has a number of limitations, which should be addressed in future research. Firstly, cross-cultural comparisons will always benefit from larger samples. Future studies regarding therapist drift in different cultural settings should include a larger number of participants, preferably from several countries and cultures. A much larger, multi-cultural sample would yield more robust results. Countries with contrasting profiles based on Hofstede’s et al.’s (2010) cultural dimensions should be included in this comparison. For example, the United States and China have very different scores on most of Hofstede’s et al. (2010) cultural dimensions. A study that includes these two countries might result in very different patterns of drift, with different psychological underpinnings. Similarly, therapist drift should also be investigated in other types of therapy, besides CBT.

Regarding cultural adaptations of therapy, future research should evaluate the effectiveness of these adaptations in more specific populations. For example, it is possible that culturally-adapted CBT works better for elder Latinos than for adolescent or young adult Latinos. The effectiveness of culturally-adapted CBT, in comparison to conventional CBT, should be further investigated with controlled trials or via meta-analyses that exclusively include controlled trials. Future research should also address which elements of culturally-adapted CBT are the ones that improve therapy outcomes – for example, whether core or peripheral modifications of therapy give better results. Qualitative studies where Latin American patients (and others outside the Anglo/European world) give their opinions regarding cultural adaptations of CBT should also be carried out. A study that addresses whether patients from certain cultural backgrounds prefer a specific type of therapy might give valuable insights about the best approaches for these populations. For example, patients from highly collectivistic societies might show a higher preference for family therapy.

Patient characteristics and their influence on therapy should also be investigated further. Besides mood and gender (factors explored in this thesis), other patient characteristics could also be investigated, such as patients’ age, religion, health condition, sexual orientation, among others. The effects of these characteristics would be better evaluated with direct observation of therapy sessions, rather than experimental vignettes. The effects of clinicians’ characteristics (such as firmness, empathy, and other personality traits) should also be tested in an empirical way. High levels of firmness might be related to therapy adherence, but might also be interpreted as involving a paternalistic approach adopted by therapists. Even when empathy has previously been shown to have positive effects on therapy outcomes (Burns & Nolen-Hoeksema, 1992), further studies that consider the potential downsides of being overly-empathetic should be conducted (e.g. Meehl’s [1973] construct of the ‘spun-glass theory of the mind’). Therapists’ self-assessment should also be considered further. It is possible that therapists who view themselves as highly competent give a better treatment to their patients, or that they are overestimating their ability and give poorer treatment.

**Conclusion**

Therapist drift is a multi-faceted phenomenon. The reasons for such drift include the patients’ characteristics, the clinician’s own psychological state, and even cultural factors. Clinicians should be willing to identify whether these aspects are affecting their practice, and should take actions to reduce such impacts. These actions might include supervision, updating training, patient monitoring, and consultation with colleagues and patients from different ethnic backgrounds when possible. Although these actions might not guarantee an effective intervention, acknowledging the existence of therapist drift might be a good way of encouraging ourselves to stay on track. Researchers are also encouraged to keep investigating therapist drift, especially in different countries and cultures. Exploring therapist drift and its cultural underpinnings can give us a good insight about how patients from different cultures might benefit from therapy. Although reaching an agreement about when and how to include these cultural aspects in CBT is certainly complex, efforts should still be made to reach such a consensus.

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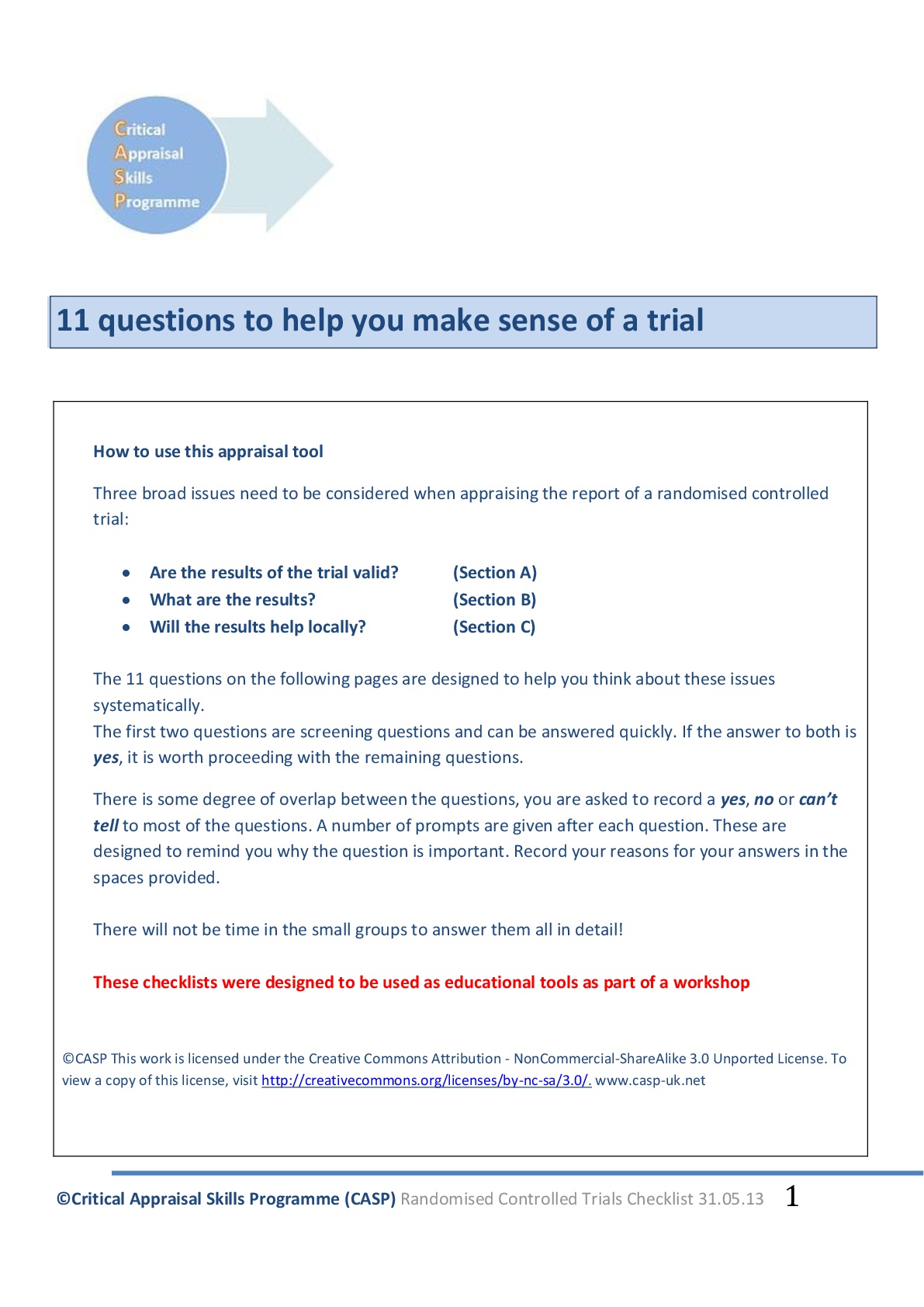
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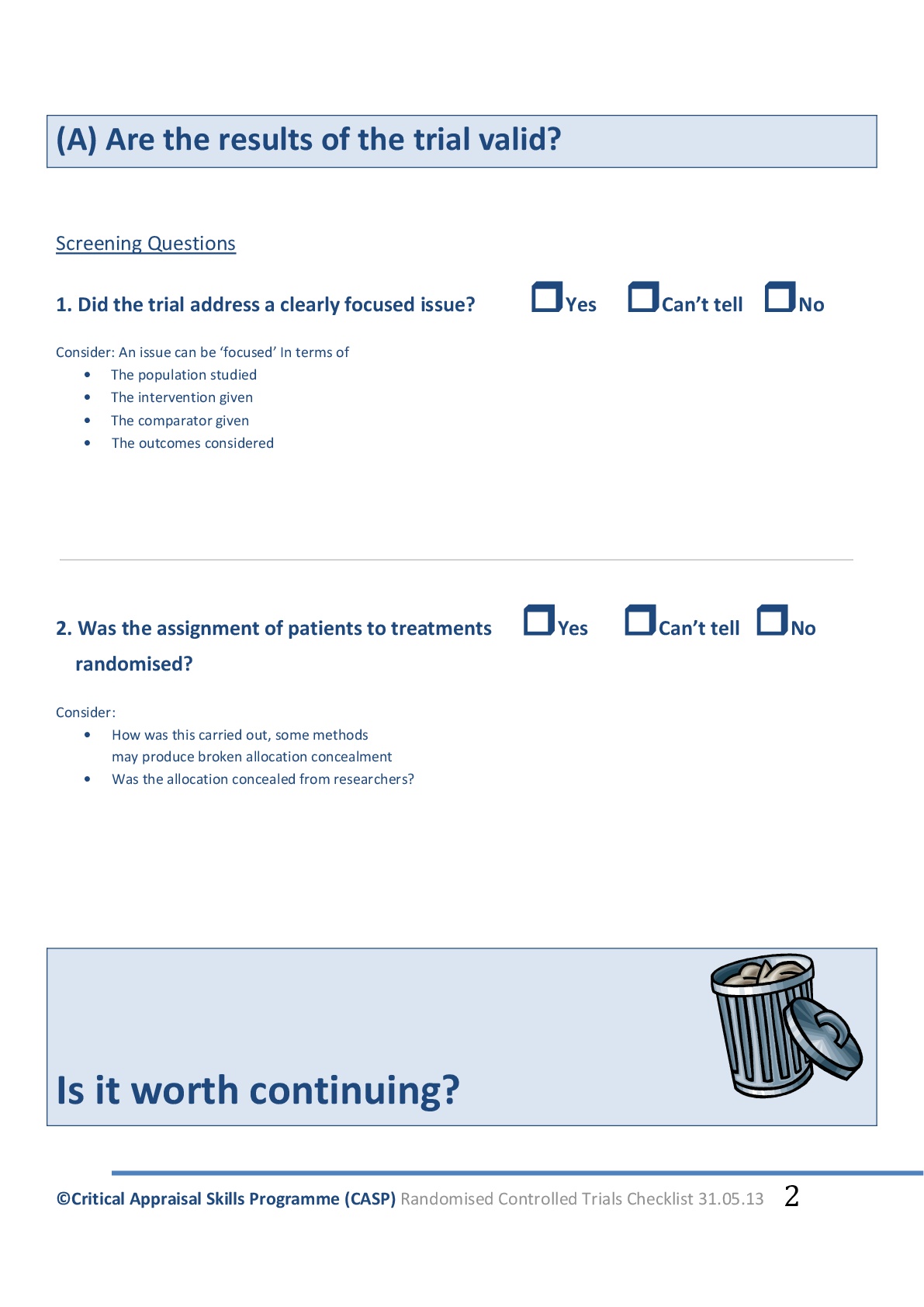
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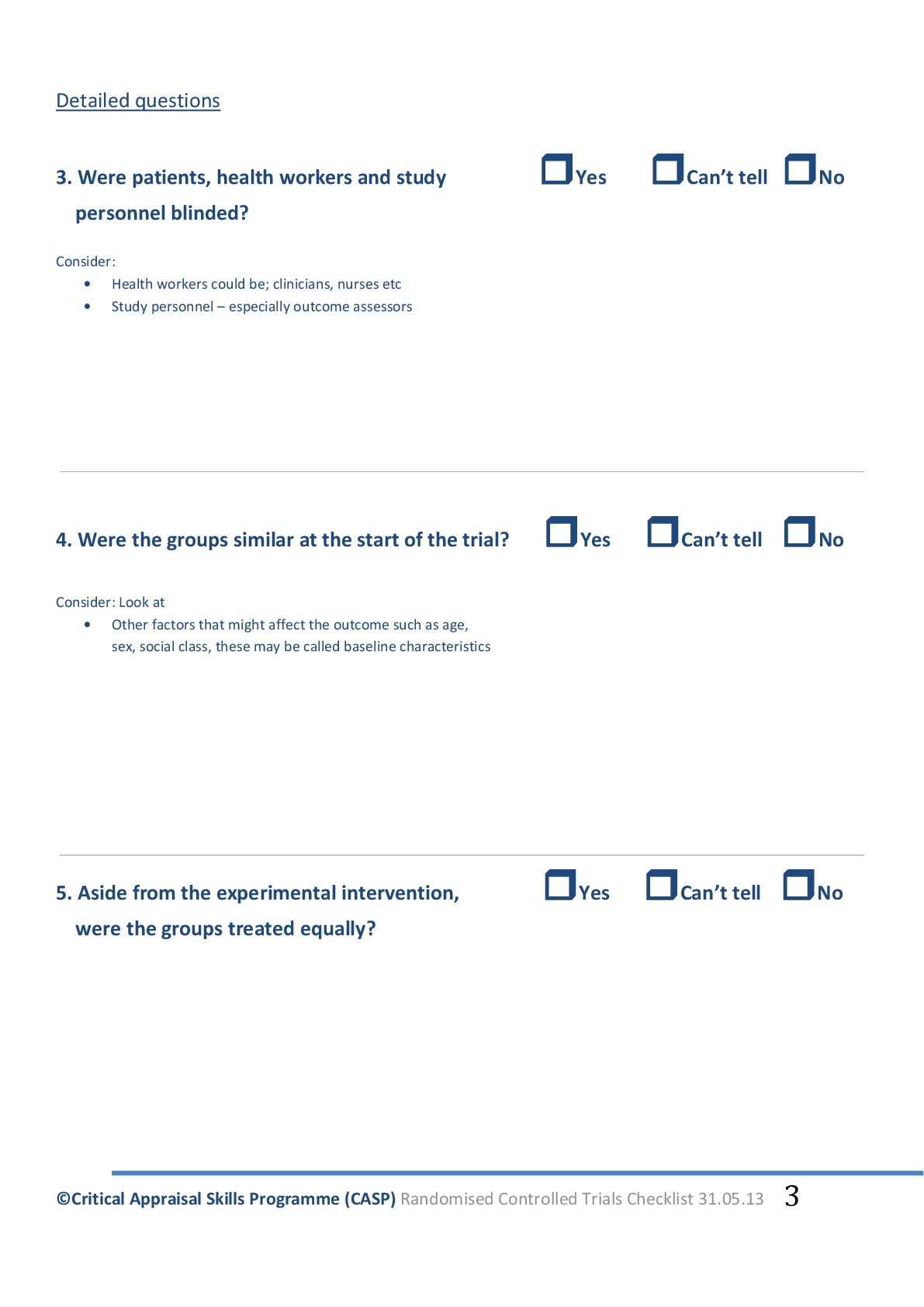
Appendices

