

INVITED CONTRIBUTION

Can CBT Be Effective for Aboriginal Australians? Perspectives of Aboriginal Practitioners Trained in CBT

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The objective of the study was to investigate whether high and low intensity versions of cognitive behaviour therapy (CBT) might be an effective therapeutic approach for enhancing the mental health of Aboriginal Australians. Five university-educated Aboriginal counsellors received in-depth training in CBT. Over the following year, they used CBT strategies with their clients, and met 10 times as a participatory action research group. The group addressed three key questions: (a) Does CBT appear to be useful for Aboriginal Australians? (b) If so, what elements of CBT are perceived to be effective? (c) What adaptations might be made to CBT to enhance its effectiveness with Aboriginal Australians? The resulting qualitative data were transcribed and analysed. Counsellors perceived CBT to be very useful for their Aboriginal clients and for themselves. They reported that it enhanced their clients' well-being, their own clinical skills, and their own well-being, and it reduced burnout. The qualities of CBT that were perceived to be effective were its adaptability, pragmatic here-and-now approach, capacity for low-intensity interventions, safe containing structure, promotion of self-agency, and valuable techniques. It was suggested that the prime requirement for adaptations to CBT were that they would need to fit different social and cultural contexts.

Key words: Aboriginal mental health; CBT training; cognitive behavioural therapy; culturally responsive practice; Indigenous health.

Introduction

While it is clear that the rates of psychological distress among Australia's Aboriginal and Torres Strait Islander Peoples are high (Hunter, 2007; Kelly, Dudgeon, Gee, & Glaskin, 2009; Larney, Topp, Indig, O'Driscoll, & Greenberg, 2012; Parker, 2010; Purdie, Dudgeon, & Walker, 2010), it is less clear what can be done to reduce them. Cognitive therapy as developed by Dr. Aaron T. Beck, now commonly referred to as cognitive behavioural therapy (CBT) is a therapeutic approach that has a strong evidence base in the successful treatment of depression, anxiety, and other mental health problems (Department of Health and Ageing, 2011; Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Depression, 2004; Tolin, 2010). Furthermore, it is the preferred treatment in the Australia's Better Access programme (Department of Health and Ageing, 2011).

In this paper, we use the term CBT to refer to high and low intensity versions of CBT. The high intensity version is based on the cognitive therapy of Aaron T. Beck, placing strong emphasis on the B as well as the C. This tradition is exemplified in key

books such as the seminal texts of Beck, Rush, Shaw & Emery (1979) and Hawton, Salkovskis, Kirk & Clark (1989), and the more recent Westbrook, Kennerley and Kirk (2007, 2011). High intensity CBT refers to 'usual' face-to-face therapy with a specialist CBT therapist, typically 6–20 sessions for depression or anxiety disorders. A more recently developed mode of delivery is low intensity CBT (Bennett-Levy et al., 2010). Low intensity CBT uses internet-based, mobile phone-based or written resources where the CBT therapeutic expertise is already embedded in the materials. Low intensity CBT can be self-guided, or can be supported by practitioners without specialist therapist skills. Low intensity CBT is often presented in 'bite size pieces', and because of the mode of delivery, can be accessed at any time of day in any place (provided there is internet or mobile access).

CBT focuses on learning specific strategies to think and act more adaptively, to recognise and challenge negative and unhelpful belief systems, and to increase coping skills. There is a growing literature on the value of CBT in culturally diverse minority populations (Bennett, 2009; De Coteau, Anderson, & Hope, 2006; Grey & Young, 2008; Hays & Iwamasa, 2006; Leibowitz, 2010), including a successful Australian trial of "motivational care planning," which is a therapist-guided, low intensity 2-hr programme offered in remote Aboriginal communities founded on CBT principles (Laliberte, Nagel, & Haswell, 2010; Nagel, Robinson, Condon, & Trauer, 2009).

However, with the exception of the Northern Territory motivational care planning trials (Laliberte et al., 2010; Nagel et al.,

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Accepted for publication 27 November 2012

doi:10.1111/ap.12025

2009), there is a dearth of empirical literature evaluating the use of CBT with Aboriginal and Torres Strait Islander Peoples. Some writers have suggested that CBT holds promise as a psychological therapy for Aboriginal and Torres Strait Islander Peoples (Davies, 2011; Gilbert & Wilson, 2009), while others have suggested that “CBT doesn’t work for Aboriginal people” (Day, 2003; Sydney South West Area Health Service, 2010). This ambivalence towards CBT is enshrined in the Better Access programme guidelines where, for Aboriginal and Torres Strait Islander Peoples only, the recommendation is to use narrative therapy (Department of Health and Ageing, 2011).

