Article

Cross-Cultural Research on Psychotherapy: The Need for a Change

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Abstract

Psychotherapy models, some of which now have a history over a century, have been practiced worldwide. However, considering that the most prevalently applied psychotherapy models are the products of Western culture, questioning the extent of these models' effectiveness and efficiency for people belonging to diverse cultural backgrounds is legitimate. No doubt, ethnocultural groups living in Western multicultural societies will interact with Western culture more deeply compared with people living in non-Western countries; therefore, to also think that their needs will differ is reasonable. In this case, the quantity and quality of the required adaptations may also change. Although a promising number of studies exist on intercultural adaptations necessitated by the needs of multicultural societies, the literature on the effectiveness of these models in the non-Western world and the local psychotherapy models is quite limited. One important question is whether psychotherapy models can be adapted to address non-Western cultures without transforming their fundamental assumptions, and if so, can this be conducted efficiently? With these questions in mind, the aim is to review the current state of scientific studies on psychotherapy practices in various cultures. In addition, considering the large spectrum of cultural migration taking place in modern days and the difficulty of receiving mental health services in underdeveloped countries, the importance of adapted and local psychotherapy research has been emphasized and some suggestions for consideration in future research have been made.

Keywords

local psychotherapy, cultural adaptation, Western psychology

In today's world, psychological disorders constitute a serious problem, with psychopharmacology and psychotherapy being the primary intervention methods resorted to although psychotherapy is slightly more favored by clients (McHugh, Whitton, Peckham, Welge, & Otto, 2013). Despite having more detailed descriptions (Brent & Kolko, 1998), psychotherapy can basically be defined as a psychological intervention, as opposed to organic, to emotional/psychological problems (Varma, 1982), or in Winnicott's (1968) witty words, "two people playing together" (p. 571). This kind of broad definition appears theoretically flexible enough to have provided

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grounds for the more than 400 psychotherapy models developed throughout the world (Corsini & Wedding, 2008). In practice, however, a few theoretical orientations of Western origin among all seem to dominate psychotherapy practice (Orlinsky et al., 1999). Considering that each psychotherapy model reflects the culture of the society in which it flourishes, the extent to which people from different cultural backgrounds can benefit from these models and which alternatives exist for further gains if needed inevitably pose as important issues to address. Indeed, a significant body of literature interested in related topics has currently been formed, though this issue continues to be a hot topic. This study, hoping to make a meaningful contribution, reviews the relation between culture and psychotherapy, questions the effectiveness and acceptance of Western psychotherapy models for people of different cultural backgrounds, and finally examines the theory and application of psychotherapy, including cultural adaptation efforts and local psychotherapies in non-Western societies.

Culture and Psychotherapy

Due to its historical background, countless definitions and connotations of the term *culture* exist both in academic literature and in everyday use (see Kroeber & Kluckhohn, 1952). However, Marsella and Yamada (2010), in their effort to understand the link between culture and human behavior, defined culture as follows:

> Culture is shared learned behavior and meanings that are socially transmitted for purposes of adjustment and adaptation. Culture is represented externally in artifacts (e.g., food, clothing, music), roles (e.g., the social formation), and institutions (e.g., family, government). It is represented internally (i.e., cognitively, emotionally) by values, attitudes, beliefs, epistemologies, cosmologies, consciousness patterns, and notions of personhood. Culture is coded in verbally, imagistically, proprioceptively, viscerally, and emotionally, resulting in different experiential structures and processes. (p. 105)

As this definition suggests, people from different cultures can and will see the world from different perspectives, which in turn will bring about various interpretations of the structure of the human mind and norms of behavior; definitions of abnormality will also be shaped by the standards cultures determine for normality (Avasthi, 2011; Draguns & Tanaka-Matsumi, 2003; Rathod, 2016; Scharff, 2013; Sodi & Bojuwoye, 2011; Tseng, 2004). Therefore, investigating cultural determinants' role in the formation and maintenance of mental disorders is essential (Adebayo & Ilori, 2013; Bojuwoye & Sodi, 2010). In addition to influencing the formation of mental illnesses, cultural background can also shape the reaction patterns that will eventually result in psychological disorders; therefore, disorder symptoms, behavioral reaction levels, frequency with which illness occurs, perceptions and reactions toward illness (Viswanath & Chaturvedi, 2012), and willingness to receive psychotherapy (Yalvac, Kotan, & Unal, 2015) can all be affected.

All of these inevitably affect psychotherapy models. For example, Avasthi (2011) claimed the fact that diagnosing mental illnesses being substantially based on "listening" means the treatment process is inevitably affected by the interviewer's and client's communication skills, personalities, sociocultural beliefs, and interpretations. Similarly, Carstairs (as cited in Neki, 1973) suggested the roles of therapist and patient in Western culture to not have been determined by a few psychotherapists who create and apply psychotherapy but by the product of a number of therapists and patients (i.e., creation of a culture).

Leaving aside the theoretical differences between various psychotherapy models, some researchers have suggested certain universal factors of psychotherapy to be vital for positive outcomes. Wampold (2015), in his efforts to explain these common elements that include alliance, empathy, and expectation within a contextual model, emphasized that, keeping in mind the

need for patients to accept the given explanation for their distress and therapeutic actions, the treatment process should also be compatible with patients' culture.

Is It Psychology or Western Psychology?