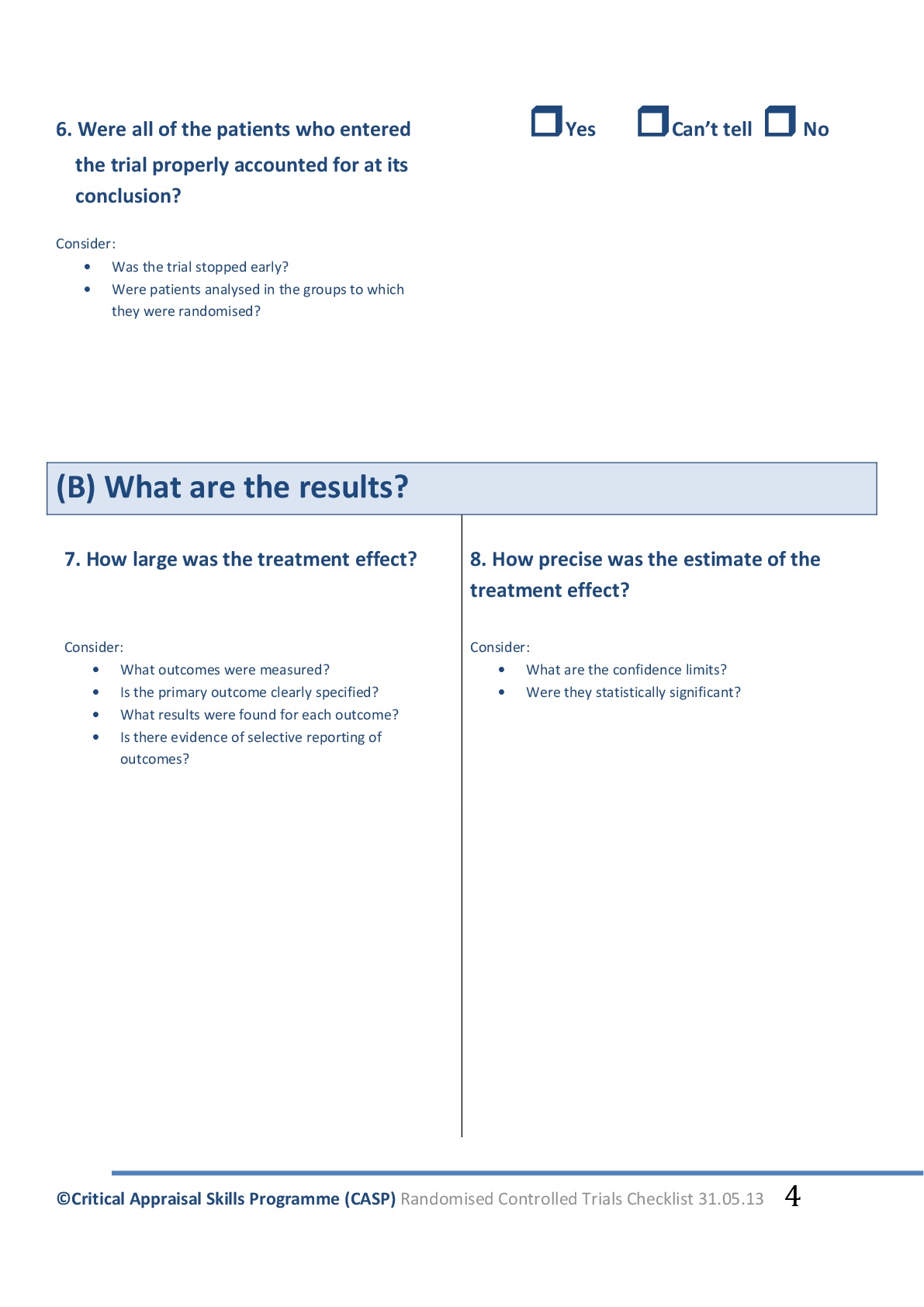
**Appendix 1.1**

CASP assessment tool











**Appendix 1.2**

Scorings per paper according to the CASP assessment tool

| Paper | **Are the results valid?** | | | | | | **What are the results?** | | **Will the results help locally?** | | | Total score (min = 11; max = 35) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. Did the trial address a clearly focussed issue? | 2. Was the assignment of patients to treatment randomised? | 3. Were the patients, health workers and study personnel blinded? | 4. Were the groups similar at the start of the trial? | 5. Aside from the experimental intervention, were the groups treated equally? | 6. Were all of the patients who entered the trial properly accounted for at its conclusion? | 7. How large was the treatment effect?  (Cohen’s d, where stated) | 8. How precise was the estimate of the treatment effect? | 9. Can the results be applied in your context? (or the local population) | 10. Were all clinically important outcomes considered? | 11. Are the benefits worth the harms and costs? |
| *Yes = 3*  *Can’t tell = 2*  *No = 1* | *Yes = 3*  *Can’t tell = 2*  *No = 1* | *Yes = 3*  *Can’t tell = 2*  *No = 1* | *Yes = 4*  *No groups = 3*  *Can’t tell = 2*  *No = 1* | *Yes = 4*  *No groups = 3 Can’t tell = 2*  *No = 1* | *Yes = 3*  *Can’t tell = 2*  *No = 1* | *Large = 5 Medium = 4 Small = 3*  *Can’t tell = 2*  *No effect = 1* | *Significant = 3 Can’t tell = 2*  *Non-significant = 1* | *Yes = 3*  *Can’t tell = 2*  *No = 1* | *Yes = 3*  *Can’t tell = 2*  *No = 1* | *Yes = 3*  *Can’t tell = 2 No = 1* |
| **Adapted CBT in Latin American countries** | | | | | | | | | | | | |
| 1. Cabiya et al., 2008 | 3 | 3 | 1 | 4 | 4 | 3 | 3  (0.32 on average) | 3  (Significant for 3 out of 5 measures) | 3 | 3 | 3 | 33  High |
| 1. Díaz-Martínez et al., 2011 | 3 | 3 | 1 | 4 | 4 | 3 | 2 | 1 | 3 | 3 | 3 | 30  Medium |
| 1. De la Rosa Gomez & Cardenas Lopez, 2012 | 3 | 3 | 1 | 4 | 4 | 3 | 5 | 3 | 3 | 3 | 3 | 35  High |
| 1. Rossello & Bernal, 1999 | 3 | 3 | 2 | 1 | 4 | 3 | 4 | 3  (Significant for both treatments vs control. No significant vs interventions) | 3 | 3 | 3 | 32  High |
| 1. Rossello & Jimenez-Chafey, 2006 | 3 | 1 | 1 | 3 | 3 | 3 | 5  (Large [0.96-1.27] for depression, self-concept and self-efficacy) | 5  (Significant except for glycaemic control or self-care behaviours) | 3 | 3 | 3 | 31  Medium |
| 1. Rossello et al., 2011 | 3 | 1 | 1 | 3 | 3 | 3 | 5 | 3 | 3 | 3 | 3 | 31  Medium |
| **Non-adapted CBT in Latin American countries** | | | | | | | | | | | | |
| 1. Aguilera-Sosa et al., 2009 | 3 | 1 | 1 | 3 | 3 | 3 | 5  (Large for BMI [1.19 pre-post intervention] | 3 | 3 | 3 | 3 | 31  Medium |
| 1. Alcázar-Olán et al., (2018) | 3 | 1 | 1 | 3 | 3 | 3 | 5 | 3 | 2 | 2 | 2 | 28  Low |
| 1. Arrivillaga Quintero et al., 2007 | 3 | 3 | 1 | 4 | 4 | 3 | 4  (Medium [0.68] for systolic blood pressure) | 3 | 3 | 3 | 3 | 34  High |
| 1. Becerra Galvez et al., 2016 | 3 | 1 | 1 | 3 | 3 | 3 | 5  (1.23 on average) | 3 | 3 | 3 | 3 | 31  Medium |
| 1. Botero Garcia, 2005 | 3 | 1 | 1 | 3 | 3 | 3 | 5  (1.16-1.67) | 3 | 2 | 3 | 3 | 29  Low |
| 1. Caceres-Ortiz et al., 2011 | 3 | 1 | 1 | 3 | 3 | 3 | 5  (1.98 Hedges’ g) | 3 | 3 | 3 | 3 | 31  Medium |
| 1. Castro et al., 2012 | 3 | 3 | 1 | 1 | 4 | 3 | 4 | 3  (Significant for pain intensity) | 3 | 3 | 3 | 31  Medium |
| 1. Contreras et al., 2006 | 3 | 3 | 1 | 4 | 4 | 3 | 4  (0.64 on average) | 3 | 3 | 3 | 3 | 34  High |
| 1. Cordioli et al., 2002 | 3 | 1 | 1 | 3 | 3 | 3 | 5 | 3 | 3 | 3 | 3 | 31  Medium |
| 1. Cruz-Almanza et al., 2006 | 3 | 3 | 1 | 4 | 4 | 3 | 5  (1.34 at first follow-up) | 3 | 3 | 3 | 3 | 35  High |
| 1. De Souza et al., 2013 | 3 | 1 | 1 | 3 | 3 | 3 | 4  (Moderate-large for anxiety, no effect on depression or improvement in quality of life) | 3  Significant for anxiety | 3 | 3 | 3 | 30  Medium |
| 1. Duchesne et al., 2007 | 3 | 1 | 1 | 3 | 3 | 3 | 5  (2.7 for binge eating frequency) | 3 | 3 | 3 | 3 | 31  Medium |
| 1. Escoto Ponce de León et al., 2010 | 3 | 3 | 1 | 4 | 4 | 3 | 5 | 3 | 3 | 3 | 3 | 35  High |
| 1. Furlan, 2013 | 3 | 1 | 1 | 3 | 3 | 3 | 5  (Cliff’s delta 0.44 on average, equivalent to d=0.7) | 3 | 2 | 3 | 3 | 30  Medium |
| 1. Garduno et al., 2010 | 3 | 1 | 1 | 3 | 3 | 3 | 2 | 3 | 3 | 3 | 3 | 28  Low |
| 1. Gil-Bernal & Hernandez Guzman, 2009 | 3 | 3 | 1 | 4 | 4 | 3 | 4  (Medium for the parent group [1.66]) | 3 | 3 | 3 | 3 | 34  High |
| 1. Gomez et al., 2009 | 3 | 1 | 1 | 3 | 3 | 3 | 5 | 3 | 3 | 3 | 3 | 31  Medium |
| 1. Gonzalez Fragoso et al., 2012 | 3 | 1 | 1 | 4 | 4 | 4 | 2 | 2 | 3 | 3 | 2 | 28  Low |
| 1. Gonzalez Garcia et al., 2015 | 3 | 1 | 1 | 3 | 3 | 3 | 5 | 3 | 3 | 3 | 2 | 30  Medium |
| 1. Guerra Vio et al., 2009 | 3 | 1 | 1 | 1 | 4 | 4 | 5 | 3 | 3 | 3 | 3 | 30  Medium |
| 1. Habigzang et al., 2016 | 3 | 1 | 1 | 2 | 2 | 3 | 4 | 3 | 2 | 3 | 3 | 27  Low |
| 1. Habigzang et al., (2018) | 3 | 1 | 1 | 4 | 4 | 4 | 4 | 3 | 3 | 3 | 3 | 32  High |
| 1. Meyer et al., 2010 | 3 | 3 | 3 | 4 | 4 | 3 | 5 | 3 | 3 | 3 | 3 | 37  High |
| 1. Montero Pardo et al., 2012 | 3 | 1 | 1 | 3 | 3 | 3 | 4 | 3 | 3 | 3 | 3 | 30  Medium |
| 1. Pegado et al., (2018) | 3 | 2 | 1 | 4 | 4 | 3 | 4 | 3 | 3 | 3 | 3 | 33  High |
| 1. Perez Baquero et al., 2014 | 3 | 1 | 1 | 3 | 3 | 3 | 2 | 3 | 3 | 3 | 3 | 28  Low |
| 1. Reyes Jarquin & Gonzalez-Celis Rangel, 2016 | 3 | 1 | 1 | 3 | 3 | 3 | 5 | 3 | 3 | 3 | 3 | 31  Medium |
| 1. Riveros et al., 2005 | 3 | 1 | 1 | 3 | 3 | 3 | 2 | 3 | 3 | 3 | 3 | 28  Low |
| 1. Tapia et al., 2014 | 3 | 3 | 1 | 4 | 2 | 3 | 2 | 3  Significant pre-post in perception, not in saliva production | 3 | 3 | 3 | 30  Medium |
| 1. Vergara Lope Tristan & Gonzalez-Celis Rangel, 2009 | 3 | 1 | 1 | 1 | 4 | 3 | 2 | 3 | 3 | 3 | 3 | 27  Low |
| 1. Villalobos Perez et al., 2005 | 3 | 1 | 1 | 3 | 3 | 3 | 5 | 3 | 3 | 2 | 2 | 29  Low |
| 1. Zimmer et al., 2007 | 3 | 3 | 3 | 4 | 4 | 3 | 2 | 3 | 3 | 3 | 3 | 34  High |
| **Adapted CBT for Latinos in the United States** | | | | | | | | | | | | |
| 1. Alegria et al., 2014 | 3 | 3 | 3 | 1 | 4 | 3 | 4 | 3 | 3 | 3 | 3 | 33  High |
| 1. Burrow-Sanchez & Wrona, 2012 | 3 | 3 | 1 | 4 | 4 | 3 | 4 | 2 | 2 | 3 | 3 | 32  High |
| 1. Cachelin et al., 2014 | 3 | 1 | 1 | 3 | 3 | 3 | 4 | 3 | 3 | 3 | 3 | 30  Medium |
| 1. Dwight-Johnson et al., 2011 | 3 | 3 | 3 | 4 | 4 | 3 | 5 | 3  Significant after 6 months | 3 | 3 | 3 | 37  High |
| 1. Evans-Hudnall et al., 2014 | 3 | 3 | 1 | 2 | 4 | 3 | 3 | 3 | 3 | 3 | 3 | 31  Medium |
| 1. Feldman et al., (2016) | 3 | 3 | 3 | 4 | 1 | 3 | 5 | 3 | 3 | 3 | 3 | 34  High |
| 1. Gallagher-Thompson et al., 2008 | 3 | 3 | 3 | 4 | 4 | 3 | 4 | 3 | 1 | 3 | 3 | 34  High |
| 1. Gesell et al., 2015 | 3 | 3 | 1 | 4 | 4 | 3 | 2 | 3 | 3 | 3 | 3 | 32  High |
| 1. Gonyea et al., (2016) | 3 | 3 | 1 | 4 | 4 | 3 | 3 | 3 | 3 | 3 | 3 | 33  High |
| 1. Hinton et al., 2011 | 3 | 3 | 1 | 4 | 4 | 3 | 5 | 3 | 3 | 3 | 3 | 35  High |
| 1. Holden et al., 2008 | 3 | 3 | 1 | 4 | 4 | 3 | 2 | 3 | 3 | 3 | 3 | 33  High |
| 1. Kanter et al., 2010 | 3 | 3 | 3 | 4 | 1 | 1 | 5 | 3 | 1 | 3 | 3 | 30  Medium |
| 1. Le et al., 2011 | 3 | 3 | 3 | 4 | 4 | 3 | 3  (Small for intervention vs usual care) | 3 | 3 | 3 | 3 | 35  High |
| 1. Mauldon et al., 2006 | 3 | 1 | 1 | 3 | 3 | 3 | 5  Large for diabetes knowledge | 3 | 2 | 3 | 3 | 30  Medium |
| 1. Miranda et al., 2003 | 3 | 3 | 1 | 4 | 4 | 3 | 2 | 3  Significant for Spanish- speaking participants | 3 | 3 | 3 | 32  High |
| 1. Penedo et al., 2007 | 3 | 3 | 3 | 4 | 4 | 3 | 2 | 3 | 3 | 3 | 3 | 34  High |
| 1. Perez Foster, 2007 | 3 | 3 | 1 | 1 | 4 | 3 | 2 | 2  Significant after treatment, not between groups | 3 | 3 | 3 | 28  Low |
| 1. Pina et al., 2003 | 3 | 3 | 1 | 1 | 4 | 3 | 3 | 3 | 3 | 3 | 3 | 30  Medium |
| 1. Pina et al., 2012 | 3 | 3 | 3 | 2 | 4 | 3 | 2 | 3 | 2 | 3 | 3 | 31  Medium |
| **Non-adapted CBT for Latinos in the United States** | | | | | | | | | | | | |
| 1. Gil et al., 2004 | 3 | 3 | 1 | 3 | 3 | 3 | 2 | 2 | 2 | 2 | 3 | 27  Low |
| 1. Marchand et al., 2010 | 3 | 3 | 1 | 2 | 4 | 3 | 5 | 3 | 3 | 3 | 3 | 33  High |
| 1. Melnyk et al., 2009 | 3 | 3 | 3 | 4 | 4 | 3 | 4 | 3  Significant for anxiety | 2 | 3 | 3 | 35  High |

**Appendix 1.3**

Papers discarded by having a relatively low CASP score

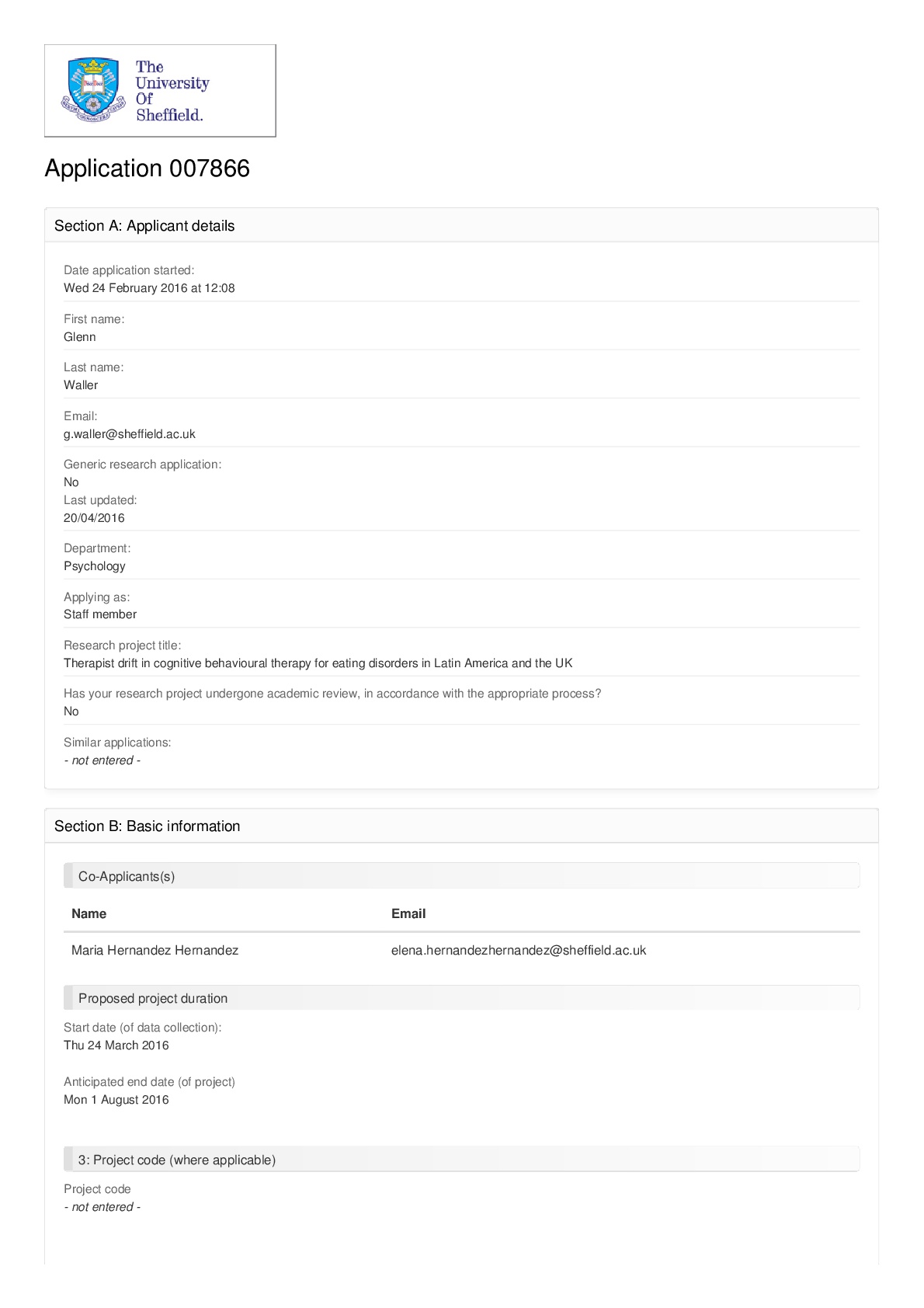
1. Araujo Fialho, Köenig, Lemos dos Santos, Tonidandel Barbosa, & Caramelli (2012) [failed on item 1, score = 26];
2. Bedoya, Traeger, Trinh, Chang, Brill, Hails, Hagan, Flaherty, & Yeung (2014) [score = 26];
3. Braga, Cordioli, Niederauer, & Manfro (2005) [score = 26];
4. Candelaria Martínez, García Cedillo & Estrada Aranda (2016) [score = 21];
5. Cerquera Córdoba, Pabón Poches & Lorenzo Ruíz (2017) [score = 22];
6. Coiro, Riley, Broitman, & Miranda (2012) [failed on item 1, score = 26];
7. García Flores, Vázquez López, de la Paz Ross Arguelles, García Hernández, Mercado Ibarra, & Acosta Quiroz (2012) [score = 26];
8. García-Cardoza, Zapata-Vázquez, Rivas-Acuña & Quevedo-Tejero (2017) [score = 24];
9. García Quiñones, Martínez Soler, & Cáceres Ortiz (2001) [score = 26];
10. Guerra & Barrra (2017) [score = 22];
11. Lira-Mandujano, González-Betanzos, Carrascoza Venegas, & Cruz-Morales (2009) [failed on item 1, score = 25];
12. Mensorio, & Costa-Júnior (2016) [score = 22];
13. Miranda, Duan, Sherbourne, Schoenbaum, Lagomasino, Jackson-Triche, & Wells (2003) [failed on item 1, score = 22];
14. Morales Rodriguez, Gonzalez Ramirez, & Molina Landaverde (2014) [score = 25];
15. Paredes Cisneros, Rodríguez Villa, & Lira Mandujano (2014) [score = 25];
16. Quiroga Anaya, Sánchez Sosa, Medina-Mora Icaza, & Aparicio Naranjo (2007) [score = 26];
17. Ramírez Orozco & Rojas Russell (2017) [score = 25];
18. Riveros, Cortázar-Palapa, Alcázar, & Sánchez-Sosa (2005) [score = 26];
19. Saffi, & Lotufo Neto (2013) [failed on item 1, score = 25];
20. Serfaty, Haworth, & Buszewicz (2009) [score = 26];
21. Vanega-Romero, Sosa-Correa & Castillo-Ayuso (2018) [score = 24];
22. Vera-Villarroel, Valenzuela, Abarca, & Ramos, (2005) [failed on item 1, score = 22].