The purpose of this study was to explore Aboriginal counsellors’ perspectives on the suitability and effectiveness of CBT for people living in Australia’s Aboriginal community. To achieve this aim, in-depth CBT training was provided to five university-educated Aboriginal counsellors, with the specific purpose of gaining their insights from using CBT over a 12-month period. Within the context of a participative action research study, their observations based on their experience of using CBT with clients were recorded and analysed. To our knowledge, this is the first Australian study that has directly sought the views of CBT-trained Aboriginal counsellors.

The principal research questions were the following: Do CBT-trained Aboriginal counsellors perceive CBT to be useful with their Aboriginal Australian clients? If so, what are the elements of CBT that appear to be effective? What adaptations might make CBT effective, or more effective, with Aboriginal Australians?

Method

Methodology

A qualitative methodology, participatory action research (PAR; Kemmis & McTaggart, 2000; Kendall, Sunderland, Barnett, Nalder, & Matthews, 2011; Wallerstein & Duran, 2010), was selected. A number of authors have argued that PAR is consistent with Indigenous practice and research values (Kendall et al., 2011; National Health and Medical Research Council, 2003; Wilson, 2008), and is culturally safe (Tsey et al., 2004; Wilson, 2008). PAR is a process-driven research methodology that utilises cycles of planning, intervention/action, observation, and evaluation (Kemmis & McTaggart, 2000). The methodology emphasises egalitarian and emancipatory participation in the research process. As such, PAR is especially useful in conducting research with disadvantaged groups (L’Etang & Theron, 2011). Implementation of a PAR design allowed us to fulfil recommended criteria of qualitative research in health-related journals with regard to procedural, interpretive, and evaluative rigour, and reflexivity including feedback and review of data interpretation by group members to ensure validity (“member checking”; Cohen & Crabtree, 2008; Kitto, Chesters, & Grbich, 2008).

The research spanned a 3-year period (2 years of planning and consultation, plus 1 year of action and evaluation). Consistent with recent guidelines for conducting research with Indigenous participants (Jamieson et al., 2012), Aboriginal people participated in every stage of project, including its planning, implementation, observation, and evaluation (Kendall et al., 2011; Wilson, 2008). All participants were paper authors. Seven of the eight authors are Aboriginal.

Participants

Potential participants were identified through the senior Aboriginal executive with the local health district and through word of mouth. Selection criteria included (a) being Aboriginal or Torres Strait Islander; (b) having relevant university qualifications in mental health; (c) a minimum of 2 years of clinical experience; and (d) having a clinical caseload with appropriate clinical supervision (see Table 1 for further details of the participants). Recruiting Aboriginal clinicians ensured that cultural competence was not confounding the study. Appropriate supervision safeguarded the clinician’s clients from possible negative effects.

The rationale for selecting university-trained Aboriginal counsellors was the need for focused reflection as part of the PAR methodology: High-level reflective skills and the capacity to learn and use CBT were central to the study’s success. Previous counselling qualifications also helped differentiate the effect of CBT training versus *any* form of therapy training, which we assume would be beneficial for untrained or inexperienced mental health workers.

Training

The counsellors undertook 10 days of formal training in CBT. An initial 4-day training in some of the core skills of CBT (e.g., agenda setting, goal setting, Socratic questioning, thought records, behavioural experiments) was followed 3 months later by a 5-day training focused on the treatment of anxiety disorders and depression. This training was based on the core CBT skills identified in the recommended course textbook (Westbrook et al., 2007, 2011), and on evidence-based high intensity CBT approaches to the treatment of anxiety and depression (Beck et al., 1979; Clark & Beck, 2010). Training was provided by the first author and colleagues through the University Centre for Rural Health’s CBT training programme. Both the 4-day and 5-day training were endorsed for CPD points by the Australian Psychological Society, and the Australian College of Rural and Remote Medicine.