Today, the discipline of psychology is dominated by the United States (Adair, Coêlho, & Luna, 2002; Adair & Kagitcibasi, 1995). Thirty years ago, Moghaddam (1987) studied the influence of various countries over the field of psychology based on their capacity to produce and spread knowledge, splitting them into three categories (*worlds*). Moghaddam (1987) stated the first world to consist of the United States, which dominates and shapes the psychological scene and has a substantial influence on the second and third worlds. He then added that countries such as the United Kingdom, Australia, and Canada, which fall under the second world in his categorization, rival the first world in some areas but do not have a similar impact on the first world, just on the second and third worlds. According to Moghaddam (1987), the capacity of third world countries to produce psychological knowledge by themselves is quite low; they mainly import it from the first and second worlds.

Psychology, being a modern discipline born in the West, has been under its dominance, having been substantially shaped by the historical, linguistic, and sociopolitical influence of Western cultural traditions and reflecting the cultural knowledge and practices of Western traditions (Marsella, 2009; Marsella & Yamada, 2010). Indeed, an analysis of six premier American Psychological Association (APA) journals revealed 95% of the research published in these journals to have been conducted on either Americans or Europeans, with 77% of the American samples being European Americans (Arnett, 2008). Avasthi (2011), arguing in the favor of the Indianization of psychiatry in India, claimed that what is currently defined as normal or abnormal is based on the personality structure of Western people, conventional psychotherapy techniques and diagnosis and treatment criteria and techniques have been developed in parallel with needs and problems of a Western context, and people of other nations are considered "ethnic" or "culture bound" when they do not fit these models of diagnosis and treatment.

Marsella (2009) suggested North American and Western European psychology, with its roots and attachments to logical positivism and Western "Enlightenment" thought, to have ontological, epistemological, and praxiological assumptions from its own historical and cultural context and these assumptions, which continue to dominate the world of psychology, to be driven by their commitment to 10 basic factors: individuality, reductionism, experiment-based empiricism, scientism, quantification/measurement, materialism, male dominance, objectivity, nomothetic laws, and rationality. However, the Western worldview based on these assumptions is in direct conflict with the worldviews of non-Western cultures, which have their own ontological, epistemological, and praxiological assumptions resulting from their own cultural and historical background (Marsella, 2009).

Acceptance of Psychotherapy in Non-Western Cultures

Considering the current state of psychology and psychotherapy in various countries, their currency can be seen to differ widely. A few countries will be examined below to portray this diversity. In Argentina, a notable current example of a second world country in Moghaddam's model, the field of psychology was strengthened by scientists who had fled the holocaust; as a result, the country has witnessed and contributed to developments in the field of psychology since a relatively early date (Gómez, 2007; Taiana, 2006). Psychotherapy is generally embraced by the people of Argentina; they are comfortable talking about their therapy experiences, recommend it to others, and seek psychological help not only when they face serious problems but also to increase the quality of their lives (Fernández-Álvarez, 2008; Gómez, 2007).

The landscape is quite different in countries constituting the third world; they have little influence designing the field of psychology. For instance, Haque and Masuan (2002) argued that Muslims have no confidence in the science of psychology, one of the reasons for this being psychology's reputation as a secular science that refuses humans' spiritual dimension, and Muslims are concerned that their beliefs will be analyzed and taken away from them. Furthermore, in the world of Muslim psychology, most of the misunderstandings in the field of psychology are believed to stem from incorrect assumptions regarding human nature, ranging from Darwinian view of human nature to the model of information processing units. Similarly, according to research conducted by Rogers-Sirin et al. (2017), religious Muslim people in Turkey have negative attitudes toward seeking psychological services, an attitude mediated by hierarchal family values though weakened by independent self-construal. This indicates the aforementioned negative attitudes to stem substantially from the incompatibility between the cultural values in Turkey and those inherent in psychotherapy.

Uzoka (1983) stated that Western psychotherapy techniques based substantially on verbalization may become a burden for noncommunicative people from cultures that differ from Western culture where verbalization is reinforced. He noted that in Africa, where the traditional healer discretely collects information on the patient's background from the patient's family, communicates with "higher forces" over long silences during therapy, and ultimately is the one who carries the burden of verbalization and assumes an active role, emphasis on the communicativeness of the patient may hinder therapy's effectiveness. Dwairy and Van Sickle (1996) also claimed the emphasis on individualism in Western psychotherapies prevents the needs of collectivist Arabic societies from being addressed. Similarly, Carstairs (as cited in Neki, 1973) argued that one of the problems psychologists who receive Western education in India face is having clients who insist on adopting a helpless, dependent attitude and who force their therapist to take the active role.

Kumaraswamy (2007), in his work on the application of psychotherapies in Brunei where psychology has not been able to secure its position as a legitimate science, stated that psychotherapists in this country who receive education in Western countries lack knowledge of the cultural beliefs and traditions of their patients and thus are unable to communicate properly with them. For example, he claimed that a certain dependence on parents is normal in Malay culture and efforts by a mental health professional to have the client gain independence in Western standards would bring the client more harm than good. According to Kumaraswamy (2007), the fact that traditional healers are members of the same society often helps them communicate more effectively with their client than mental health professionals, and 80% of psychiatric patients prefer consulting traditional healers before seeking professional help. This condition is not unique to Brunei. According to the results of a study conducted in Pakistan, 66% of the people who apply to psychiatric clinics had sought multiple traditional healing methods beforehand (Farooqi, 2006). Similarly, in Malaysia (Razali, 1995) and Turkey (Yalvac et al., 2015), a considerable percentage of people seek help from traditional and religious healers before applying to psychiatric clinics.