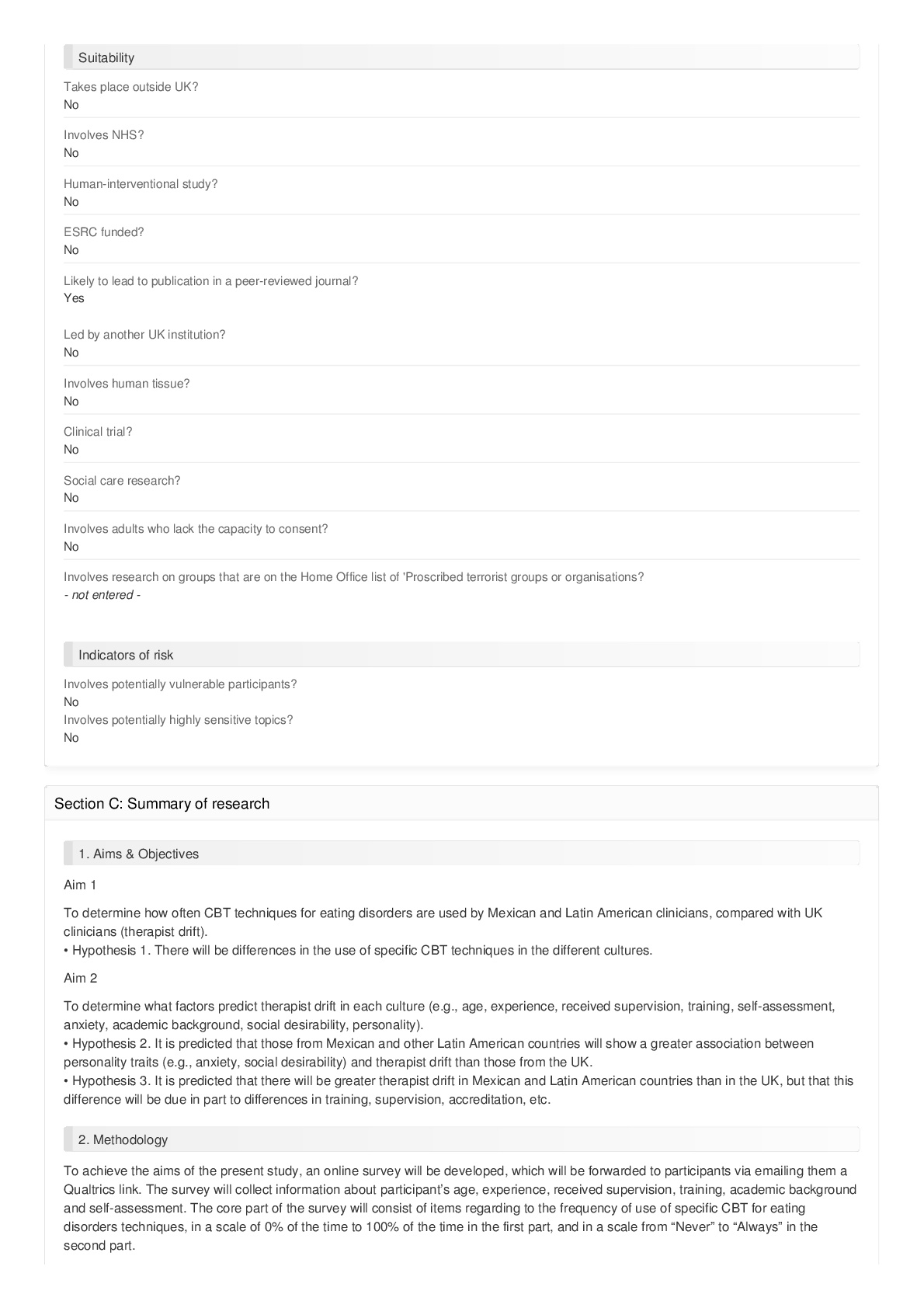
**Appendix 1.4**

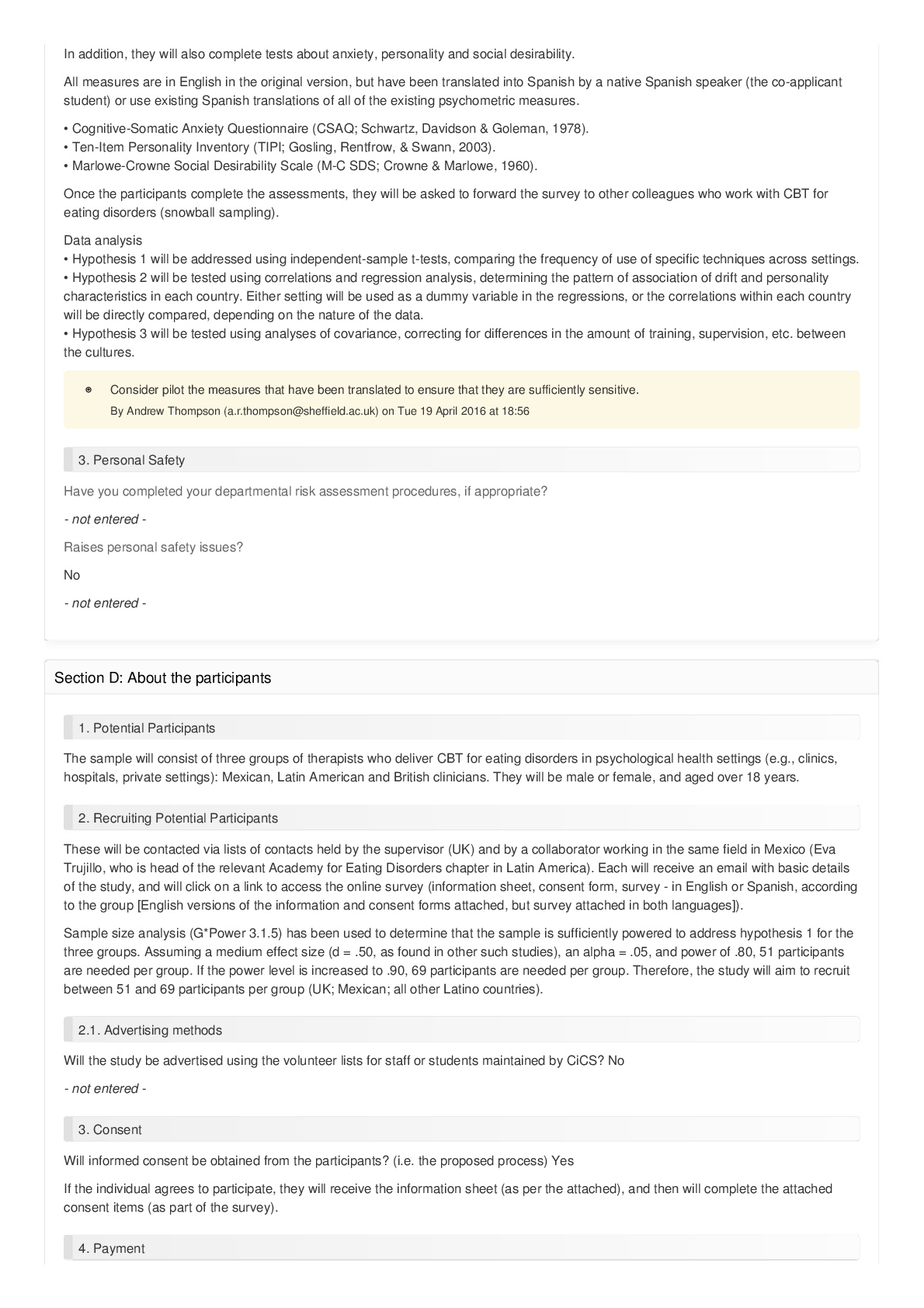
Studies’ quality evaluation by main researcher and external examiner, according to the CASP assessment tool

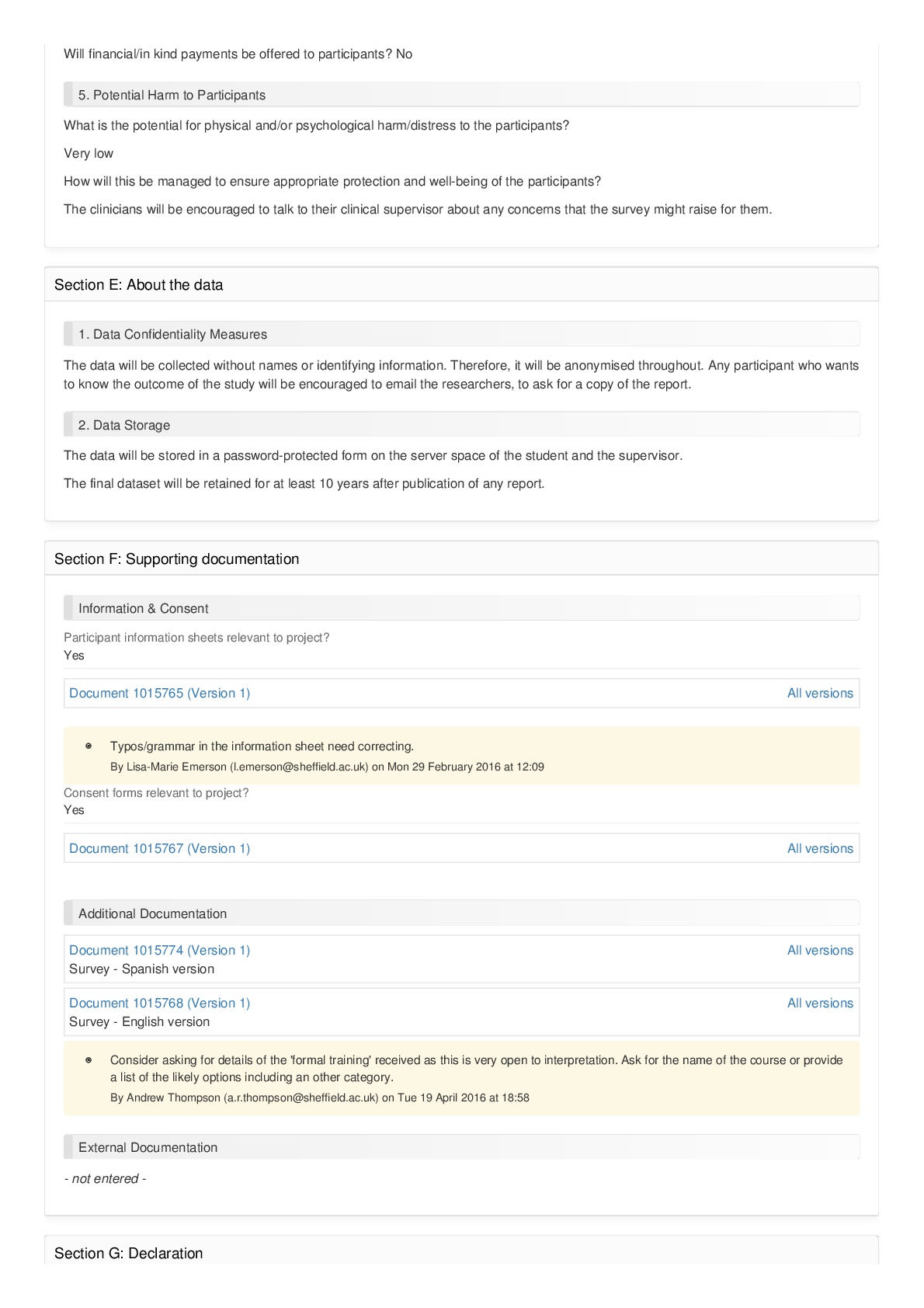
| Reviewer | Paper | Evaluation questions | | | | | | | | | | | Total rating |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. Did the trial address a clearly focused issue? | 2. Was the assignment of patients to treatment randomised? | 3. Were patients, health workers and study personnel blinded? | 4. Were the groups similar at the start of the trial? | 5. Aside from the experimental intervention, were the groups treated equally? | 6. Were all of the patients who entered the trial properly accounted for at its conclusion? | 7. How large was the treatment effect? | 8. How precise was the estimate of the treatment effect? | 9. Can the results be applied in your context? (or to the local population) | 10. Were all clinically important outcomes considered? | 11. Are the benefits worth the harms and costs? |
| Ext | Botero Garcia, 2005 | 3 | 1 | 1 | 3 | 3 | 2 | 2 | 3 | 2 | 2 | 3 | 25  Very low |
| Res | 3 | 1 | 1 | 3 | 3 | 3 | 5 | 3 | 2 | 2 | 3 | 29  Low |
| Ext | Castro et al., 2012 | 3 | 3 | 1 | 2 | 4 | 3 | 3 | 3 | 3 | 3 | 3 | 31  Medium |
| Res | 3 | 3 | 1 | 1 | 4 | 3 | 4 | 3 | 3 | 3 | 3 | 31  Medium |
| Ext | Contreras et al., 2006 | 3 | 3 | 1 | 4 | 4 | 3 | 5 | 3 | 3 | 3 | 3 | 35  High |
| Res | 3 | 3 | 1 | 4 | 4 | 3 | 4 | 3 | 3 | 3 | 3 | 34  High |
| Ext | Cordioli et al., 2002 | 3 | 1 | 1 | 2 | 3 | 3 | 5 | 3 | 3 | 3 | 3 | 30  Medium |
| Res | 3 | 1 | 1 | 3 | 3 | 3 | 5 | 3 | 3 | 3 | 3 | 31  Medium |
| Ext | Evans-Hudnall et al., 2014 | 3 | 3 | 1 | 2 | 4 | 3 | 3 | 3 | 3 | 3 | 3 | 31  Medium |
| Res | 3 | 3 | 1 | 2 | 4 | 3 | 3 | 3 | 3 | 3 | 3 | 31  Medium |
| Ext | Feldman et al., 2016 | 3 | 3 | 3 | 4 | 4 | 3 | 5 | 3 | 3 | 3 | 3 | 37  High |
| Res | 3 | 3 | 3 | 4 | 4 | 3 | 5 | 3 | 3 | 3 | 3 | 37  High |
| Ext | Habigzang et al., 2016 | 3 | 1 | 1 | 2 | 2 | 3 | 4 | 3 | 2 | 3 | 3 | 27  Low |
| Res | 3 | 1 | 1 | 2 | 2 | 3 | 4 | 3 | 2 | 3 | 3 | 27  Low |
| Ext | Mauldon et al., 2006 | 3 | 1 | 2 | 3 | 3 | 3 | 2 | 3 | 3 | 3 | 3 | 29  Low |
| Res | 3 | 1 | 1 | 3 | 3 | 3 | 5 | 3 | 2 | 3 | 3 | 30  Medium |
| Ext | Miranda et al., 2003 | 3 | 3 | 1 | 4 | 4 | 3 | 2 | 2 | 2 | 3 | 3 | 30  Medium |
| Res | 3 | 3 | 1 | 4 | 4 | 3 | 2 | 3 | 3 | 3 | 3 | 32  High |
| Ext | Rosello & Bernal, 1999 | 3 | 3 | 2 | 4 | 4 | 3 | 3 | 3 | 3 | 3 | 3 | 34  High |
| Res | 3 | 3 | 2 | 1 | 4 | 3 | 4 | 3 | 3 | 3 | 3 | 32  High |
| Ext | Vergara Lope Tristan & Gonzalez-Celis Rangel, 2009 | 3 | 1 | 1 | 1 | 2 | 2 | 4 | 3 | 2 | 3 | 3 | 25  Very low |
| Res | 3 | 1 | 1 | 1 | 4 | 3 | 2 | 3 | 3 | 3 | 3 | 27  Low |
| Ext | Villalobos Perez et al., 2005 | 3 | 1 | 1 | 3 | 3 | 3 | **5** | 3 | 2 | 1 | 2 | 27  Low |
| Res | 3 | 1 | 1 | 3 | 3 | 3 | 5 | 3 | 3 | 2 | 2 | 29  Low |
| Note: Ext = External reviewer; Res = Main researcher | | | | | | | | | | | | | |

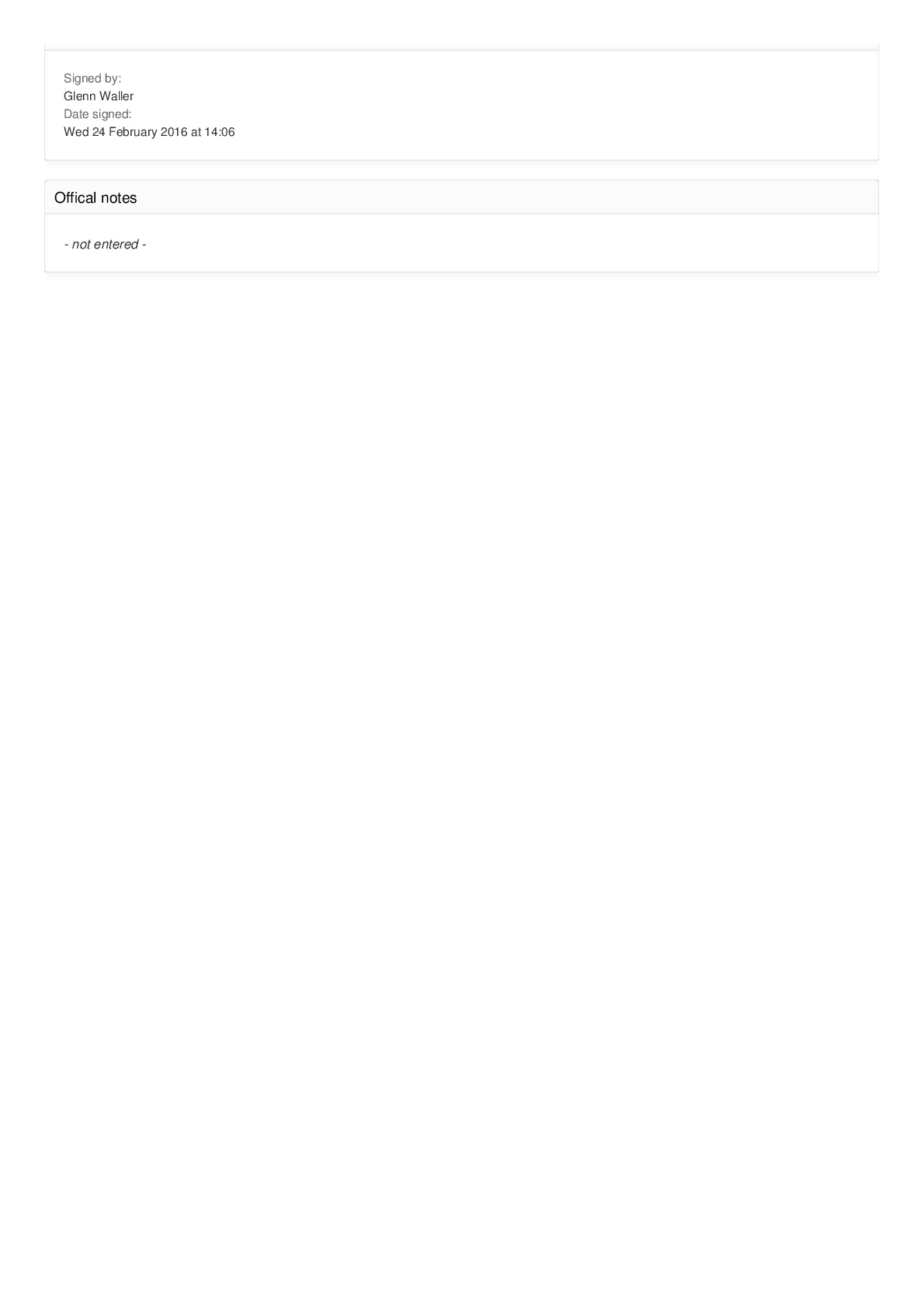
**Appendix 2.1**

Ethical approval for Study 2 (Chapter III)









**Appendix 2.2.1**

E-mail invitation for participants – Study 2 (Chapter III)

Dear colleague

We are conducting research into the patterns of use of CBT for eating disorders in different countries (the UK, Mexico, other Latin American countries). This work is being undertaken with Eva Trujillo and Glenn Waller.