Four months after the anxiety and depression workshop, a 1-day workshop on “low-intensity CBT” was provided by three leading low-intensity CBT researcher-trainers at the request of the group. This workshop covered: definitions of low intensity interventions and scope and range of delivery methods (Bennett-Levy et al., 2010); low intensity CBT research findings; examples of

Table 1 Action Research Group Participants

University qualifications	All (up to Ph.D.)
Relevant counselling experience	Average 5 years (range 3–14)
Profession	Psychologists (2) Counsellors (2) Mental health worker/nurse (1)
Previous counselling training	Self-identified therapy styles as combination of generalist, client-centred, narrative, pastoral, and art therapy. Two had some previous cognitive behavioural therapy training

internet-based interventions (Titov et al., 2011); and examples of written/pictorial interventions specifically tailored to the needs of Indigenous clients (Nagel et al., 2009, 2011).

In all, counsellors practised CBT with clients over a 12-month period following the initial training. Ethics approval was obtained from the Southern Cross University Human Research Ethics Committee, approval number ECN-10-111.

Data Gathering and Analysis

Ten meetings of the group and two individual interviews were conducted, with 22 hr of digital audio-recording transcribed for analysis (see Table 2). The initial group meeting was held prior to commencing the formal CBT training in order to capture the members' pre-conceptions of CBT. Once the training began, group meetings focusing on the members' initial thoughts and perceptions of CBT and its utility were held immediately after each training session. Further meetings at 1, 6, 9, and 12 months focused on their observations regarding whether CBT practices had been effective with their Aboriginal clients. All authors reflected critically on their engagement in the research process. Analysis was undertaken independently by authors JBL and SW to sort the data into initial categories before combining their results. Once agreement was reached, a thematic analysis was undertaken (Kitto et al., 2008).

The thematic analysis and interpretation were presented to and checked by members of the action research group (ARG), who also reflected on their contributions to the group. Conflicting perspectives were identified by group members, resulting in some small adjustments to the analysis. These changes were endorsed by all participants, and it was agreed that further data were not needed. Finally, a draft of the paper was circulated to all participant-authors, resulting in full author agreement after one small addition as a result of participant feedback.

Results

The results are organised under three key questions: (a) Is CBT perceived to be useful by Aboriginal counsellors who have undergone CBT training? (b) What elements of CBT are perceived to be effective? (c) What adaptations need to be made to CBT for Aboriginal Australians? The main themes are summarised in Table 3. Illustrative quotes are provided under each heading.

Is CBT Perceived to be Useful by Aboriginal Counsellors Who have Undergone CBT Training?

While the ARG pre-conceptions varied from scepticism (not sure CBT works for Aboriginal people) to curiosity (willingness to give it a go), high intensity CBT was endorsed by all counsellors as being very useful after they had used it with clients. CBT was perceived to have a positive impact on the following:

1 Clients' well-being

All of the ARG observed that high intensity CBT worked well when they implemented it in their practice and that it improved the well-being of their clients.

I really am excited by how some of the people have taken to it.

2 Counsellors' therapeutic knowledge, skills, and confidence

The ARG also observed that receiving the training in CBT had increased not only their therapeutic knowledge and skills, but also their professional confidence.

I find the CBT knowledge has given the confidence to not panic.

With CBT I'm becoming more confident with being able to deal with whatever walks through the door and be able to deal with it.

Table 2 Timeline, Meetings, and Aims

Date	Meeting type	Duration	Data sought
August 2010	ARG meeting	4.5 hr	Preconceptions of CBT
September 2010	CBT Training: Essential Skills in CBT	27 hr	N/A
September 2010	ARG meetings	2 × 1.5 hr	Initial impressions of potential usefulness
October 2010	ARG meeting	3 hr	Perceptions after 1 month of use
November 2010	2x Individual interviews (ARG members who missed the October meeting)	2 × 1 hr	Perceptions after 1 month of use
November 2010	CBT Training: Evidence-based CBT for depression	15 hr	N/A
November 2010	ARG meeting	1.5 hr	Initial impression of potential usefulness of CBT for depression
November 2010	CBT Training: Evidence-based CBT for anxiety	21 hr	N/A
November 2010	ARG meeting	1.5 hr	Initial impressions of potential usefulness of CBT for anxiety
February 2011	Two ARG meetings	1 hr+	Perceptions after 6 months of use
March 2011	CBT Training: Low Intensity CBT	2 hr	N/A
March 2011	ARG meeting	3 hr	Impressions of potential usefulness of low-intensity CBT
May 2011	ARG meeting	5 hr	Perceptions after 9 months of use
October 2011	ARG meeting	4.5 hr	Changes in perceptions after 12 months of use? Clarification of data; review, revision, and approval of analysis

Note. ARG, action research group; CBT, cognitive behavioural therapy.