The acceptance of psychotherapy does not vary solely between countries but also between various ethnic/cultural groups within the same country. For instance, according to the results of a study conducted by Vicary and Bishop (2005) in Australia, which Moghaddam (1987) placed among second world countries, psychotherapy approaches of Western origins do not address Aboriginal people's needs. Non-Aboriginal practitioners' application of these approaches without having sought cultural appropriateness or getting sufficient knowledge about Aboriginal people has caused Aborigines to be suspicious of these practices and to apply to a mental health professional only after all alternatives have failed. Similarly, in the United States, which is the only country Moghaddam (1987) placed in the first world category, numerous studies indicate the psychological needs of people of ethnic or non-White origin to not be properly met by modern psychotherapy techniques (Vasquez, 2007).

In sum, although psychotherapy theories and applications have gained a certain currency throughout the world, the lack of consideration regarding adaptations to the cultures they interact with and inadequacy with which these theories and applications address regional needs may cause significant problems (Adair & Kagitcibasi, 1995). Under these circumstances, people's acceptance of psychotherapy applications might be hampered (Avasthi, 2011; Haque & Masuan, 2002; Kumaraswamy, 2007; Marsella & Yamada, 2010), and ethnic minorities in multicultural countries might not benefit from psychotherapy services sufficiently and quit treatment all too soon (Rathod, Kingdon, Phiri, & Gobbi, 2010; Vasquez, 2007; Vicary & Bishop, 2005).

Theory and Application of Psychotherapy in Non-Western Cultures

Different countries' prevalent theoretical orientation in psychotherapy varies depending on their intellectual and academic history (Rehm, 2007). For example, while psychodynamic psychotherapy approaches are predominantly favored in countries like Argentina (Muller, 2008) and Mexico (Sanchez-Sosa, 2007), cognitive-behavioral psychotherapy techniques are generally preferred in other countries such as Spain (Caballo & Irurtia, 2007), Australia (Kavanagh, Littlefield, Dooley, & O'Donovan, 2007), and Turkey (Bilican & Soygut-Pekak, 2015). In China, where the Chinese have already developed their own rooted holistic approaches to meet the physical, psychological, and social needs of the people for managing various mental and physical disorders prior to the spread of Western medicine to the country, cognitive-behavioral psychotherapies that highlight balanced thinking, mindfulness, acceptance, and commitment are readily accepted by mental health practitioners (Ng et al., 2016).

However, some changes in practice occur almost spontaneously according to various cultures' needs. For instance, Iran, where family bonds are relatively strong and therefore family plays a significant role in the development, maintenance, and treatment of mental disorders, has quite a demand for cognitive-behavioral therapy in the family context (Khodayarifard, Rehm, & Khodayarifard, 2007). Japan, on the contrary, has a very education-oriented society, and adults' therapy processes, even though applied for individual problems, likely will direct clinical attention toward the education-related problems of the client's children (Kanazawa, 2007).

Cultural Adaptations on Psychotherapy

Support for the idea of culture being a vital factor that should be taken into account in theory and practice of psychotherapy is growing, as also reflected in the APA Presidential Task Force on Evidence-Based Practice's (2006) definition of evidence-based practice in psychology: "Evidence-based practice in psychology is the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences" (p. 273). In addition to this, efforts to make mental health services more culturally competent in multicultural countries have given rise to the need for cross-cultural psychotherapy studies (Whaley & Davis, 2007). Mentioning a few, Pan, Huey, and Hernandez (2011) found in their study with phobic Asian Americans that cultural adaptations such as emphasizing and facilitating emotional control and exploiting the vertical nature of the therapeutic relationship in single-session treatments provide benefits beyond the standard course of treatment; they think this is because it enhances working alliance and cultural process factors. Their work also notably shows the difference between the effectiveness of culturally adapted treatment and standard treatment to be less in more acculturated clients, and vice versa. A study by Owen, Tao, Leach, and Rodolfa (2011) on the effects of psychotherapists' perceived multicultural orientation on the success of treatment outcomes reveals psychotherapists being more oriented toward cultural issues facilitates more improvement in psychological well-being. They suggested this may be due to clients perceiving

their psychotherapist as more oriented toward cultural issues; they see the therapist more credibly and feel more comfortable in the therapeutic process. In another study with Indian and South Korean international students in America, Sodowsky (1991) let the participants watch tapes of two different treatment sessions, one consistent with students' cultural values and the other culturally discrepant; the students found the culturally consistent counselor significantly more expert-like and trustworthy. A similar study conducted with Mexican American students used two videotapes, one where the therapist was culturally sensitive and responsive to cultural elements presented by the client and another where the therapist was culturally insensitive and responsive only to client's comments unrelated to culture, and showed the effect of cultural sensitivity to be found in perceptions of cultural competence (Atkinson, Casas, & Abreu, 1992).