If you use CBT with eating disordered individuals in the UK, then I would be grateful if you would consider taking part in this research. If you do so, then it will involve completing an online survey about your clinical work and your own personal style, so that we can see whether there are differences between those countries. It should take about 10 minutes. All your responses will be anonymous and strictly confidential. You may withdraw from the study at any time.

To participate, please click on the following link:

Survey in English: https://sheffieldpsychology.eu.qualtrics.com/SE/?SID=SV\_b40iIe7q9OncOTX

Survey in Spanish: https://sheffieldpsychology.eu.qualtrics.com/SE/?SID=SV\_7P88i25kouCiT65

Please feel free to forward this link to colleagues who might be interested in participating.

This study has been approved by the Ethics committee of the Department of Psychology, University of Sheffield. If you have any problems, queries or require further information, please contact me at mehernandezhernandez1@sheffield.ac.uk.

Thank you for your help.

**Appendix 2.2.2**

E-mail invitation for participants – Study 2 (Chapter III)

*Spanish version*

Estimado colega,

Soy estudiante del doctorado en Psicología de la Universidad de Sheffield, y estoy realizando una investigación acerca de los patrones de uso de la terapia cognitivo conductual en distintos países (específicamente, en el Reino Unido, México, y otros países latinoamericanos). Este trabajo de investigación es en colaboración con Eva Trujillo y Glenn Waller.

Si usted emplea la terapia cognitivo conductual con pacientes con trastornos alimenticios en cualquier país latinoamericano, le agradecería mucho si considerara tomar parte en este estudio. De acceder a ello, se le pediría completar una encuesta en línea sobre su trabajo como terapeuta y su propio estilo personal, y con ello, ver si existen diferencias entre distintos países. El proceso tomaría aproximadamente 10 minutos.

Todas sus respuestas serán anónimas y estrictamente confidenciales. Puede abandonar el estudio en cualquier momento. Para participar, dé click en el siguiente link:

https://sheffieldpsychology.eu.qualtrics.com/SE/?SID=SV\_7P88i25kouCiT65

Le agradeceríamos mucho si pudiera re-enviarle este correo a cualquiera de sus colegas que estuviera interesado en participar. Este estudio ha sido aprobado por el comité de ética del Departamento de Psicología de la Universidad de Sheffield. Si tuviera usted algún problema, queja, o si requiere de información adicional, por favor, contácteme al siguiente correo electrónico: mehernandezhernandez1@sheffield.ac.uk.

Muchas gracias por su ayuda.

**Appendix 2.3.1**

Informed consent – Study 2 (Chapter III)

Cognitive behavioral therapy (CBT) has been proven to be effective for the treatment of many eating disorders. However, recent studies have found that clinicians focus CBT differently. The present research aims to examine the different patterns of use of CBT techniques for eating disorders, and to compare of the use of such techniques between different countries, particularly, the United Kingdom, Mexico, and other Latin American countries.

If you agree to participate, you will be asked to complete an online survey about what methods you use when working with CBT for eating disorders, and how often do you use them. Your answers will be entirely confidential, and all data will be accessed only by the researchers. The information you provide will be used exclusively for the purposes of this study, and individual responses will not be identified.

Participation is completely voluntary and you are free to withdraw at any time until you submit your data. This study has been approved by the Psychology Research Ethics Committee at the University of Sheffield, and it is supervised by Professor Glenn Waller. If you have any further concerns, please contact the University of Sheffield’s office of the Registrar and Secretary at 01142221101. For any further information or questions about this study, feel free to contact me at mehernandezhernandez1@sheffield.ac.uk.

Do you agree to participate in this study?

□ Yes

□ No

**Appendix 2.3.2**

Informed consent – Study 2 (Chapter III)

*Spanish version*

La terapia cognitivo conductual (TCC) ha probado ser efectiva para el tratamiento de varios trastornos de la conducta alimentaria. Sin embargo, estudios recientes han indicado que los terapeutas cognitivo conductuales tienden a enfocar la terapia de distintas maneras. La presente investigación tiene como objetivo examinar los distintos patrones de uso de las técnicas de la TCC para los trastornos alimenticios, y comparar el uso de dichas técnicas entre distintos países, particularmente, entre el Reino Unido, México, y otros países latinoamericanos.

De acceder a participar, se le pedirá completar una encuesta en línea acerca de los métodos que utiliza cuando trabaja con la TCC para los trastornos alimenticios, y qué tan frecuentemente los utiliza. Completar la encuesta toma aproximadamente 10 minutos. Sus respuestas serán completamente confidenciales, y sólo los investigadores involucrados tendrán acceso a la información recabada. Dicha información será utilizada exclusivamente para los propósitos de este estudio, y las respuestas individuales nunca serán referidas.

Su participación es completamente voluntaria, y puede interrumpirla en cualquier momento hasta antes de enviar sus respuestas. Este estudio ha sido aprobado por el Comité de Ética del Departamento de Psicología de la Universidad de Sheffield, y es supervisado por el Profesor Glenn Waller. Para mayor información, puede contactarme por medio del correo electrónico mehernandezhernandez1@sheffield.ac.uk.

¿Acepta participar en este estudio?

□ Sí

□ No

**Appendix 2.4.1**

Survey – Study 2 (Chapter III)

**Part I – Sociodemographic information**

1. In what country do you practice as a clinician?

* United Kingdom
* Mexico
* Other Latin American country (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other country non listed above (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. What is your age? (in years)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Are you male or female?

* Male
* Female
* Prefer not to say

4. What is your core profession?

* Psychologist
* Psychiatrist
* Social worker
* Physician
* Other (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. For how long have you been practicing as a clinician? (in years)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. For how long have you been practicing CBT? (in years)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Have you completed a formal training course in CBT?

* Yes
* No

8. How many years is it since you completed that training in CBT?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. For how long have you been working with the eating disorders? (in years)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. How often do you attend refresher courses or conferences on CBT?

* Every 1 - 6 months
* Every 6 months - 1 year
* Every 1 - 3 years
* Every 3 - 5 years
* Less often than every 5 years
* Never

11. How many eating disorder cases do you treat weekly using CBT?

* Fewer than 1 per week
* 1 - 5 per week
* 6 - 10 per week
* 11 - 15 per week
* 15 - 20 per week
* More than 20 per week

12. How many hours of supervision per week do you receive?

* Less than 1 per week
* 1 - 2 per week
* 3 or more per week

**Part II – Use of eating disorder-specific techniques**

Below is a series of specific CBT techniques for eating disorders. Please, tick a box in each item indicating how often you use each technique with your patients.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1  Never | 2 | 3 | 4 | 5 | 6 | 7  Always |
| 1. Introducing regular eating | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 2. Cognitive restructuring | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 3. Behavioural experiments | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 4. Body image exposure work | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 5. Other exposure work | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 6. Monitoring physical risk | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 7. Pre-therapy motivational enhancement | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 8. Weighing the patient | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 9. Focusing on the therapeutic alliance | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 10. Monitoring change in behaviours, cognitions and emotions | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

**Part III – Use of general CBT techniques**

Clinicians often use more generic techniques in CBT for eating disordered patients. Please indicate how commonly you use the following techniques when delivering CBT to patients.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1  Never | 2 | 3 | 4 | 5 | 6 | 7  Always |
| 1. Drawing a diagram for the patient explaining the problem, which includes the link between thoughts, feeling and behaviours | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 2. Drawing a diagram that shows the patient's patterns in relating to people | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 3. Mindfulness techniques | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 4. Coping in the present and the future | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 5. Exploring the patient's childhood and past | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 6. Spending time looking at links between beliefs, thoughts and feelings | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 7. Exploring the patient's patterns of relating to people | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 8. Letting the patient lead the content of the session | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 9. Asking patients to keep records of their thougts | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 10. Looking at other problems besides eating difficulties | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 11. Relaxation exercises | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 12. Talking about childhood or past experiences | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 13. Changing the meaning attached to thoughts | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 14. Giving the patient tasks / homework to do between sessions | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 15. Asking the patient to complete monitoring surveys and / or questionnaires regularly | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 16. Spending sessions talking about whatever is on the patient's mind | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 17. Setting an agenda at the beginning of each session | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

**Part IV – Questions regarding therapists’ own performance**

1. Do you use a CBT manual for the eating disorders?

* No
* Yes (please specify which one) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. From the total of the patients that you treat with CBT for eating disorders, what percentage of them achieve recovery?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. From the total of the patients that you treat with CBT for eating disorders, what percentage of them improve?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. From the total of the patients that you treat with CBT for eating disorders, what percentage stays the same?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. From the total of the patients that you treat with CBT for eating disorders, what percentage gets worse?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Compared to other mental health professionals within your field, how would you rate your overall clinical skills and performance in terms of a percentile? (e.g. 25% = below average, 50% = average, 75% = above average)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part V – Debrief**

Thank you for your participation in this study. The general purpose of this research was to determine how often CBT techniques for eating disorders are used by clinicians from different cultural backgrounds, specifically, Latin American countries and the United Kingdom. In this study, you were asked to indicate how often do you use several CBT techniques for the eating disorders, as well as answering additional questions regarding demographics, academic background, and other psychological variables. We intend compare the different patterns of use of CBT techniques for the eating disorders among countries, and to assess the influence of several other factors on such patterns of use (e.g. location, training, anxiety, etc). If you have any concerns about this study, feel free to contact the main researcher, Maria Elena Hernandez, at mehernandezhernandez1@sheffield.ac.uk, who will happily answer any questions that you have. We would very much appreciate if you could pass this survey to any of your colleagues that might be willing to participate, sending them the link that was in the original email.

Please click 'yes' to submit your responses

* + Yes
  + No

**Appendix 2.4.2**

Survey – Study 2 (Chapter III)

*Spanish version*

**Part I – Sociodemographic information**

1. ¿En qué país ejerce como terapeuta?

* Reino Unido
* México
* Otro país latinoamericano (por favor, especifique) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Otro país no enlistado anteriormente (por favor, especifique) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. ¿Cuál es su edad? (en años)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. ¿Es usted hombre o mujer?

* Hombre
* Mujer
* Prefiero no decirlo

4. ¿Cuál es su profesión?

* Psicólogo
* Psiquiatra
* Trabajador social
* Médico
* Otro (por favor, especifique) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. ¿Por cuánto tiempo ha trabajado como terapeuta? (en años)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. ¿Por cuánto tiempo ha practicado la TCC? (en años)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. ¿Ha completado un curso formal en TCC?

* Sí
* No

8. ¿Cuánto tiempo ha pasado desde que completó dicho curso en TCC? (en años)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. ¿Por cuánto tiempo ha tratado pacientes con trastornos alimenticios? (en años)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. ¿Qué tan frecuentemente asiste a cursos de actualización o conferencias sobre TCC?

* Cada 1 - 6 meses
* Cada 6 meses - 1 año
* Cada 1 - 3 años
* Cada 3 - 5 años
* Menos frecuentemente que cada 5 años
* Nunca

11. ¿Cuántos casos de pacientes con trastornos alimenticios atiende semanalmente?

* Menos de 1 por semana
* 1 - 5 por semana
* 6 - 10 por semana
* 11 - 15 por semana
* 15 - 20 por semana
* Más de 20 por semana

12. ¿Cuántas horas de supervisión recibe semanalmente?

* + Menos de 1 por semana
  + 1 - 2 por semana
  + 3 o más por semana

**Part II – Use of eating disorder-specific techniques**

A continuación se enlista una serie de técnicas específicas de la TCC para los trastornos alimenticios. Por favor, señale una casilla en cada ítem indicando qué tan frecuentemente utiliza cada técnica con sus pacientes.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1  Nunca | 2 | 3 | 4 | 5 | 6 | 7  Siempre |
| 1. La introducción de comidas regulares | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 2. Reestructuración cognitiva | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 3. Experimentos conductuales | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 4. Trabajo de exposición sobre la imagen corporal | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 5. Otro trabajo de exposición | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 6. Monitoreo del riesgo físico | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 7. Estimular la motivación antes de la terapia | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 8. Pesar al paciente | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 9. Enfocarse en la alianza terapéutica | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 10. Monitorear los cambios en comportamientos, pensamientos y emociones | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

**Part III – Use of general CBT techniques**

Frecuentemente los terapeutas emplean técnicas más genéricas en la TCC para pacientes con trastornos alimenticios. Por favor, indique qué tan comúnmente utiliza usted las siguientes técnicas cuando implementa la TCC con sus pacientes.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1  Nunca | 2 | 3 | 4 | 5 | 6 | 7  Siempre |
| 1. Dibujar un diagrama para el paciente explicando el problema, el cual incluye el vínculo entre pensamientos, sentimientos y comportamientos. | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 2. Dibujar un diagrama que ilustre los patrones con los cuales el paciente se relaciona con otras personas | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 3. Técnicas de mindfulness (atención plena) | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 4. Afrontar el presente y el futuro | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 5. Explorar la niñez y el pasado del paciente | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 6. Dedicar tiempo a observar los vínculos entre creencias, pensamientos y sentimientos | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 7. Explorar los patrones con los que el paciente se relaciona con otras personas | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 8. Dejar al paciente guiar el contenido de las sesiones | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 9. Pedir al paciente que mantenga un diario sobre sus pensamientos | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 10. Explorar otros problemas del paciente además de sus dificultades alimentarias | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 11. Ejercicios de relajación | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 12. Hablar sobre la niñez del paciente y sus experiencias pasadas | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 13. Cambiar el significado ligado a los pensamientos del paciente | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 14. Dar al paciente tareas o ejercicios para hacer entre sesiones | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 15. Pedir al paciente completar encuestas o cuestionarios de monitoreo regularmente | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 16. Hablar sobre cualquier tema que estuviese en la mente del paciente | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 17. Establecer una agenda al inicio de cada sesión | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

**Part IV – Questions regarding therapists’ own performance**

1. ¿Usa usted un manual de TCC para los trastornos alimenticios?

* No
* Sí (por favor, especifique cuál) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Del total de pacientes que usted trata con TCC para los trastornos alimenticios, ¿Qué porcentaje de ellos se recupera?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Del total de pacientes que usted trata con TCC para los trastornos alimenticios, ¿Qué porcentaje de ellos mejora?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Del total de pacientes que usted trata con TCC para los trastornos alimenticios, ¿Qué porcentaje de ellos continúa igual?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Del total de pacientes que usted trata con TCC para los trastornos alimenticios, ¿Qué porcentaje de ellos empeora?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Comparado con otros profesionales de la salud mental en su área, ¿Cómo calificaría sus propias habilidades clínicas y rendimiento en una escala del 0% al 100%? (por ejemplo, 25% = Debajo del promedio; 50% = Promedio; 75% = Por encima del promedio, etc).

**Part V – Debrief**

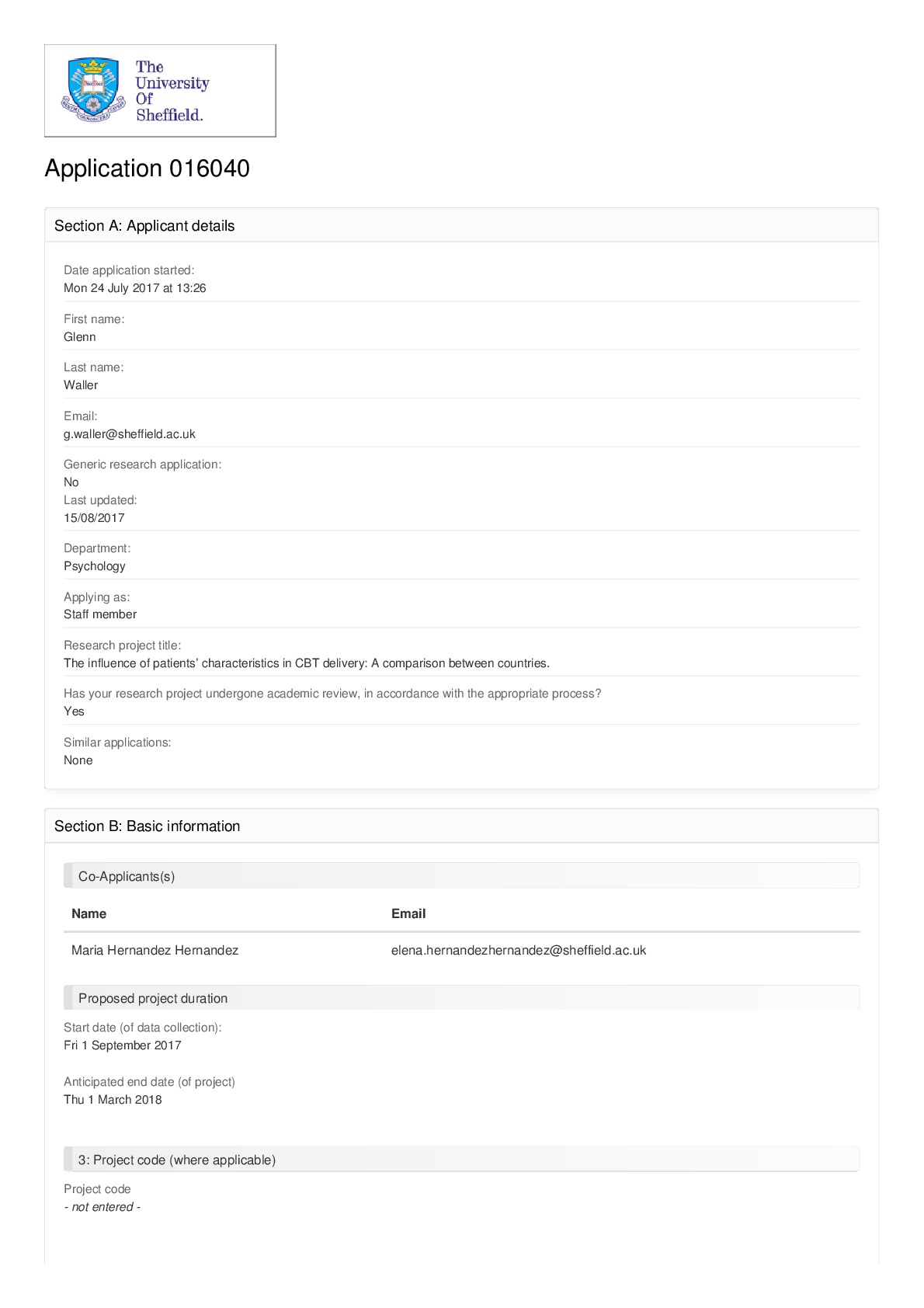
Gracias por participar en este estudio. El propósito general de esta investigación fue el determinar qué tan frecuentemente las técnicas de la TCC para los trastornos de la conducta alimentaria son utilizadas por los terapeutas de diferentes trasfondos culturales, específicamente, de los países latinoamericanos y el Reino Unido. En este estudio, se le pidió indicar qué tan frecuentemente usted utiliza distintas técnicas de la TCC para los trastornos alimenticios, así como responder a preguntas adicionales sobre demografía, trasfondo académico, y otras variables psicológicas. Pretendemos comparar los diferentes patrones de uso de las técnicas TCC para los desórdenes alimenticios entre países, y determinar la influencia de otros factores en dichos patrones de uso (por ejemplo, la ubicación geográfica, la formación académica, niveles de ansiedad, etc). Si tiene alguna preocupación relativa a este estudio, no dude en contactar a la investigadora principal de este estudio, María Elena Hernández Hernández, en el correo mehernandezhernandez1@sheffield.ac.uk, quien con gusto responderá todas sus preguntas. Le agradeceríamos mucho si pudiera enviar esta encuesta a cualquiera de sus colegas que estuviese dispuesto a participar, enviándoles el mismo link que le fue enviado a usted vía correo electrónico.