Meta-analyses of cultural adaptations in psychotherapy techniques yield conflicting results. For example, according to the results of a meta-analysis across 76 studies conducted by Griner and Smith (2006), culturally adapted interventions are more effective compared with standard interventions, and interventions conducted in clients' native language are twice as effective. Similarly, according to a meta-analysis across 65 studies conducted by Smith, Rodriguez, and Bernal (2011), as the number of cultural adaptation elements increases so does the effectiveness of the treatment. Also, adaptations are more effective when targeting a specific cultural group rather than clients with various cultural backgrounds. In another meta-analysis conducted by Tao, Owen, Pace, and Imel (2015) investigating the effect of psychotherapists' cultural competence on therapeutic processes and outcomes, a positive correlation is suggested for therapists' cultural competence with working alliance, client satisfaction, general counseling competence, session impact, and symptom improvement. Draguns (2013) and Rathod (2016), in their systematic reviews regarding the cultural adaptation of psychotherapy models, emphasized findings that demonstrate cultural adaptation to increase treatment effectiveness and called for further research on the subject. Falicov (2009), in his work on culturally attuned treatments for Latinos, also supported the idea of cultural adaptation positively affecting the outcome of treatment. On the contrary, Benuto and O'Donohue (2015) reviewed cultural sensitivity studies on Hispanics and claimed them to have serious methodological limitations, with little evidence that cultural adaptations consistently increase effect size. In their meta-analysis, Huey and Polo (2008) also emphasized the deficiencies of research on evidence-based treatments for ethnic minorities, such as low statistical power, poor representation of less acculturated groups, and lack of culturally validated outcome measures in the literature. Though a lack of consensus exists, various guidelines are suggested for psychotherapists to be culturally sensitive when working with clients from diverse backgrounds and for researchers willing to work in this area (e.g., Hinton, Rivera, Hofmann, Barlow, & Otto, 2012; Huey & Polo, 2008; Kalibatseva & Leong, 2014; Moodley & Sutherland, 2010; Vicary & Bishop, 2005).

However, various studies have been conducted in countries where psychotherapy approaches of Western origin are imported and modern techniques are applied, often together with traditional methods (Abbo, Okello, Musisi, Waako, & Ekblad, 2012) on deep-rooted local solutions to mental problems (e.g., Bhargava, Kumar, & Gupta, 2016; Kumar, Bhugra, & Singh, 2005; Neki, 1973; Vitebsky, 2001), the similarities and differences between Western psychotherapy techniques and traditional methods, and the conformance of Western techniques to cultural values (e.g., Chen, 1995; Jock et al., 2013; Kakar, 2003; Maiello, 1999; Scorzelli & Reinke-Scorzelli, 2001). Western psychotherapy techniques have been adapted to countries' culture, or traditional methods have been integrated into modern therapy techniques at various levels (e.g., Bergman, Witzum, & Bergman, 1991; Berthold, 1989; Madu, 2013; Moodley & Sutherland, 2010; Moodley, Sutherland, & Oulanova, 2008; Sato, 1998; Tseng, 2004). That professionals in various countries call for the inclusion of traditional healers in mental health services and cooperation between modern and traditional methods is worth noting (Abbo et al., 2012; Bojuwoye & Sodi, 2010; Chong, Abdin, Vaingankar, Kwok, & Subramaniam, 2012). Supporting this idea, Gómez (2007)

suggested psychotherapy to be able to reach a large population in Argentina, as psychotherapists are willing to work in cooperation with traditional healers.

Inclusion of Religion and Spirituality

A number of studies have been conducted on the blending of worldviews and religious values with psychotherapy practices. For instance, Hisham Abu-Raiya (2015) built a personality theory on the idea that, from an Islamic perspective, the human soul consists of divine and evil aspects and developed the Qur'an-Based Psychotherapy Model that aims to treat psychological problems by taming the evil side and empowering the divine side. Another example is Religious Cognitive-Behavioral Therapy, which integrates cognitive, humanistic, and existentialist theories, as well as takes Islamic beliefs into consideration (Rajaei, 2010).

Similarly, healing methods drawn from Christian religious values have been integrated into psychotherapy techniques in several ways. For example, Pastoral and Christian therapies, based on divine revelation and theological reflection, are often used in marriage counseling (Mutter, 2011). McMinn, Staley, Webb, and Seegobin (2010) separated psychotherapy approaches addressed to Christian clients into five categories, describing each one: Biblical counseling, Pastoral counseling, Christian psychology, Christian ministry, and other approaches. Meanwhile, attempts are also found to integrate psychotherapy approaches of Buddhist origin, like Acceptance and Commitment Therapy and Christian worldview (Sisemore, 2014).

Smith, Bartz, and Richards (2007) conducted a meta-analysis on religiously and spiritually oriented psychotherapy studies, investigating several therapy techniques applied to different groups and their effectiveness; they concluded spiritual and religious adaptations to psychotherapy to be effective enough to deserve future research. Similarly, Hook et al. (2010) investigated the specificity, follow-up, clinical significance, effectiveness, and client-characteristic matching of religious/spiritual therapies. Although they encouraged caution in interpreting the positive findings, they stated religious/spiritual therapies to be generally helpful for clients with different types of psychological problems, positive outcomes to be generally maintained in follow-ups, and these therapies to also work mostly for highly religious people who view their world through a religious lens (not for people who lack high religiosity). With such results in mind, several professionals have called for the inclusion of spiritual and religious elements into psychotherapy in accordance with clients' needs (D'Souza & George, 2006; Smith et al., 2007).

Local Psychotherapy Models

In addition to importing and adapting psychotherapy models, several local psychotherapy models originating from different cultures that reflect their own cultural and religious values and worldviews have been developed in various parts of the world. A strong example of this is Morita therapy, proposed by Japanese psychiatrist Shoma Morita who himself suffered from, and in his studies substantially focused on, anxiety disorders (Takeda, 1964) in 1919; it is mainly applied in Japan and China today (Wu et al., 2015). Morita therapy involves a behavioral, structured program and aims to get patients who display somatic symptoms to gain a natural and outward perspective on life and increase their social functioning (Li & He, 2008; Sato, 1998; for a detailed description of the original application of Morita therapy, see Chen, 2010; Takeda, 1964, 2010). Chen (1996, 2010) claims that the distinctive feature of Morita therapy is how it sees the negative state of mind leading to anxiety to be a normal part of human nature, and its presence should be accepted while living a constructive life so that the negativity of those feelings will have little or no effect. Meanwhile, the aim of Western therapies is to reduce anxiety symptoms and eventually eliminate them from the client's life. The effectiveness of Morita therapy in treating various mental problems has been subjected to research. Nagata et al. (2006) combined Balneo and

Morita therapies and applied them in addition to pharmacotherapy to patients with fibromyalgia syndrome, reporting the patients' conditions to have improved significantly after treatment, with only one out of 10 patients relapsing a year later according to follow-up checks. Gomibuchi, Gomibuchi, Akiyama, Tsuda, and Hayakawa (2000) applied Morita-based therapy to five Japanese patients who had what the authors called "obsession of hearing music" and obtained positive results both immediately after the treatment and in a 5-year follow-up. Maeda (2017) presented a case study with a school-refusing adolescent with neurotic symptoms; the report of positive results implies that Morita therapy can be effective in dealing with school refusals. In addition to these are several other cases: Chang (2011) described a number of successful clinical vignettes containing Morita therapy, Ishiyama (1983) pointed out a successful treatment case of severe test anxiety, and LeVine (1993) presented an overview of classical inpatient Morita therapy, illustrating an intervention program for bulimia nervosa. On the contrary, Wu et al. (2015) conducted a meta-analysis on studies utilizing Morita therapy for anxiety disorders in adults and concluded the power of the study to be weak due to the quality of the included trials being unsatisfactory, thus leaving the efficacy of Morita therapy for anxiety disorders still unclear. Li and He (2008), in their study investigating the effect of Morita therapy on the social aspect of the lives of patients with schizophrenia, reported modest results and concluded that Morita therapy remains an experimental intervention. A number of studies have discussed utilizing Morita therapy in treating various anxiety-based problems (e.g., Chen, 2010; Ishiyama, 1983, 1990, 2003; Kurokawa, 2006; Sugg, Richards, & Frost, 2016), comparing it with other therapy techniques (e.g., Hedstrom, 1994).

Another form of psychotherapy originating from Japan is Naikan therapy, developed by Ishin Yoshimoto and based on Buddhist teachings; it aims to increase patients' self-awareness and acceptance in the context of their interpersonal relationships without being judgmental (Maeshiro, 2009; Sato, 1998). Naikan therapy is built on the Japanese belief that basic human happiness derives from harmonious interpersonal relationships, and its method is compatible with the Japanese cultural emphasis on nonverbal rather than direct verbal communication (Gielen, Fish, & Draguns, 2004). During therapy, clients are asked to reflect on their relationships with their significant others using certain questions (Maeshiro, 2009). Ding et al. (2018), in their study on the effect of Naikan therapy with 92 male offenders, found that the therapy had improved perceived social support and decreased externalized blame. Zhang, Li, Zhao, and Zhan (2015) investigated the possible benefits of adjunctive Naikan therapy for the treatment of schizophrenia, and the follow-up study showed that while 20.5% of the control group who had received routine medication and inpatient rehabilitative treatment relapsed after 12 months, only 10.6% of the intervention group relapsed. Suwaki (1979) discussed his experiences with alcoholic patients who also received support from Danshukai, a support organization for alcoholics, and reported satisfactory results. Ozawa-de Silva and Ozawa-de Silva (2010) claimed that Naikan operates therapeutically on an existential level and discussed the possible applicability and efficacy of it outside a Buddhist context. The considerable efforts to adapt Morita and Naikan therapies to American culture are also worth noting here (Hedstrom, 1994).

Various psychotherapy methods based on cultural and religious values have also been developed in Africa. One of these is Meseron therapy, which means "I reject it"; it was developed by clinical psychologist Alfred Awaritefe in Nigeria and aims to enable clients to use their resources to dissociate from undesirable situations, to become constructive, and to "reject the negative and accept the positive" (Afolabi & Joy, 2014). On the contrary, Ubuntu therapy of South Africa origin is based on a worldview that highlights collectiveness and interdependence and aims to solve clients' problems by addressing them in relation to the creator, other people, and the self; it uses various techniques from dancing to storytelling (Van Dyk & Nefale, 2005). Van Dyk and Matoane (2010) presented a case study of a 43-year-old client where Ubuntu therapy had been

applied for treating a family affected with AIDS. Another therapy originating from Nigeria, Harmony Restoration therapy, is based on the cultural belief that for one to be psychologically and physically in good health, one must be in harmony with immediate and extended family members, ancestors, and the community one lives in; therefore, it focuses on restoring harmony with the client's environment for treating psychological problems (Onyekwere, Lekwas, Eze, Chukwunenyem, & Uchenna, 2013).