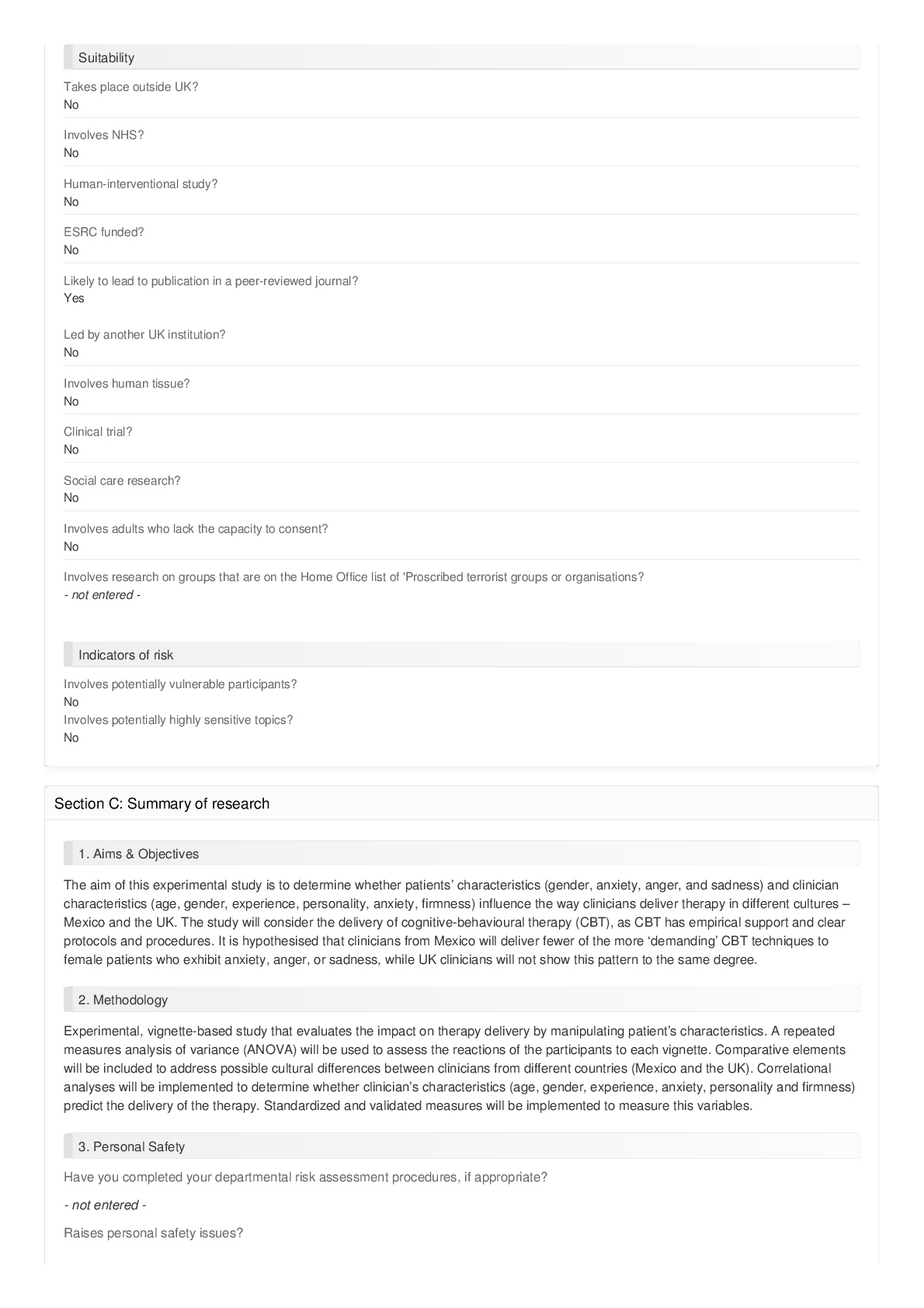
Por favor, de click en "Sí" para enviar sus respuestas.

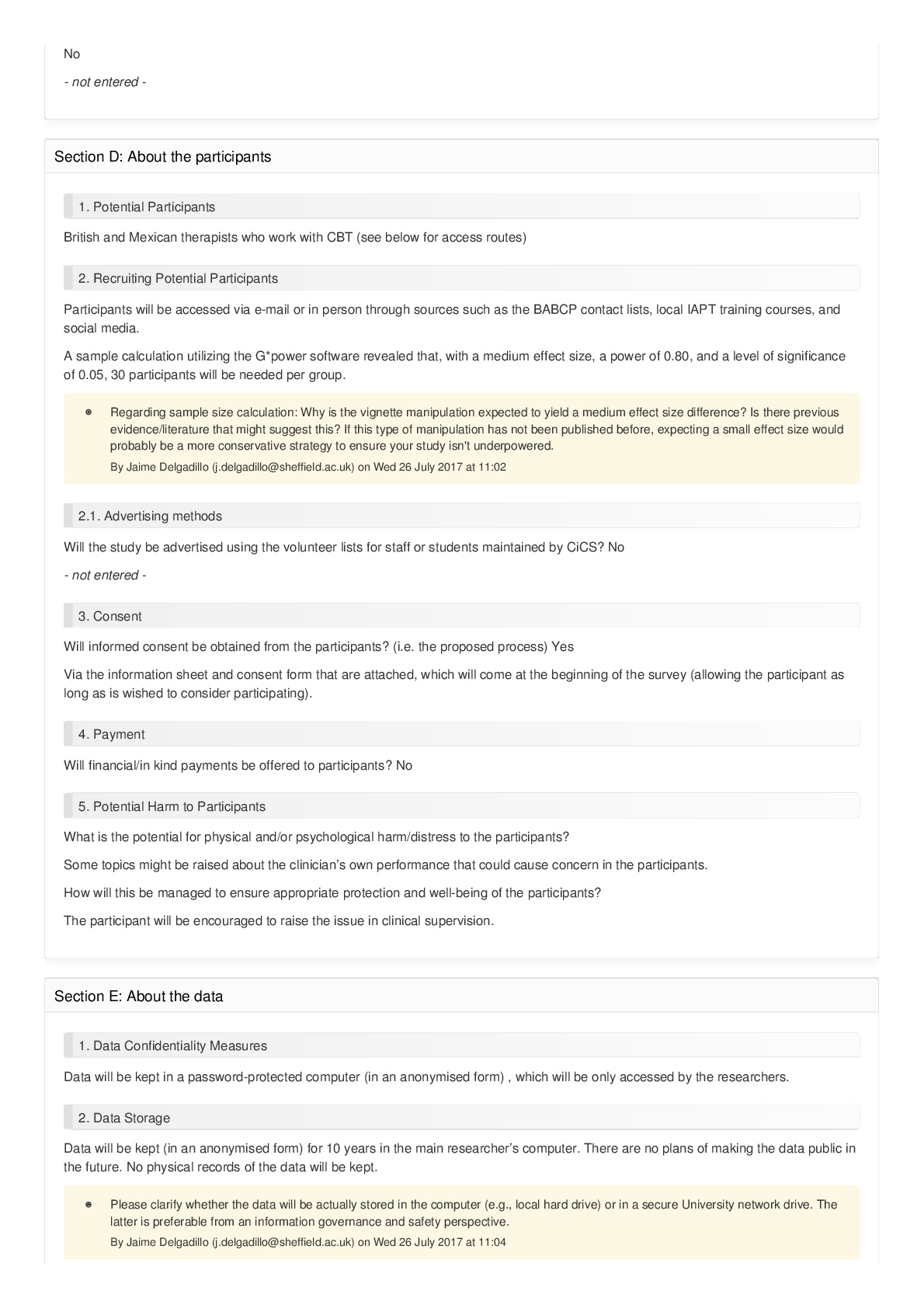
* Sí
* No

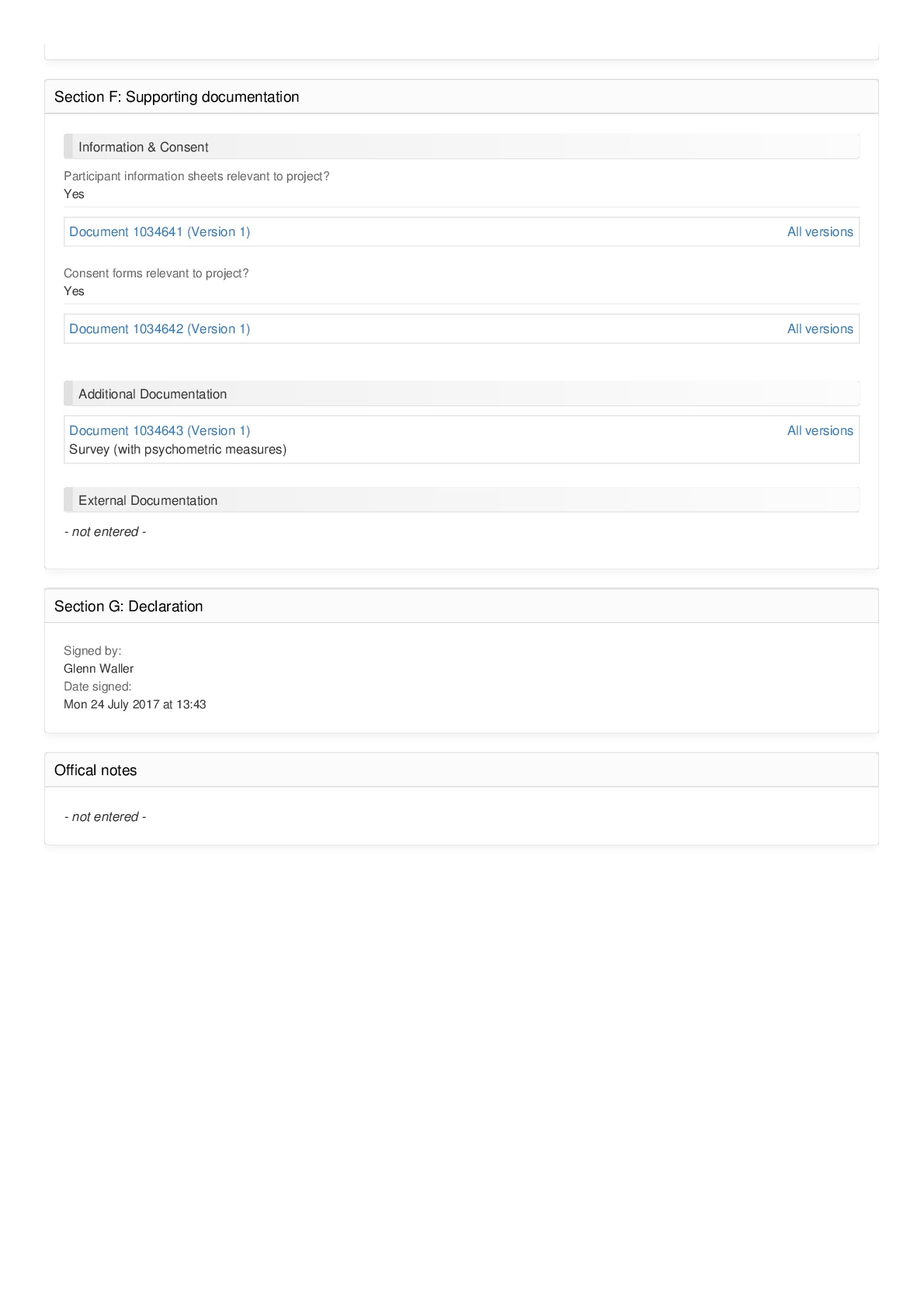
**Appendix 3.1**

Ethics approval for Study 3 (Chapter IV)









**Appendix 3.2.1**

E-mail invitation for participants – Study 3 (Chapter IV)

Dear colleague,

My name is Elena Hernandez, and I am a psychology PhD student from the University of Sheffield. I am inviting clinicians from the UK and Mexico to participate in a study as part of my PhD. If you deliver or have delivered Cognitive Behavioural Therapy (CBT) to your patients, we would be grateful if you would consider participating in this study, which examines the choices that clinicians make when delivering CBT. The process will take 20 minutes approximately, and if you want to do it in parts, you can return to the study within a week and start where you left off.

To participate, please click the following link:

https://sheffieldpsychology.eu.qualtrics.com/jfe/form/SV\_bOscoCaBThvs49D

We would be grateful if you could forward this e-mail to any of your colleagues who might be interested in taking part.

Thank you very much for your help.

**Appendix 3.2.2**

E-mail invitation for participants – Study 3 (Chapter IV)

*Spanish version*

Estimado colega,

Mi nombre es Elena Hernandez, y soy estudiante del doctorado en psicología en la Universidad de Sheffield. Estoy invitando a psicoterapeutas mexicanos a participar en uno de mis proyectos de investigación, que explora las decisiones que los terapeutas toman al aplicar la Terapia Cognitivo Conductual (TCC). Si usted emplea o ha empleado la TCC con sus pacientes, le agradecería mucho si considerara tomar parte en este estudio. El proceso tomaría aproximadamente 20 minutos, y puede ser completado en partes durante el transcurso de una semana.

Para participar en el estudio, por favor dé clic en el siguiente link:

https://sheffieldpsychology.eu.qualtrics.com/jfe/form/SV\_d5PpZOX7zR59ln7

Como muestra de agradecimiento por su colaboración, usted puede participar en el sorteo para ganar una de cinco tarjetas de regalo de Amazon, con un valor de $500 MXN cada una, al proveer su correo electrónico al final del estudio. Este paso es opcional, y su correo no será utilizado para ningún otro propósito.

Le agradeceríamos mucho si pudiera re-enviar este correo a cualquiera de sus colegas que pudieran estar interesados en participar.

Muchas gracias por su ayuda.

**Appendix 3.3.1**

Informed consent for Study 3 (Chapter IV)

Cognitive behavioural therapy (CBT) has proven to be effective for the treatment of several psychological disorders. However, studies have suggested that clinicians tend to focus CBT in different ways. We are interested in UK clinicians deliver CBT compared to clinicians in another country (Mexico).

If you agree to participate in this study, you will be asked to read a series of fictional clinical cases and complete a questionnaire about what techniques would you use when working with CBT. We will ask you some questions about your clinical work and qualifications, but nothing that would identify you. Your answers will be entirely confidential, and all data will be accessed only by the researchers. The information you provide will be used exclusively for the purposes of this study, and individual responses will never be identified. Participation is completely voluntary, and you are free to withdraw at any time until you submit your data.

This study has been approved by the Psychology Research Ethics Committee at the University of Sheffield, and it is supervised by Professor Glenn Waller. For any further information or questions about this study, feel free to contact the main researcher at elena.hernandezhernandez@sheffield.ac.uk.

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| I have read and understood the information sheet relating to this study | ○ | ○ |
| I understand that I can withdraw at any time without any consequences | ○ | ○ |
| I agree to take part in this study | ○ | ○ |

**Appendix 3.3.2**

Informed consent for Study 3 (Chapter IV)

*Spanish version*

La terapia cognitivo conductual (TCC) ha probado ser efectiva para el tratamiento de varios trastornos psicológicos. Sin embargo, investigaciones recientes han sugerido que los terapeutas suelen enfocar la TCC en distintas maneras. Si usted acepta participar en este estudio, se le pedirá leer una serie de casos clínicos ficticios, y completar un cuestionario acerca de las técnicas que usted utiliza al aplicar la TCC. Estamos invitando a terapeutas de México y del Reino Unido a participar. Se le harán preguntas sobre su trabajo clínico y cualificaciones, pero no sobre sus datos de identificación personal. Sus respuestas serán enteramente confidenciales, y sólo los investigadores involucrados en el proyecto tendrán acceso a ellas. La información que usted provea será utilizada exclusivamente para propósitos de este estudio, y sus respuestas individuales nunca serán referidas. Su participación es completamente voluntaria, y puede abandonar el estudio en cualquier momento si así lo desea. Usted puede participar en el sorteo por una tarjeta de regalo de Amazon con un valor de $500 MXN, escribiendo su correo electrónico al final del estudio. El sorteo se llevará a cabo una vez completada la muestra. Este estudio ha sido aprobado por el Comité de Ética del Departamento de Psicología de la Universidad de Sheffield, y es supervisado por el Profesor Glenn Waller. Para cualquier información adicional, o si tiene usted alguna pregunta, puede contactar a la investigadora principal, Elena Hernandez, mediante el correo electrónico elena.hernandezhernandez@sheffield.ac.uk.

|  |  |  |
| --- | --- | --- |
|  | Sí | No |
| He leído y comprendido la información sobre este estudio | ○ | ○ |
| Comprendo que puedo abandonar el estudio en cualquier momento | ○ | ○ |
| Acepto participar en este estudio | ○ | ○ |

**Appendix 3.4.1**

Survey for Study 3 (Chapter IV)

**Part I – Demographic information**

1. In what country do you practice as a therapist?

* United Kingdom
* Mexico
* Other

2. Do you use or have you used cognitive behavioural therapy with your patients?

* Yes
* No

3. What is your age? (in years)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Are you male or female?

* Male
* Female
* Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. What is your core profession?

* Psychologist
* Psychiatrist
* Social worker
* Physician
* Other (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. What is your primary theoretical orientation?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Have you received formal training in CBT?

* Yes
* No

8. For how long have you been practicing as a clinician? (in years)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. For how long have you been practicing CBT? (in years)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. How many patients do you treat each week?

* Fewer than 1 per week
* 1 - 5 per week
* 6 - 10 per week
* 11 - 15 per week
* 15 - 20 per week
* More than 20 per week

11. How many of those patients do you treat using a CBT approach?

* 0-10%
* 11-20%
* 21-30%
* 31-40%
* 41-50%
* 51-60%
* 61-70%
* 71-80%
* 81-90%
* 91-100%

12. How many hours of supervision per week do you receive?

* Less than 1 per week
* 1 - 2 per week
* 3 or more per week

**Part II – Case vignettes**

Below you will be presented with a series of hypothetical clinical situations, accompanied by a list of techniques commonly used when delivering CBT. Please, read each case carefully, and state how likely it is that you will use each technique for that specific case.