Discussion

With a history now of over a century, the effectiveness of the current state of psychotherapy is commonly accepted. However, some critical deficiencies apparently still exist. In particular, the question "How does psychotherapy work?" remains a subject of debate (Kazdin, 2009; Miller, Hubble, Chow, & Seidel, 2013). As mentioned above, one of the problems is that although psychotherapy is a product of Western culture, its application has been attempted in societies that have contributed little, if any, to the formation of these widely used psychotherapy models. Psychotherapy can be observed to take three forms in non-Western societies. First, Western-origin psychotherapy models are imported as they are and some nonsystematic spontaneous alterations are observed in accordance with the country's culture. Another form is the systematic adaptation of standard psychotherapy methods in line with the needs of the people of an individual culture. Finally are models that are products of the cultures themselves. The prominent form taking culture into account appears to be adaptations of psychotherapy methods, and the number of local psychotherapy models and research on their outcomes appear quite limited.

That culturally adapted standard evidence-based therapies are given the priority may sound reasonable; however, this also has some drawbacks. First, considering that Western-origin therapies themselves are local models, the question of whether it is possible to adapt a product of a specific culture to another follows. In this case, what is in question is not the adjustment of a model based on universal psychological principles with cultural sensitivity. This preconception would be proper to claim as quite common in discussions regarding the adaptation of psychotherapies of Western origin. This means a model that may not be providing universal explanations and is local itself has been taken as if it is universal and adapted to another culture. Making a distinction between adaptations in multicultural Western societies and non-Western societies may be necessary on this point. Considering the example of United States, an ethnic minority in the United States will clearly be in much further contact with Western culture compared with people living in a country of the Far East. Although the data of comparative experimental studies on this subject are limited, adaptation efforts in communities that are in close contact with Western societies can be presumed more efficient. Therefore, even if a certain culturally adapted psychotherapy model is proved to be effective for a certain ethnic minority group in a Western country, importing that adapted version to another country populated by people of the same ethnic origin may be a mistake, resembling direct importation of psychotherapy models. Although these two groups of people may have similar backgrounds, they will have different needs, and therefore, the validation of a certain adapted model in a Western country cannot provide sufficient grounds for its application in another country.

Second, although the current literature on cultural adaptations of psychotherapy models is promising, meta-analyses have revealed conflicting results. The lack of standardization in cultural adaptations makes it difficult to identify the source of this conflict. As Falicov (2009) noted in many studies, so-called adaptations consisting of language translations and considerations of cultural values and contextual stressors can be regarded more like cultural attunements. She suggested that cultural theories of psychological distress should be studied more deeply. On this point, the two dimensions suggested by Resnicow, Baranowski, Ahluwalia, and Braithwaite

(1999) regarding the definition of cultural sensitivity (i.e., surface structure and deep structure) can be useful in understanding the nature of adaptation studies and provide guidance for future research. According to these authors, surface structure involves adapting psychotherapy practices to the superficial characteristics of a target population, such as language, music, and clothing, while deep structure requires considering cultural, social, historical, environmental, and psychological forces that influence the health behaviors of the target population. How much a society displays characteristics in common with Western societies or how closely it is in contact with them may determine whether adaptations targeting surface or deep structures will suffice or not and whether there will be a need for local psychotherapies. In the case of societies with limited contact or features in common with Western societies, a crucial question is whether a transformation without altering the basic assumptions of Western psychology such as individualism is possible, and if it is, how efficient would it be?

Numerous studies are found focusing on the factor of culture for multicultural societies of the West, and the next step to take in this area might be to educate and raise awareness among specialists. However, non-Western societies have a serious deficit in psychotherapy research and practice. Considering that receiving psychological treatment in underdeveloped countries is quite hard alongside a deficiency in mental health systems (Kohn, Saxena, Levav, & Saraceno, 2004) and that a tendency exists to utilize unadapted psychotherapies, one can deduce that individuals in these societies do not receive efficient psychotherapy services. Therefore, adaptation efforts in these societies should be reinforced by taking the compatibility of conventional psychotherapy models with their culture into consideration. On this point, the depth of contact a society has with Western culture will determine the quantity and quality of the changes required in psychotherapy practice. Finally, the question on which steps are needed to be taken to increase the efficiency of psychotherapy services in societies that have limited contact with Western culture needs to be dealt with. That few local psychotherapy models have been developed leaves non-Western societies, especially underdeveloped ones, with a dilemma. Constructing local psychotherapy models compatible with their culture will be a long and tedious process. On the contrary, these societies are in urgent need for efficient intervention methods that will tend to be accepted by the people of these countries and be compatible with the characteristics of their culture. This inevitably brings one back to adapting Western-origin psychotherapies. In the short run is at least a need for experimental studies for improving the efficiency and effectiveness of adapted therapies. In the long run, putting more effort into developing and testing local psychotherapy models may be beneficial, especially in comparing them with psychotherapy models of Western origin and their adapted versions. In all these efforts, cultural elements that potentially can reinforce the variables of global relationships such as therapeutic alliance and empathy (Draguns, 2013) must be given special attention.

To sum up, the existing literature of cross-cultural psychotherapy studies seems promising, and the following issues should be considered for further research:

(a) Effectiveness of current psychotherapy models in non-Western societies should be subjected to examination.
(b) Acceptance of psychotherapy in a specific country and its unmet needs should be determined.
(c) Instead of importing or spontaneously adapting psychotherapy models, systematical adaptation studies in conformance with the needs of countries should be encouraged.
(d) Initiatives to develop local psychotherapy methods should be supported as alternative solutions.
(e) Potential benefits of local psychotherapy models that psychotherapy models of Western origin can draw from should be considered.