1. Gloria is a 27 year old woman. She describes herself as a very shy, introverted person, and has been struggling in her new job. She says that she feels very intimidated by her boss, and that she’s afraid of being judged by her colleagues, so she tends to avoid everyone as much as possible. Gloria recognizes that this will eventually damage her career, so she looks for psychological support. While in therapy, she is clearly nervous, stating that she is afraid of ‘opening up to a complete stranger’.

As her therapist, you decide that cognitive-behavioural therapy would suit Gloria’s situation. How likely is it that you would use each of the following techniques as part of that approach?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1  Extremely unlikely | 2 | 3 | 4 | 5 | 6 | 7  Extremely likely |
| 1. Mindfulness techniques | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 2. Coping in the present and the future | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 3. Exploring the patient's childhood and past | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 4. Spending time looking at the link between beliefs, thoughts and feelings | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 5. Exploring the patient's patterns of relating to people | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 6. Letting the patient lead the content of the sessions | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 7. Asking patients to keep records of their thoughts | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 8. Relaxation exercises | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 9. Changing the meaning attached to thoughts | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 10. Giving the patient homework to do between sessions | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 11. Spending sessions talking about whatever is on the patient's mind | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 12. Setting an agenda at the beginning of each session | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 13. Remain silent | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 14. Cognitive restructuring | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 15. Behavioural activation | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 16. Motivational work | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 17. Addressing therapy interfering behaviours | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

2. Clara is a 20 year old psychology student. She was referred to therapy after recently threatening to kill herself when she failed one of her course modules. Clara shows up in therapy, where she complains that she doesn’t need therapy, and that she knows as much about psychology as any therapist. She starts to behave more aggressively, raising her voice and cursing.

You decide that a cognitive-behavioural approach would be suitable for Clara’s situation. How likely is that you will use the following techniques with her?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1  Extremely unlikely | 2 | 3 | 4 | 5 | 6 | 7  Extremely likely |
| 1. Mindfulness techniques | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 2. Coping in the present and the future | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 3. Exploring the patient's childhood and past | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 4. Spending time looking at the link between beliefs, thoughts and feelings | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 5. Exploring the patient's patterns of relating to people | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 6. Letting the patient lead the content of the sessions | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 7. Asking patients to keep records of their thoughts | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 8. Relaxation exercises | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 9. Changing the meaning attached to thoughts | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 10. Giving the patient homework to do between sessions | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 11. Spending sessions talking about whatever is on the patient's mind | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 12. Setting an agenda at the beginning of each session | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 13. Remain silent | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 14. Cognitive restructuring | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 15. Behavioural activation | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 16. Motivational work | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 17. Addressing therapy interfering behaviours | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

3. Sara is a 40 year old patient, who seeks therapy after the loss of her father. She acknowledges that she is going through a very difficult time, and that she needs additional help to go through it. Sara attends therapy punctually, and seems very interested and willing to work in order to get better.

As her therapist, you chose a cognitive behavioural approach to treat her. How likely is that you will implement each of these techniques with Sara?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1  Extremely unlikely | 2 | 3 | 4 | 5 | 6 | 7  Extremely likely |
| 1. Mindfulness techniques | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 2. Coping in the present and the future | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 3. Exploring the patient's childhood and past | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 4. Spending time looking at the link between beliefs, thoughts and feelings | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 5. Exploring the patient's patterns of relating to people | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 6. Letting the patient lead the content of the sessions | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 7. Asking patients to keep records of their thoughts | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 8. Relaxation exercises | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 9. Changing the meaning attached to thoughts | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 10. Giving the patient homework to do between sessions | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 11. Spending sessions talking about whatever is on the patient's mind | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 12. Setting an agenda at the beginning of each session | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 13. Remain silent | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 14. Cognitive restructuring | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 15. Behavioural activation | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 16. Motivational work | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 17. Addressing therapy interfering behaviours | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

4. Daniel is a 25 year old men with severe claustrophobia. He recently started working in an office that he describes as being ‘too small’, and says that he can ‘barely breathe when he’s there’. Daniel doesn’t want to lose this job, so he looks for psychological help. While in therapy, Daniel is extremely nervous. He says he has 'always been like this’, and that it will be ‘impossible’ for him to get better.

As Daniel’s therapist, you decide that a cognitive-behavioural approach would suit his needs. How likely is it that you would use each of the following techniques as part of the therapy?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1  Extremely unlikely | 2 | 3 | 4 | 5 | 6 | 7  Extremely likely |
| 1. Mindfulness techniques | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 2. Coping in the present and the future | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 3. Exploring the patient's childhood and past | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 4. Spending time looking at the link between beliefs, thoughts and feelings | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 5. Exploring the patient's patterns of relating to people | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 6. Letting the patient lead the content of the sessions | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 7. Asking patients to keep records of their thoughts | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 8. Relaxation exercises | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 9. Changing the meaning attached to thoughts | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 10. Giving the patient homework to do between sessions | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 11. Spending sessions talking about whatever is on the patient's mind | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 12. Setting an agenda at the beginning of each session | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 13. Remain silent | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 14. Cognitive restructuring | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 15. Behavioural activation | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 16. Motivational work | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 17. Addressing therapy interfering behaviours | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

5. Gabriel is a 26 year old men who recently started working as a police officer. Some weeks ago, one of his co-workers was shot and killed. Since then, Gabriel has experienced several panic attacks. One of those panic attacks occurred during working hours in the presence of his boss, who required him to get psychological help. Gabriel is clearly angry. He is reluctant to speak, and states that he doesn’t want to be in therapy. He believes that therapy is a waste of his time, and that the panic attacks will eventually go away on their own.

As Gabriel's therapist, you decide that a cognitive-behavioural approach would suit his needs. How likely is it that you would use the following techniques as part of the approach?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1  Extremely unlikely | 2 | 3 | 4 | 5 | 6 | 7  Extremely likely |
| 1. Mindfulness techniques | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 2. Coping in the present and the future | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 3. Exploring the patient's childhood and past | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 4. Spending time looking at the link between beliefs, thoughts and feelings | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 5. Exploring the patient's patterns of relating to people | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 6. Letting the patient lead the content of the sessions | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 7. Asking patients to keep records of their thoughts | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 8. Relaxation exercises | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 9. Changing the meaning attached to thoughts | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 10. Giving the patient homework to do between sessions | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 11. Spending sessions talking about whatever is on the patient's mind | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 12. Setting an agenda at the beginning of each session | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 13. Remain silent | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 14. Cognitive restructuring | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 15. Behavioural activation | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 16. Motivational work | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 17. Addressing therapy interfering behaviours | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

6. Alan is 30 years old, and has been unable to hold a job for the last year. He says that some days he feels very active and motivated, but suddenly he starts feeling depressed and miserable, and doesn’t want to go to work. He recognizes that he has a problem and that he has to do something about it, or things could get worse. Alan attends therapy, where he shows his willingness to cooperate, and seems very involved in the process.

As Alan’s therapist, you decide that you’ll treat him using a cognitive-behavioural approach. How likely is that you will use the following techniques with Alan?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1  Extremely unlikely | 2 | 3 | 4 | 5 | 6 | 7  Extremely likely |
| 1. Mindfulness techniques | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 2. Coping in the present and the future | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 3. Exploring the patient's childhood and past | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 4. Spending time looking at the link between beliefs, thoughts and feelings | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 5. Exploring the patient's patterns of relating to people | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 6. Letting the patient lead the content of the sessions | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 7. Asking patients to keep records of their thoughts | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 8. Relaxation exercises | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 9. Changing the meaning attached to thoughts | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 10. Giving the patient homework to do between sessions | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 11. Spending sessions talking about whatever is on the patient's mind | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 12. Setting an agenda at the beginning of each session | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 13. Remain silent | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 14. Cognitive restructuring | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 15. Behavioural activation | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 16. Motivational work | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 17. Addressing therapy interfering behaviours | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

**Part III – Debrief**

Thank you for your participation in this study. The general purpose of this research was to determine how clinicians focus CBT according to their patient's characteristics, and to assess the influence of several other factors in therapy delivery (e.g. age, anxiety, country of origin). If you have any concerns about this study, feel free to contact the main researcher, Elena Hernandez, at elena.hernandezhernandez1@sheffield.ac.uk, who will happily answer any questions. We would very much appreciate if you could pass this survey to any of your colleagues who might be willing to participate, sending them the link that was provided to you in the original email.

**Apendix 3.4.2**

Survey for Study 3 (Chapter IV)

*Spanish version*

**Part I – Demographic information**

1. ¿En qué país trabaja usted como terapeuta?

* Reino Unido
* México
* Otro

2. ¿Emplea o ha empleado la TCC con sus pacientes?

* Sí
* No

3. ¿Cuál es su edad? (en años)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. ¿Es usted hombre o mujer?

* Hombre
* Mujer
* Otro (por favor, especifique) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. ¿Cuál es su profesión?

* Psicólogo/a
* Psiquiatra
* Trabajador/a social
* Médico
* Otro (por favor, especifique) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. ¿Cuál es su orientación teórica principal?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. ¿Ha recibido entrenamiento formal en TCC?

* Sí
* No

8. ¿Por cuánto tiempo ha trabajado como terapeuta? (en años)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. ¿Por cuánto tiempo ha trabajado con la TCC? (en años)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. ¿Cuántos pacientes trata por semana?

* Menos de 1 por semana
* 1 - 5 por semana
* 6 - 10 por semana
* 11 - 15 por semana
* 15 - 20 por semana
* Más de 20 por semana

11. ¿A cuántos de esos pacientes trata usted con la TCC?

* 0-10%
* 11-20%
* 21-30%
* 31-40%
* 41-50%
* 51-60%
* 61-70%
* 71-80%
* 81-90%

12. ¿Cuántas horas de supervisión recibe por semana?

* Menos de 1 por semana
* 1 - 2 por semana
* 3 o más por semana

**Part II – Case vignettes**

A continuación se le presentará una serie de situaciones clínicas hipotéticas, acompañadas de una lista de técnicas comúnmente utilizadas al emplear la terapia cognitivo conductual. Por favor, lea cada caso detenidamente, e indique qué tan probable es que usted utilice cada técnica para ese caso en particular.

1. Gloria es una mujer de 27 años de edad. Ella se describe a sí misma como una persona muy tímida e introvertida. Recientemente, ella ha estado teniendo problemas en su nuevo trabajo. Gloria dice sentirse muy intimidada por su jefe, y teme ser juzgada por sus colegas, así que tiende a evitar a todos en su trabajo lo más posible. Gloria reconoce que esta situación puede dañar seriamente su carrera, así que busca ayuda psicológica. En terapia, ella luce claramente nerviosa, y dice sentir mucho miedo de "abrirse ante un completo extraño".

Como su terapeuta, usted decide que la terapia cognitivo conductual sería adecuada para tratar a Gloria. ¿Qué tan probable es que usted utilice cada una de las siguientes técnicas como parte de la terapia?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1  Totalmente improbable | 2 | 3 | 4 | 5 | 6 | 7  Totalmente probable |
| 1. Técnicas de "mindfulness" o "atención plena" | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 2. Enfrentar el presente y el futuro | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 3. Explorar la infancia y el pasado del paciente | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 4. Dedicar tiempo a explorar el vínculo entre creencias, pensamientos y sentimientos | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 5. Explorar los patrones en los cuales el paciente se relaciona con otras personas | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 6. Dejar al paciente guiar el contenido de la sesión | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 7. Pedirle al paciente mantener un registro de sus pensamientos | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 8. Ejercicios de relajación | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 9. Cambiar el significado asociado a los pensamientos | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 10. Dar al paciente tareas para hacer entre sesiones | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 11. Dedicar tiempo a hablar sobre cualquier cosa que esté en la mente del paciente | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 12. Establecer una agenda al inicio de cada sesión | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 13. Permanecer en silencio | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 14. Reestructuración cognitiva | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 15. Activación conductual | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 16. Trabajo de motivación | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 17. Abordar los comportamientos que interfieren con la terapia | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 18. Psicoeducación | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 19. Mantener un diario | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 20. Diálogo socrático | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 21. Experimentos conductuales | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 22. Trabajo de exposición | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

2. Clara es una estudiante de psicología de 20 años de edad. Ella fue referida a terapia después de amenazar con quitarse la vida al reprobar una de sus materias. Clara se presenta en terapia, donde se muestra claramente molesta. Ella dice no necesitar terapia, pues dice saber de psicología tanto o más que cualquier otro terapeuta. Clara se comporta cada vez más agresivamente, alzando la voz y usando lenguaje altisonante.

Usted decide que un enfoque cognitivo conductual sería adecuado para tratar a Clara. ¿Qué tan probable es que usted utilice las siguientes técnicas con ella?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1  Totalmente improbable | 2 | 3 | 4 | 5 | 6 | 7  Totalmente probable |
| 1. Técnicas de "mindfulness" o "atención plena" | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 2. Enfrentar el presente y el futuro | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 3. Explorar la infancia y el pasado del paciente | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 4. Dedicar tiempo a explorar el vínculo entre creencias, pensamientos y sentimientos | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 5. Explorar los patrones en los cuales el paciente se relaciona con otras personas | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 6. Dejar al paciente guiar el contenido de la sesión | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 7. Pedirle al paciente mantener un registro de sus pensamientos | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 8. Ejercicios de relajación | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 9. Cambiar el significado asociado a los pensamientos | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 10. Dar al paciente tareas para hacer entre sesiones | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 11. Dedicar tiempo a hablar sobre cualquier cosa que esté en la mente del paciente | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 12. Establecer una agenda al inicio de cada sesión | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 13. Permanecer en silencio | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 14. Reestructuración cognitiva | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 15. Activación conductual | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 16. Trabajo de motivación | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 17. Abordar los comportamientos que interfieren con la terapia | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 18. Psicoeducación | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 19. Mantener un diario | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 20. Diálogo socrático | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 21. Experimentos conductuales | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 22. Trabajo de exposición | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

3. Sara es una paciente de 40 años de edad, quien busca terapia después del fallecimiento de su padre. Ella reconoce estar pasando por un momento muy difícil, y que necesita apoyo adicional para enfrentarlo. Sara acude a terapia puntualmente, y parece estar muy interesada y dispuesta en cooperar en la terapia para mejorar.

Como su terapeuta, usted elije un enfoque cognitivo conductual para tratarla. ¿Qué tan probable es que usted implemente cada una de las siguientes técnicas con Sara?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1  Totalmente improbable |  |  |  |  |  | 7  Totalmente probable |
| 1. Técnicas de "mindfulness" o "atención plena" | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 2. Enfrentar el presente y el futuro | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 3. Explorar la infancia y el pasado del paciente | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 4. Dedicar tiempo a explorar el vínculo entre creencias, pensamientos y sentimientos | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 5. Explorar los patrones en los cuales el paciente se relaciona con otras personas | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 6. Dejar al paciente guiar el contenido de la sesión | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 7. Pedirle al paciente mantener un registro de sus pensamientos | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 8. Ejercicios de relajación | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 9. Cambiar el significado asociado a los pensamientos | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 10. Dar al paciente tareas para hacer entre sesiones | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 11. Dedicar tiempo a hablar sobre cualquier cosa que esté en la mente del paciente | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 12. Establecer una agenda al inicio de cada sesión | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 13. Permanecer en silencio | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 14. Reestructuración cognitiva | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 15. Activación conductual | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 16. Trabajo de motivación | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 17. Abordar los comportamientos que interfieren con la terapia | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 18. Psicoeducación | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 19. Mantener un diario | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 20. Diálogo socrático | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 21. Experimentos conductuales | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 22. Trabajo de exposición | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

4. Daniel es un hombre de 25 años de edad con un caso severo de claustrofobia. Recientemente comenzó a trabajar en una oficina que él considera muy pequeña, donde dice que “a penas y puede respirar”. Daniel no quiere perder su trabajo, así que busca ayuda psicológica. En terapia, Daniel está extremadamente nervioso. Él dice haber sufrido de este problema toda su vida, y teme que le sea imposible mejorar.

Como el terapeuta de Daniel, usted decide que la terapia cognitivo conductual sería adecuada para sus necesidades. ¿Qué tan probable es que usted utilice las siguientes técnicas como parte de la terapia?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1  Totalmente improbable |  |  |  |  |  | 7  Totalmente probable |
| 1. Técnicas de "mindfulness" o "atención plena" | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 2. Enfrentar el presente y el futuro | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 3. Explorar la infancia y el pasado del paciente | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 4. Dedicar tiempo a explorar el vínculo entre creencias, pensamientos y sentimientos | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 5. Explorar los patrones en los cuales el paciente se relaciona con otras personas | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 6. Dejar al paciente guiar el contenido de la sesión | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 7. Pedirle al paciente mantener un registro de sus pensamientos | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 8. Ejercicios de relajación | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 9. Cambiar el significado asociado a los pensamientos | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 10. Dar al paciente tareas para hacer entre sesiones | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 11. Dedicar tiempo a hablar sobre cualquier cosa que esté en la mente del paciente | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 12. Establecer una agenda al inicio de cada sesión | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 13. Permanecer en silencio | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 14. Reestructuración cognitiva | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 15. Activación conductual | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 16. Trabajo de motivación | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 17. Abordar los comportamientos que interfieren con la terapia | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 18. Psicoeducación | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 19. Mantener un diario | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 20. Diálogo socrático | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 21. Experimentos conductuales | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 22. Trabajo de exposición | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

5. Gabriel es un hombre de 26 años que recientemente comenzó a trabajar como oficial de policía. Hace algunas semanas, uno de sus compañeros de trabajo fue muerto a tiros. Desde entonces, Gabriel ha experimentado ataques de pánico constantemente. Uno de estos ataques ocurrió en su trabajo en la presencia de su jefe, quien le exigió buscar ayuda psicológica. Gabriel acude a terapia, claramente molesto. Se niega a hablar de su situación y dice no querer estar ahí. Gabriel dice que la terapia psicológica “una pérdida de tiempo”, y que los ataques de pánico eventualmente desaparecerán por sí solos.

Como su terapeuta, usted decide que la terapia cognitivo conductual sería adecuada para Gabriel. ¿Qué tan probable es que usted emplee las siguientes técnicas como parte de este enfoque?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1  Totalmente improbable |  |  |  |  |  | 7  Totalmente probable |
| 1. Técnicas de "mindfulness" o "atención plena" | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 2. Enfrentar el presente y el futuro | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 3. Explorar la infancia y el pasado del paciente | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 4. Dedicar tiempo a explorar el vínculo entre creencias, pensamientos y sentimientos | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 5. Explorar los patrones en los cuales el paciente se relaciona con otras personas | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 6. Dejar al paciente guiar el contenido de la sesión | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 7. Pedirle al paciente mantener un registro de sus pensamientos | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 8. Ejercicios de relajación | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 9. Cambiar el significado asociado a los pensamientos | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 10. Dar al paciente tareas para hacer entre sesiones | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 11. Dedicar tiempo a hablar sobre cualquier cosa que esté en la mente del paciente | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 12. Establecer una agenda al inicio de cada sesión | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 13. Permanecer en silencio | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 14. Reestructuración cognitiva | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 15. Activación conductual | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 16. Trabajo de motivación | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 17. Abordar los comportamientos que interfieren con la terapia | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 18. Psicoeducación | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 19. Mantener un diario | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 20. Diálogo socrático | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 21. Experimentos conductuales | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 22. Trabajo de exposición | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

6. Alan tiene 30 años de edad, y le ha sido imposible mantener un trabajo durante todo este año. Él dice que algunos días se siente activo y motivado, pero de pronto comienza a sentirse deprimido y desdichado, y no se siente en condiciones para ir a trabajar. Él reconoce tener un problema, y que necesita hacer algo al respecto o las cosas podrían empeorar. Alan acude a terapia, donde muestra su voluntad en cooperar y mejorar, y parece estar muy interesado en el proceso.

Como el terapeuta de Alan, usted decide que lo tratará empleando un enfoque cognitivo conductual. ¿Qué tan probable es que usted emplee las siguientes técnicas con Alan?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1  Totalmente improbable |  |  |  |  |  | 7  Totalmente probable |
| 1. Técnicas de "mindfulness" o "atención plena" | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 2. Enfrentar el presente y el futuro | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 3. Explorar la infancia y el pasado del paciente | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 4. Dedicar tiempo a explorar el vínculo entre creencias, pensamientos y sentimientos | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 5. Explorar los patrones en los cuales el paciente se relaciona con otras personas | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 6. Dejar al paciente guiar el contenido de la sesión | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 7. Pedirle al paciente mantener un registro de sus pensamientos | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 8. Ejercicios de relajación | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 9. Cambiar el significado asociado a los pensamientos | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 10. Dar al paciente tareas para hacer entre sesiones | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 11. Dedicar tiempo a hablar sobre cualquier cosa que esté en la mente del paciente | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 12. Establecer una agenda al inicio de cada sesión | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 13. Permanecer en silencio | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 14. Reestructuración cognitiva | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 15. Activación conductual | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 16. Trabajo de motivación | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 17. Abordar los comportamientos que interfieren con la terapia | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 18. Psicoeducación | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 19. Mantener un diario | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 20. Diálogo socrático | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 21. Experimentos conductuales | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 22. Trabajo de exposición | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

**Part III – Debrief**

Gracias por su participación en este estudio. El propósito general de esta investigación es el determinar cómo los terapeutas que practican la TCC tienden a enfocar la terapia acorde a las características de sus pacientes, y explorar la asociación de otros factores en la implementación de la terapia (e.g. edad, ansiedad, locación).

Le recordamos que si tiene alguna inquietud respecto a este estudio, puede contactar a la investigadora principal, Elena Hernandez, en el correo electrónico elena.hernandezhernandez@sheffield.ac.uk, quien con gusto responderá cualquier pregunta.

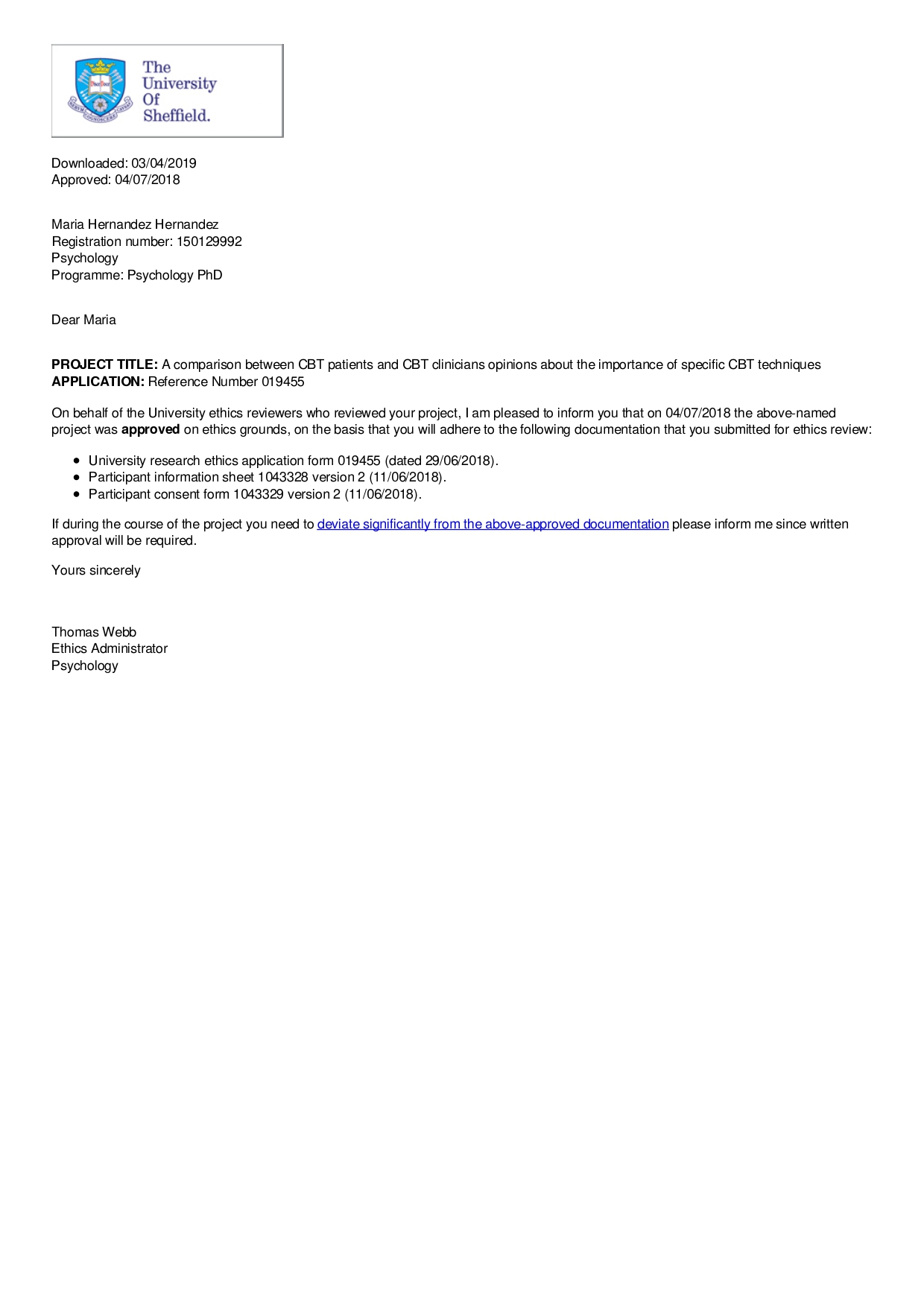
Le agradeceríamos si pudiera enviar esta encuesta a sus colegas, enviándoles el mismo link que le fue enviado a usted mediante correo electrónico.

Si desea participar en el sorteo para ganar una de cinco tarjetas de regalo de Amazon con un valor de $500 MXN, por favor escriba su correo electrónico en el siguiente recuadro. Su correo será utilizado únicamente para este propósito.

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**Appendix 4.1**

Ethics approval for Study 4 (Chapter V)



**Appendix 4.2.1**

E-mail invitation for Study 4 (Chapter V)

*Version for patients*

We are looking for participants who have received Cognitive Behavioural Therapy (CBT). The participation involves answering a short online survey about some specific elements of CBT, and other psychological measures. The whole process will take approximately 10 minutes. As a compensation for your time, you can participate in a draw to win one of five GBP20 Amazon gift cards by providing your email at the end of the study. This step is optional, and your email will not be used for any other purpose.

To participate in this study, click on the following link:

https://sheffieldpsychology.eu.qualtrics.com/jfe/form/SV\_6GznQKa6WTdqB1z

If you have any questions about the study or would like further information, please contact the main researchers, Elena Hernandez (elena.hernandezhernandez@sheffield.ac.uk) or Glenn Waller (g.waller@sheffield.ac.uk). This research has been approved by the Department of Psychology's Ethics Committee (REF 019455).

We would greatly appreciate it if you could re-send this email to anyone who might be interested in participating.

Thank you very much for your help.

**Appendix 4.2.2**

E-mail invitation for Study 4 (Chapter V)

*Version for therapists*

Dear colleague,

My name is Elena Hernandez, and I am a psychology PhD student from the University of Sheffield. I am inviting clinicians who deliver Cognitive Behavioural Therapy (CBT) to participate in one of my PhD studies. The participation involves answering a short online survey about some specific elements of CBT, and an additional psychological measure. The whole process will take approximately 10 minutes

To participate, please click on the following link:

https://sheffieldpsychology.eu.qualtrics.com/jfe/form/SV\_2t8sPaYthfad7yR

We would be very grateful if you could forward this e-mail to any of your colleagues who might be interested in taking part.

Thank you very much for your help.

**Appendix 4.3.1**

Informed consent for Study 4 (Chapter V)

*Version for patients*

Cognitive behavioural therapy (CBT) is a type of psychological intervention that has proven to be effective for the treatment of several psychological disorders. However, patients and therapists might consider that some of the elements of this type of intervention are more important or beneficial than others. Furthermore, people’s cultural background might also have an influence in the importance they attribute to some CBT elements. If you agree to participate in this study, you will be asked to rate how important you consider certain CBT techniques to be in an intervention. We will also ask you some demographic questions, but nothing that would identify you personally.

The results of this study will be written up and submitted as part of a PhD thesis. Your answers will be entirely confidential, and all data will be accessed only by the researchers. The information you provide will be used exclusively for the purposes of this study, and individual responses will never be identified. Participation is completely voluntary and you are free to withdraw at any time until you submit your data.

This study has been approved by the Psychology Research Ethics Committee at the University of Sheffield, and it is supervised by Professor Glenn Waller. For any further information or questions about this study, feel free to contact the main researcher at elena.hernandezhernandez@sheffield.ac.uk.

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| I have read and understood the information related to this study | ○ | ○ |
| I understand that I can withdraw at any time without any consequences | ○ | ○ |
| I agree to take part in this study | ○ | ○ |

**Appendix 4.3.2**

Informed consent for Study 4 (Chapter V)

*Version for therapists*

Cognitive behavioral therapy (CBT) has proven to be effective for the treatment of several psychological disorders. However, its origins and major developments come mainly from highly developed Anglo/European countries. This cultural specificity has led clinicians and researchers to question the validity of such interventions on patients from different cultural backgrounds. The current literature extensively recommends modifying therapies to address these cultural differences. If you agree to participate in this study, you will be asked to indicate how important do you believe some specific techniques of CBT would be in an intervention with a patient with the same cultural background as you, and with a patient with a different cultural background. We will also ask you some questions about your clinical work and qualifications, but nothing that would identify you. The results of this study will be written up and submitted as part of a PhD thesis. Your answers will be entirely confidential, and all data will be accessed only by the researchers. The information you provide will be used exclusively for the purposes of this study, and individual responses will never be identified. Participation is completely voluntary and you are free to withdraw at any time until you submit your data. This study has been approved by the Psychology Research Ethics Committee at the University of Sheffield, and it is supervised by Professor Glenn Waller. For any further information or questions about this study, feel free to contact the main researcher at elena.hernandezhernandez@sheffield.ac.uk.

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| I have read and understood the information related to this study | ○ | ○ |
| I understand that I can withdraw at any time without any consequences | ○ | ○ |
| I agree to take part in this study | ○ | ○ |

**Appendix 4.4.1**

Survey for Study 4 (Chapter V)

*Version for patients*

**Part I – Demographic Information**

1. Are you receiving Cognitive Behavioural Therapy or have you received it in the past?

* Yes
* No

2. What is your age (in years)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. What is your gender?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. What is your current level of studies?

* Undergraduate
* Postgraduate
* Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. What is your country of origin?

* United Kingdom
* Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Do you consider that your country of origin is the one that has influenced your values and beliefs the most?

* Yes
* No (Please specify the country that has influenced your values and beliefs the most) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. What is your ethnicity?

* + White/Caucasian
  + Black or African descent
  + South Asian
  + East Asian
  + Middle eastern
  + Hispanic
  + Mixed
  + Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. For how long have you been living in the UK? (in years)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part II – Questions regarding CBT and CBT techniques**

1. For how long have you received / did you receive CBT?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Did you complete the CBT treatment?

* + Yes
  + No
  + I continue under treatment
  + Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Below is a list with some techniques commonly used in CBT. Please indicate the level of importance you give to each technique, where 1 is 'Not important' and 7 is 'Very important'.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1  Not important | 2 | 3 | 4 | 5 | 6 | 7  Very important |
| Changing the meaning attached to your thoughts | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Completing surveys regularly to monitor your progress | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Behavioural activation (Activity scheduling to encourage you to approach activities that you might be avoiding, in order to refocus on your goals and valued directions in life) | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Coping in the present and the future | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Doing homework or tasks between therapy sessions | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Behavioural experiments (Planned experiential activities, based on experimentation or observation, with the purpose to obtain new information to test the validity of your beliefs | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Exploring your childhood and past | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Exploring the patterns in your relationships with other people | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Cognitive restructuring (Process of learning to identify and dispute irrational or maladaptive thoughts, and to analyse its emotional reasoning). | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Looking at other problems besides your initial reason for searching therapy | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Enhancing your motivation in therapy | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Exposure work (Confronting the objects or situations that provoke your anxiety) | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Relaxation exercises | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Having a session to set treatment goals | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Mindfulness (Sitting silently and paying attention to thoughts, sounds, and the sensations of breathing or parts of the body, bringing the attention back whenever the mind starts to wander). | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Setting an agenda at the beginning of each therapy session | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Having a good patient-therapist alliance | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Psychoeducation (Providing you with all the necessary information about your condition, so you can have a better understanding and cope better with it). | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Allow you to do most of the talking | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Develop a case formulation (Theoretically-based description of your presenting problems, with the purpose of developing the most suitable treatment approach). | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

**Part III – Final opinions**

1. Lastly, please indicate to what extent you agree or disagree with the following statements:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1  Strongly disagree | 2 | 3 | 4 | 5 | 6 | 7  Strongly agree |
| Psychological therapies in the UK would merge well with my cultural values and beliefs | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Psychological therapies in the UK would need to be adapted to be compatible with my cultural values and beliefs | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Psychological therapies only work in Western countries and for Western people | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Western psychological problems are not relevant to my cultural context | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Western therapists would lack the necessary empathy to understand my issues | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

**Part IV – Survey end**

Thank you for participating in this study. If you have any comments, questions or complaints regarding this study, feel free to contact the main researchers, Elena Hernandez at elena.hernandezhernandez@sheffield.ac.uk, or Glenn Waller at g.waller@sheffield.ac.uk

If you wish to enter the draw for five £20 Amazon vouchers, please write your e-mail in the box below. The draw will take place once the sample is completed, and the winners will be contacted via e-mail.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appendix 4.4.2**

Survey for Study 4 (Chapter V)

*Version for therapists*

**Part I – Demographic information**

1. Do you use or have you used Cognitive Behavioural Therapy (CBT) with your patients?

* Yes
* No

2. What is your age? (in years)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. What is your gender?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. What is your country of origin?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. What is your ethnicity?

* White/Caucasian
* Black or African descent
* South Asian
* East Asian
* Middle eastern
* Hispanic
* Mixed
* Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. What is your core profession?

* + Psychologist
  + Psychiatrist
  + Social worker
  + Physician
  + Other (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. What is your primary theoretical orientation?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. For how long have you been practicing as a clinician? (in years)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. For how long have you been practicing CBT? (in years)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. How many hours of supervision per week do you receive?

* + Less than 1 per week
  + 1 - 2 per week
  + 3 or more per week

**Part II – Questions about CBT techniques**

1. Below is a list with some techniques commonly used in CBT. Please indicate the level of importance you would give to each technique while delivering CBT to a patient from your own ethnicity, and to a patient from a different ethnicity, where 1 is 'Not important' and 7 is 'Very important'.

|  |  |  |
| --- | --- | --- |
|  | Patient of your own ethnicity | Patient from a different ethnicity |
| 1. Changing the meaning attached to the patient's thoughts | ▼ 1 Not important ... 7 Very important | ▼ 1 Not important ... 7 Very important |
| 2. Asking the patient to complete surveys regularly to monitor their progress | ▼ 1 Not important ... 7 Very important | ▼ 1 Not important ... 7 Very important |
| 3. Behavioural activation (Activity scheduling to encourage patients to approach activities that they might be avoiding, in order to refocus on their goals and valued directions in life). | ▼ 1 Not important ... 7 Very important | ▼ 1 Not important ... 7 Very important |
| 4. Coping in the present and the future | ▼ 1 Not important ... 7 Very important | ▼ 1 Not important ... 7 Very important |
| 5. Asking the patient to do homework or tasks between therapy sessions | ▼ 1 Not important ... 7 Very important | ▼ 1 Not important ... 7 Very important |
| 6. Behavioural experiments (Planned experiential activities, based on experimentation or observation, with the purpose to obtain new information to test the validity of the patient’s beliefs). | ▼ 1 Not important ... 7 Very important | ▼ 1 Not important ... 7 Very important |
| 7. Exploring the patient's childhood and past | ▼ 1 Not important ... 7 Very important | ▼ 1 Not important ... 7 Very important |
| 8. Exploring the patterns in the patient's relationships with other people | ▼ 1 Not important ... 7 Very important | ▼ 1 Not important ... 7 Very important |
| 9. Cognitive restructuring (Process of learning to identify and dispute irrational or maladaptive thoughts, and to analyse its emotional reasoning). | ▼ 1 Not important ... 7 Very important | ▼ 1 Not important ... 7 Very important |
| 10. Looking at other problems besides the patient's initial reason for searching therapy | ▼ 1 Not important ... 7 Very important | ▼ 1 Not important ... 7 Very important |
| 11. Enhancing patient's motivation | ▼ 1 Not important ... 7 Very important | ▼ 1 Not important ... 7 Very important |
| 12. Exposure work (Confronting the objects or situations that provoke the patient's anxiety). | ▼ 1 Not important ... 7 Very important | ▼ 1 Not important ... 7 Very important |
| 13. Relaxation exercises | ▼ 1 Not important ... 7 Very important | ▼ 1 Not important ... 7 Very important |
| 14. Having a session to set treatment goals | ▼ 1 Not important ... 7 Very important | ▼ 1 Not important ... 7 Very important |
| 15. Mindfulness (Sitting silently and paying attention to thoughts, sounds, and the sensations of breathing or parts of the body, bringing the attention back whenever the mind starts to wander). | ▼ 1 Not important ... 7 Very important | ▼ 1 Not important ... 7 Very important |
| 16. Setting an agenda at the beginning of each therapy session | ▼ 1 Not important ... 7 Very important | ▼ 1 Not important ... 7 Very important |
| 17. Having a good patient-therapist alliance | ▼ 1 Not important ... 7 Very important | ▼ 1 Not important ... 7 Very important |
| 18. Psychoeducation (Providing the patients with all the necessary information about their condition, so they can have a better understanding and cope with it better). | ▼ 1 Not important ... 7 Very important | ▼ 1 Not important ... 7 Very important |
| 19. Allow the patient to do most of the talking | ▼ 1 Not important ... 7 Very important | ▼ 1 Not important ... 7 Very important |
| 20. Develop a case formulation (Theoretically-based description of the patient's presenting problems, with the purpose of developing the most suitable treatment approach). | ▼ 1 Not important ... 7 Very important | ▼ 1 Not important ... 7 Very important |