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Toward Cultural Assessment of Grief and Grief-Related Psychopathology

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Ways of dealing with bereavement and grief are influenced by the norms of one's cultural identity. Cultural assessment of bereavement and grief is therefore needed for a comprehensive evaluation of grief-related psychopathology and for negotiating appropriate treatment. Cultural aspects of bereavement and grief include cultural traditions related to death, bereavement, and mourning as well as help seeking and coping. To facilitate clinical exploration of cultural aspects of bereavement and grief, the authors propose a set of brief, person-centered, and open-ended questions as a draft supplementary module to the *DSM-5* Cultural Formulation Interview.

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> Darius . . . summoned some Greeks and asked them for how much money they would be willing to eat their dead parents. But they answered that they would not do such things for any amount of money. And after that Darius summoned some Indians (called Kallatiai), who eat their parents, and asked them for what price they would agree to burn their dead fathers with fire. But they shouted aloud and bid him not to speak blasphemy. Thus these things are established by custom and quite right was Pindar, it seems to me, when he says in a poem *Custom is king of all*.—HERODOTUS (trans. Anne Carson)

The loss of loved ones can bring about manifestations of psychopathology, particularly when the loss is due to violence, accidents, or disasters, also referred to as traumatic bereavement (1). A grief disorder known as persistent complex bereavement disorder (PCBD) is included in the "Emerging Measures and Models" section of *DSM-5* (2). Prolonged grief disorder (PGD), a disorder with similar symptoms, is included in the 11th edition of the *International Classification of Diseases* (*ICD-11*) (1). Besides these specific grief-related disorders, bereaved individuals may develop symptoms consistent with a diagnosis of major depressive disorder, posttraumatic stress disorder (PTSD), or both (1,2).

How one deals with bereavement and grief is influenced by the norms of one's cultural identity. Consistent with this notion, the *DSM-5* criteria for a PCBD diagnosis state, "The bereavement reaction is out of proportion to or inconsistent with cultural, religious, or age-appropriate norms." A section on culture-related issues pertinent to the diagnosis states, "Diagnosis of the disorder requires that the persistent and severe responses go beyond cultural norms of grief responses and not be better explained by culturally specific mourning rituals." Cultural assessment of bereavement and grief is therefore pivotal for a comprehensive evaluation of grief-related mental health.

Impact of Culture on Bereavement and Grief

Culture affects every clinical encounter (3). The impact of culture on mental health care involves not only the interactions between patient and care provider but also idioms of distress and explanatory models and even patient perceptions of what types of treatment are acceptable. Therefore, the American Psychiatric Association's *DSM-5* cross-cultural issues subgroup developed the Cultural Formulation Interview (CFI) for routine use in the clinical assessment of any patient (3). The CFI instruments comprise an initial assessment interview and 12 supplementary modules that cover the following topics: explanatory model; level of functioning; social network; psychosocial stressors; spirituality, religion, and moral traditions; cultural identity; coping and help seeking; patient-clinician relationship; school-age children and adolescents; older adults; immigrants and refugees; and caregivers. Neither the CFI nor any of these modules explicitly focus on cultural aspects related to the loss of loved ones.

Individuals and communities with immigrant, minority, and indigenous backgrounds may be particularly affected by cultural dominance and its association with historical trauma, loss, and grief through generations (4). Cultural beliefs, world views, and practices are likely to be influenced by migration, acculturation, and cultural dominance. Specifically, individuals from immigrant, minority, or indigenous groups may experience cultural incongruity arising from dissimilarity between the beliefs, expectations, and practices

in the culture of origin and the dominant culture (5). Cultural dominance and incongruity may both contribute to detachment, estrangement, and distrust—phenomena that may exacerbate PCBD and PGD—as well as PTSD—following bereavement. In addition, the impossibility of performing culturally appropriate rituals related to death or mourning is often characteristic of traumatic losses of loved ones. This, too, may influence symptoms of PCBD or PGD and PTSD (6). For example, dreams about a deceased family member may evoke painful memories and guilt feelings among Cambodian survivors of the Khmer Rouge regime. A complex cultural belief system links such dreams to concerns about the spiritual status of the deceased in the afterlife. After having such dreams, survivors may want to perform various rituals to promote an auspicious rebirth of the deceased (6).

The cultural context of losing a loved one interacts with social and psychological factors. For example, the importance of certain family relationships may vary culturally. When an only son is lost, the impact on the bereaved parents may be even more devastating in the context of a patriarchal culture (7). Also, cultural rules surrounding inheritance and remarriage influence the bereaved person's possibilities to build new roles, identities, and relationships (7).

Forced migration often implies that people had no choice but to leave behind their loved ones. In some cases, people may have witnessed or learned about the death of loved ones, but because of the unexpected and sudden nature of their departure, the fate of some loved ones may be unknown. This situation, characterized as ambiguous loss, is faced by relatives of missing persons and often occurs following forced migration. Symptoms of PCBD or PGD, PTSD, and major depressive disorder may accompany ambiguous loss (1). Unlike loss due to death, the irreversibility of ambiguous loss is not self-evident. Dealing with ambiguous loss is often complicated by judicial, financial, and family issues as well as by inability to perform leave taking and other rituals that may facilitate coping.

Cultural Assessment of Grief

Cultural assessment of grief among patients seeking mental health care following the loss of loved ones, specifically patients with presumed trauma- or grief-related disorders, is important for several reasons. First, it helps the clinician in forming hypotheses about the role of bereavement in the onset of mental disorders and whether the presentation constitutes psychopathology as opposed to, for example, normal grieving. As such, cultural assessment of grief helps clinicians to understand the cultural and religious norms relevant to the descriptions of both PCBD in *DSM-5* and PGD in *ICD-11*. Second, it facilitates exploration of the psychological burden related to not having been able to perform meaningful death rituals. This may include the assessment of the role of missing persons as well as the influence of cultural traditions and beliefs about the afterlife in maintaining or exacerbating distress.