2. Below is a list with some techniques commonly used in CBT. Please indicate the level of importance you would give to each technique while delivering CBT, where 1 is 'Not important' and 7 is 'Very important' *(only displayed to non-Caucasian therapists)*.

|  |  |
| --- | --- |
| Technique | Importance |
| 1. Changing the meaning attached to the patient's thoughts | ▼ 1 Not important ... 7 Very important |
| 2. Asking the patient to complete surveys regularly to monitor their progress | ▼ 1 Not important ... 7 Very important |
| 3. Behavioural activation (Activity scheduling to encourage patients to approach activities that they might be avoiding, in order to refocus on their goals and valued directions in life). | ▼ 1 Not important ... 7 Very important |
| 4. Coping in the present and the future | ▼ 1 Not important ... 7 Very important |
| 5. Asking the patient to do homework or tasks between therapy sessions | ▼ 1 Not important ... 7 Very important |
| 6. Behavioural experiments (Planned experiential activities, based on experimentation or observation, with the purpose to obtain new information to test the validity of the patient’s beliefs). | ▼ 1 Not important ... 7 Very important |
| 7. Exploring the patient's childhood and past | ▼ 1 Not important ... 7 Very important |
| 8. Exploring the patterns in the patient's relationships with other people | ▼ 1 Not important ... 7 Very important |
| 9. Cognitive restructuring (Process of learning to identify and dispute irrational or maladaptive thoughts, and to analyse its emotional reasoning). | ▼ 1 Not important ... 7 Very important |
| 10. Looking at other problems besides the patient's initial reason for searching therapy | ▼ 1 Not important ... 7 Very important |
| 11. Enhancing patient's motivation | ▼ 1 Not important ... 7 Very important |
| 12. Exposure work (Confronting the objects or situations that provoke the patient's anxiety). | ▼ 1 Not important ... 7 Very important |
| 13. Relaxation exercises | ▼ 1 Not important ... 7 Very important |
| 14. Having a session to set treatment goals | ▼ 1 Not important ... 7 Very important |
| 15. Mindfulness (Sitting silently and paying attention to thoughts, sounds, and the sensations of breathing or parts of the body, bringing the attention back whenever the mind starts to wander). | ▼ 1 Not important ... 7 Very important |
| 16. Setting an agenda at the beginning of each therapy session | ▼ 1 Not important ... 7 Very important |
| 17. Having a good patient-therapist alliance | ▼ 1 Not important ... 7 Very important |
| 18. Psychoeducation (Providing the patients with all the necessary information about their condition, so they can have a better understanding and cope with it better). | ▼ 1 Not important ... 7 Very important |
| 19. Allow the patient to do most of the talking | ▼ 1 Not important ... 7 Very important |
| 20. Develop a case formulation (Theoretically-based description of the patient's presenting problems, with the purpose of developing the most suitable treatment approach). | ▼ 1 Not important ... 7 Very important |

**Part III – Survey end**

Thank you for participating in this study. If you have any comments, questions or complaints regarding this study, feel free to contact the main researchers, Elena Hernandez at elena.hernandezhernandez@sheffield.ac.uk, or Glenn Waller at g.waller@sheffield.ac.uk

**Appendix 5.1.1**

Cognitive and Somatic Anxiety Questionnaire (CSAQ)

Schwartz, Davidson, & Goleman (1978)

Rate the degree to which you generally feel this way when you are feeling anxious. Choose a number from 1 through 5, with 1 representing "not at all" and 5 representing "very much so".

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | 1  Not at all | 2 | 3 | 4 | 5 Very much so |
| 1. I find it difficult to concentrate because of uncontrollable thoughts. | ○ | ○ | ○ | ○ | ○ |
| 2. My heart beats faster. | ○ | ○ | ○ | ○ | ○ |
| 3. I worry too much over something that doesn't really matter. | ○ | ○ | ○ | ○ | ○ |
| 4. I feel jittery in my body. | ○ | ○ | ○ | ○ | ○ |
| 5. I imagine terrifying scenes. | ○ | ○ | ○ | ○ | ○ |
| 6. I get diahrroea. | ○ | ○ | ○ | ○ | ○ |
| 7. I can't keep anxiety provoking pictures out of my mind. | ○ | ○ | ○ | ○ | ○ |
| 8. I feel tense in my stomach. | ○ | ○ | ○ | ○ | ○ |
| 9. Some unimportant thought runs through my mind and bothers me. | ○ | ○ | ○ | ○ | ○ |
| 10. I nervously pace. | ○ | ○ | ○ | ○ | ○ |
| 11. I feel like I am losing out on things because I can't make up my mind soon enough. | ○ | ○ | ○ | ○ | ○ |
| 12. I become immobilized. | ○ | ○ | ○ | ○ | ○ |
| 13. I can't keep anxiety provoking thoughts out of my mind. | ○ | ○ | ○ | ○ | ○ |
| 14. I perspire. | ○ | ○ | ○ | ○ | ○ |

**Appendix 5.1.2**

Cognitive and Somatic Anxiety Questionnaire (CSAQ)

Schwartz, Davidson, & Goleman (1978)

Spanish version validated by Zanatta Colin, Bonilla Muñoz, & Trejo González (2003)

Evalúe el grado en el que usted experimenta las siguientes situaciones cuando se siente ansioso. Escoja un número del 1 al 5, donde el 1 representa "nada" y el 5 representa "bastante".

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | 1  Nada | 2 | 3 | 4 | 5  Bastante |
| 1. Me resulta difícil concentrarme | ○ | ○ | ○ | ○ | ○ |
| 2. Mi corazón palpita demasiado | ○ | ○ | ○ | ○ | ○ |
| 3. Me preocupo en exceso | ○ | ○ | ○ | ○ | ○ |
| 4. Tengo temblor temporal | ○ | ○ | ○ | ○ | ○ |
| 5. Imagino escenas terroríficas | ○ | ○ | ○ | ○ | ○ |
| 6. Sufro frecuentemente de diarrea | ○ | ○ | ○ | ○ | ○ |
| 7. Tengo pensamientos intrusivos | ○ | ○ | ○ | ○ | ○ |
| 8. Siento tensión en el estómago | ○ | ○ | ○ | ○ | ○ |
| 9. Frecuentemente estoy preocupado | ○ | ○ | ○ | ○ | ○ |
| 10. Camino nerviosamente | ○ | ○ | ○ | ○ | ○ |
| 11. Tengo reacciones lentas al pensar | ○ | ○ | ○ | ○ | ○ |
| 12. Me siento lento al moverme | ○ | ○ | ○ | ○ | ○ |
| 13. No puedo quitarme pensamientos que me causan ansiedad | ○ | ○ | ○ | ○ | ○ |
| 14. Sudo demasiado | ○ | ○ | ○ | ○ | ○ |

**Appendix 5.2.1**

Ten Item Personality Inventory (TIPI)

Gosling, Rentfrow, & Swann (2003)

Here are a number of personality features. Please tick one box per feature to indicate the extent to which you feel it applies to you. You should rate the extent to which the *pair* of traits applies to you, even if one characteristic applies more strongly than the other.

I see myself as:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1 Strongly disagree | 2 | 3 | 4 | 5 | 6 | 7 Strongly agree |
| 1. Extraverted, enthusiastic. | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 2. Critical, quarrelsome. | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 3. Dependable, self-disciplined. | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 4. Anxious, easily upset. | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 5. Open to new experiences, complex. | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 6. Reserved, quiet. | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 7. Sympathetic, warm. | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 8. Disorganized, careless. | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 9. Calm, emotionally stable. | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 10. Conventional, uncreative. | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

**Appendix 5.2.2**

Ten Item Personality Inventory (TIPI)

Gosling, Rentfrow, & Swann (2003)

Spanish adaptation by Renau, Oberst, Gosling, Rusiñol, & Chamarro (2013)

A continuación se presenta una serie de rasgos de personalidad que podrían o no aplicar a usted. Por favor, marque una casilla por cada rasgo para indicar el grado en que siente que este aplica a usted. Debe evaluar el grado en que ambos rasgos aplican a usted, aún si se identifica más con uno que con otro.

Me veo a mí mismo como alguien:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1  Totalmente en desacuerdo | 2 | 3 | 4 | 5 | 6 | 7  Totalmente de acuerdo |
| 1. Extrovertido, entusiasta | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 2. Crítico, peleonero | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 3. Confiable, auto-disciplinado | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 4. Ansioso, fácil de molestar | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 5. Abierto a experiencias nuevas, polifacético | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 6. Reservado, callado | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 7. Comprensivo, afectuoso | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 8. Desorganizado, descuidado | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 9. Tranquilo, emocionalmente estable | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 10. Convencional, poco creativo | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

**Appendix 5.3.1**

Marlowe-Crown Social Desirability Scale (MC-SDS)

Crowne & Marlowe (1960); shortened version (form C) by Reynolds (1982)

Below are a series of statements about patterns of behaviour with which you may or may not identify. Select "True" if you identify with the statement, or select "False" if you do not identify with it.

|  |  |  |
| --- | --- | --- |
|  | True | False |
| 1. It is sometimes hard for me to go on with my work if I am not encouraged. | ○ | ○ |
| 2. I sometimes feel resentful when I don't get my way. | ○ | ○ |
| 3. On a few occasions, I have given up doing something because I thought too little of my ability. | ○ | ○ |
| 4. There have been times when I felt like rebelling against people in authority even though I knew they were right. | ○ | ○ |
| 5. No matter who I'm talking to, I'm always a good listener. | ○ | ○ |
| 6. There have been occasions when I took advantage of someone. | ○ | ○ |
| 7. I'm always willing to admit it when I make a mistake. | ○ | ○ |
| 8. I sometimes try to get even rather than forgive and forget. | ○ | ○ |
| 9. I am always courteous, even to people who are disagreeable. | ○ | ○ |
| 10. I have never been irked when people expressed ideas very different from my own. | ○ | ○ |
| 11. There have been times when I was quite jealous of the good fortune of others. | ○ | ○ |
| 12. I am sometimes irritated by people who ask favours of me. | ○ | ○ |
| 13. I have never deliberately said something that hurt someone's feelings. | ○ | ○ |

**Appendix 5.3.2**

Marlowe-Crown Social Desirability Scale (MC-SDS)

Crowne & Marlowe (1960); shortened version (form C) by Reynolds (1982)

Spanish validation by Lara Cantú & Suzan-Reed (1988)

A continuación se presenta una serie de afirmaciones sobre patrones de comportamiento con los que usted podría o no identificarse. Seleccione "Cierto" cuando se identifique con la afirmación, o seleccione "Falso" si no se identifica.

|  |  |  |
| --- | --- | --- |
|  | Cierto | Falso |
| 1. Algunas veces me es difícil continuar con mi trabajo si no estoy presionado | ○ | ○ |
| 2. Algunas veces me siento resentido porque no me salen las cosas como quiero | ○ | ○ |
| 3. En algunas ocasiones me he dado por vencido al hacer algo porque dudo de mis capacidades | ○ | ○ |
| 4. Ha habido veces en que he sentido deseos de rebelarme contra las personas que representan la autoridad, aunque yo sepa que tienen razón | ○ | ○ |
| 5. No importa con quién hable, siempre lo escucho | ○ | ○ |
| 6. Ha habido ocasiones en que me he aprovechado de alguien | ○ | ○ |
| 7. Siempre acepto mis errores cuando los cometo | ○ | ○ |
| 8. Algunas veces trato de vengarme en lugar de olvidar y perdonar | ○ | ○ |
| 9. Siempre soy cortés, aún con gente que es desagradable | ○ | ○ |
| 10. Nunca me molesto cuando la gente expresa ideas diferentes a las mías | ○ | ○ |
| 11. Ha habido algunas veces en que me he sentido celoso de la buena suerte de otros | ○ | ○ |
| 12. Algunas veces me irrita que la gente me pida favores | ○ | ○ |
| 13. Nunca he dicho algo a propósito para ofender a alguien | ○ | ○ |

**Appendix 5.4.1**

Firmness and Empathy Questionnaire (FEQ)

McAdam Freud & Waller (in preparation)

Please indicate how strongly you identify with the following statements.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1  Low | 2 | 3 | 4 | 5 | 6 | 7  High |
| 1. I am able to put myself in other people's shoes | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 2. I feel sad when someone is genuinely upset | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 3. I find it hard to connect with others on an emotional level | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 4. I like to make sure I achieve the goals that I set for myself | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 5. I can understand other people's feelings easily | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 6. I think it is important to stick to the recommended way of carrying out tasks | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 7. I don't like to concern myself with other people's feelings | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 8. I believe that it is important to have boundaries | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 9. When other people are happy, I share that feeling | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 10. I like to make sure others achieve their tasks | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 11. Other people’s feelings do not interest me | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 12. It matters if people do not do what they were meant to do | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 13. I worry about other people who are having a hard time | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 14. When rules are violated, there should be consequences | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

**Appendix 5.4.2**

Firmness and Empathy Questionnaire (FEQ)

McAdam Freud & Waller (in preparation)

*Spanish version*

Por favor indique qué tanto se identifica con las siguientes afirmaciones:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1  Nada | 2 | 3 | 4 | 5 | 6 | 7  Bastante |
| 1. Puedo ponerme en los zapatos de otras personas | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 2. Me siento triste cuando alguien esta genuinamente descontento | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 3. Me es difícil conectar con otros a nivel emocional | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 4. Me gusta asegurarme de lograr las metas que me pongo a mí mismo | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 5. Puedo comprender los sentimientos de otras personas fácilmente | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 6. Creo que es importante adherirse a la forma recomendada de hacer las cosas | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 7. No me gusta preocuparme por los sentimientos de los demás | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 8. Creo que es importante tener límites | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 9. Cuando los demás están felices, puedo compartir ese sentimiento | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 10. Me gusta asegurarme de que otros cumplan con sus tareas | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 11. Los sentimientos de otras personas no me interesan | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 12. Importa si la gente no hace lo que se suponia que hiciera | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 13. Me preocupa cuando otras personas están pasando por un mal momento | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 14. Cuando se violan las reglas, debe haber consecuencias | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

**Appendix 5.5**

Vancouver Index of Acculturation (VIA)

(Ryder, Alden, & Paulhus, 2000)

Please indicate your degree of agreement or disagreement on each statement. Many of these statements will refer to your heritage culture, meaning the culture that has influenced you most (other than British culture). It may be the culture of your birth, the culture in which you have been raised, or another culture that forms part of your background. If there are several such cultures, pick the one that has influenced you most.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1 Strongly disagree | 2 | | 3 | | 4 | | | 5 Neutral / Depends | | 6 | 7 | 8 | 9 Strongly agree |
| 1. I often participate in my heritage cultural traditions. | ○ | ○ | | | ○ | | | ○ | | ○ | ○ | ○ | ○ | ○ |
| 2. I often participate in mainstream British cultural traditions. | ○ | ○ | | | ○ | | | ○ | | ○ | ○ | ○ | ○ | ○ |
| 3. I would be willing to marry a person from my heritage culture. | ○ | ○ | | | ○ | | | ○ | | ○ | ○ | ○ | ○ | ○ |
| 4. I would be willing to marry a White British person. | ○ | ○ | | | ○ | | | ○ | | ○ | ○ | ○ | ○ | ○ |
| 5. I enjoy social activities with people from the same heritage culture as myself. | ○ | ○ | | | ○ | | | ○ | | ○ | ○ | ○ | ○ | ○ |
| 6. I enjoy social activities with typical British people. | ○ | ○ | | | ○ | | | ○ | | ○ | ○ | ○ | ○ | ○ |
| 7. I am comfortable interacting with people of the same heritage culture as myself. | ○ | ○ | | | ○ | | | ○ | | ○ | ○ | ○ | ○ | ○ |
| 8. I am comfortable interacting with typical British people. | ○ | ○ | | | ○ | | | ○ | | ○ | ○ | ○ | ○ | ○ |
| 9. I enjoy entertainment (e.g. movies, music) from my heritage culture. | ○ | ○ | | | ○ | | | ○ | | ○ | ○ | ○ | ○ | ○ |
| 10. I enjoy British entertainment (e.g. movies, music). | ○ | ○ | | | ○ | | | ○ | | ○ | ○ | ○ | ○ | ○ |
| 11. I often behave in ways that are typical of my heritage culture. | ○ | ○ | | | ○ | | | ○ | | ○ | ○ | ○ | ○ | ○ |
| 12. I often behave in ways that are typically British. | ○ | ○ | | | ○ | | | ○ | | ○ | ○ | ○ | ○ | ○ |
| 13. It is important for me to maintain or develop the practices of my heritage culture | ○ | ○ | | | ○ | | | ○ | | ○ | ○ | ○ | ○ | ○ |
| 14. It is important for me to maintain or develop British cultural practices. | ○ | ○ | | | ○ | | | ○ | | ○ | ○ | ○ | ○ | ○ |
| 15. I believe in the values of my heritage culture. | ○ | ○ | | | ○ | | | ○ | | ○ | ○ | ○ | ○ | ○ |
| 16. I believe in mainstream British values. | ○ | ○ | | | ○ | | | ○ | | ○ | ○ | ○ | ○ | ○ |
| 17. I enjoy the jokes and humour of my heritage culture. | ○ | ○ | | | ○ | | | ○ | | ○ | ○ | ○ | ○ | ○ |
| 18. I enjoy White British jokes and humour | ○ | ○ | | | ○ | | | ○ | | ○ | ○ | ○ | ○ | ○ |
| 19. I am interested in having friends from my heritage culture. | ○ | ○ | | | ○ | | | ○ | | ○ | ○ | ○ | ○ | ○ |
| 20. I am interested in having White British friends. | ○ | ○ | ○ | | | | ○ | | | ○ | ○ | ○ | ○ | ○ |

**Appendix 5.6**

Intolerance of Uncertainty Scale (IUS-12)

Carleton, Norton, & Asmundson (2007)

Please select the number that best corresponds to how much you agree with each of the following statements.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | 1 Not at all characteristic of me | 2 | 3 | 4 | 5 Entirely characteristic of me |
| 1. Unforeseen events upset me greatly | ○ | ○ | ○ | ○ | ○ |
| 2. It frustrates me not having all the information I need | ○ | ○ | ○ | ○ | ○ |
| 3. Uncertainty keeps me from living a full life | ○ | ○ | ○ | ○ | ○ |
| 4. One should always look ahead so as to avoid surprises | ○ | ○ | ○ | ○ | ○ |
| 5. A small unforeseen event can spoil everything, even with the best of planning | ○ | ○ | ○ | ○ | ○ |
| 6. When it’s time to act, uncertainty paralyses me | ○ | ○ | ○ | ○ | ○ |
| 7. When I am uncertain I can’t function very well | ○ | ○ | ○ | ○ | ○ |
| 8. I always want to know what the future has in store for me | ○ | ○ | ○ | ○ | ○ |
| 9. I can’t stand being taken by surprise | ○ | ○ | ○ | ○ | ○ |
| 10. The smallest doubt can stop me from acting | ○ | ○ | ○ | ○ | ○ |
| 11. I should be able to organize everything in advance | ○ | ○ | ○ | ○ | ○ |
| 12. I must get away from all uncertain situations | ○ | ○ | ○ | ○ | ○ |