Third, cultural assessment helps to clarify the individual's expectations about what types of help may be appropriate and the duration of treatment (3,8). Fourth, it contributes to developing a shared cultural understanding of bereavement and grief—a common ground, so to speak—which in turn facilitates shared decision making regarding treatment interventions, including specific psychological and psychopharmacological interventions, the choice to involve important others in the treatment, and integration of culturally appropriate rituals. Fifth, cultural interviewing is likely to enhance rapport and treatment motivation (8).

To identify existing cultural assessments related to bereavement and grief for clinical use among persons seeking mental health care, we performed a systematic search of literature published before December 2017 by using Ovid databases Embase, Medline, and PsycINFO. Search terms were death OR mourning OR grief OR bereavement OR loss AND cultural AND formulation OR interview. After removal of duplicates, the search yielded 428 records. Of these, 394 were excluded because they were not primarily about grief following the loss of loved ones, 27 because they were nonclinical studies on grief in specific groups, and six because they were studies on epidemiology, standardized diagnostic instruments, or treatment of grief-related disorders. Only one record concerned a clinical cultural interview related to bereavement and grief, and therefore it was selected to provide a possible basis for cultural assessment of grief (9). The selected study, by Eisenbruch (9), describes the Cultural Bereavement Interview for the clinical assessment of refugee distress resulting from losses of loved ones, country, and culture. It discusses perceptions of the past, visitations from ghosts or spirits in dreams, guilt feelings, personal experience of death, funerals and graves, absence of leave taking, anger and ambivalence, and religious beliefs and practices.

A Supplement to the *DSM-5* CFI

Cultural assessment of bereavement and grief should complement rather than duplicate information elicited during diagnostic interviewing. Therefore, the assessment should focus beyond symptoms of grief-related disorders, biographical details, and history of trauma and loss to include cultural ways of dealing with bereavement and grief, especially those that influence adaptation to loss and therefore may be relevant for treatment. The assessment should be suitable for use in early stages of the process of care, validating diagnostic assessment and supporting treatment negotiation.

We propose adoption of a bereavement and grief supplementary module to the *DSM-5* CFI that can be used as a tool for in-depth cultural assessment of bereavement and grief among patients with presumed grief-related psychopathology. We intend for the assessment to be both more focused and more generally applicable compared with the Cultural Bereavement Interview. The goal of the module is

to facilitate the assessment of cultural ways of dealing with bereavement and grief among patients from any cultural background or with any cultural identity. The proposed module should be considered a draft subject to modification based on results of pilot studies evaluating its feasibility, acceptability, and clinical utility (10). [A draft of the module is available as an online supplement to this column.]

Modeled after the existing *DSM-5* CFI instruments, the proposed bereavement and grief supplementary module consists of brief, person-centered, and open-ended questions mapping cultural ways of dealing with bereavement and grief. The module discusses cultural traditions related to death, bereavement, and mourning and concludes by exploring help seeking and coping related to the loss of loved ones. It includes prompts enabling the clinician to maintain the natural flow of conversation and to make adaptations for patients with limited language skills if necessary. Using these questions, the clinician may explore cultural aspects of bereavement and grief among patients seeking mental health care following the loss of loved ones in order to enhance understanding as well as tailor interventions to alleviate distress.

To this aim, the module addresses the following two topics.

Death, bereavement, and mourning. A key function of death-related rituals is to provide structured ways to mourn and express grief. Rituals may include time frames for immediate mourning and actions to be completed at specific points thereafter (such as a wake or yearly commemoration), prescribe how to handle and dispose of the body of the deceased, and indicate when and in what way it is appropriate to talk about the deceased (7). Encounters with the deceased that may occur in dreams or when bereaved persons report having seen, felt, smelled, or talked with the deceased may have cultural explanations. The person may experience exhortation, a feeling of being strongly encouraged or urged by the deceased to perform specific actions. Also, the person may interpret the dream as evidence that the deceased is in a dire spiritual state, indicating the need to make merit—e.g., to make offerings—and perform appropriate rituals (6,9). Many death rituals allow the bereaved to settle accounts or convey apologies or gratitude to the deceased. Mourning rituals are often piacular, meaning that not performing them creates guilt. Some rituals may be thought of as having implications for the afterlife. More generally, performing prescribed rituals may be necessary for proper role fulfillment, assuring a good spiritual status of the deceased, or an auspicious rebirth (6). Within many religions, the mode of death, e.g., suicide, has implications for the afterlife (7).

Help seeking and coping. Many bereaved individuals engage in practices related to spiritual, religious, or moral traditions to cope with the loss of a loved one, such as prayer, meditation, or other practices. In addition, they may participate in worship or religious gatherings and speak with other people in their religious group or with religious or spiritual leaders. Spiritual, moral, or religious practices and activities may be perceived as helpful in coping with the loss, especially in dealing with guilt feelings. Survivor guilt frequently occurs among traumatically bereaved survivors, notably refugees, and may be linked to cultural concepts of fairness and fate, sometime involving past and future incarnations (6,7,9). Family, friends, or others may have suggested other kinds of help. For clinicians, it is essential to explore these as well as other kinds of help considered useful by the patient for dealing with the loss of a loved one.

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