Table 3 Qualitative Analysis Summary for the Three Research Questions

1. Is CBT useful for Aboriginal people?	2. What elements of CBT are perceived to be effective?	3. What adaptations might make CBT more effective with Aboriginal Australians?
<p>For clients</p> <ul style="list-style-type: none"> • <i>Positive impact on clients' well-being</i> <p>For counsellors</p> <ul style="list-style-type: none"> • <i>Increased therapist knowledge, skills, and confidence</i> • <i>Personally useful, provides role clarity and boundaries, and prevents burnout</i> 	<ul style="list-style-type: none"> • <i>CBT is highly adaptable</i> e.g., preventive or therapy; high or low intensity; adults youth and children • <i>Simple interventions can make a difference with complex problems</i>; CBT is not re-traumatising • <i>"Low-intensity" CBT can be used opportunistically</i> e.g., psychoeducational one-off interventions • <i>CBT structure is containing, safe, and focused</i> e.g., focus on here-and-now thoughts, emotions, behaviour • <i>CBT is empowering and promotes self-agency</i> e.g., easily transmitted skills from therapist to client, and client to community • <i>CBT techniques work well with Aboriginal clients</i> e.g., problem solving, goal setting, behavioural experiments 	<ul style="list-style-type: none"> • <i>Use a variety of different methods of presentation</i> (pictures, verbal, computer, SMS etc.), depending on context and clients • <i>Translate CBT's formal language</i> in culturally appropriate ways • <i>Adapt therapy to informal spaces</i> • <i>Develop culturally safe low-intensity interventions</i> including anonymity • <i>Consider which types of intervention may not work or may need adapting for different Aboriginal people or communities</i> <p>N.B. Most of these adaptations are not uniquely relevant to Aboriginal people</p>

Note. CBT, cognitive behavioural therapy.

3 Counsellors' well-being

The counsellors also found that practising the CBT skills on themselves (self-practice) was personally useful. They discussed how CBT might protect them from burnout, and that CBT provided greater role clarity and boundaries between counsellor and client, and between counsellor and community.

So, yeah, it's opened up my world and I think it's actually going to make me, not only a better worker, but I'll probably . . . last longer in the industry . . . I'm finding I'm feeling a lot better because I'm feeling a lot safer . . .

What Elements of CBT are Perceived to be Effective?

Counsellors perceived that CBT has certain qualities that render it particularly effective with Aboriginal clients. Chief among these are the following:

1 CBT is highly adaptable.

The counsellors noted how adaptable CBT is to a variety of circumstances. They saw that it is as applicable for children as well as for adults. In addition to use in therapy, CBT was also perceived to be useful as a preventive intervention—one counsellor suggested that it could be "mental health hygiene just like dental hygiene." CBT was also seen as being adaptable in that it could be delivered in high-intensity (standard one-to-one therapy) or low-intensity forms (e.g., guided self-help, internet-based, mobile apps).

2 CBT is a pragmatic therapy that sees that simple interventions (e.g., goal setting) can be effective for complex problems. Importantly, counsellors perceived CBT as not re-traumatising.

The counsellors contrasted CBT with its primary focus on the here-and-now, with approaches that emphasise "healing the trauma." They reported that clients usually want to focus on current issues, and not in the first instance talk about past traumas:

I don't have people coming in and saying, "I really want to talk about the pain, or the trauma and everything." You've got people coming in

and talking about the everyday events that impact on people . . . people want to get on with things.

3 CBT encompasses "low-intensity" approaches, which enable counsellors to make the most of the often-limited opportunities for engagement.

Due to a range of factors that may militate against longer term therapy (e.g., remote communities, lack of services, life disruptions), the ARG suggested that therapeutic approaches with Indigenous clients need to be opportunistic, making the most of each occasion.

I only have a really short timeframe to make a difference. I have very little support when I leave, for those people to leave them with. So I have to be really strategic about how I work and what I do, and what I teach them.

4 CBT has a structure that is containing, safe, and focused.

Due to conditions in Aboriginal communities, clients often have multiple life problems. The ARG saw the structure of high intensity CBT (agenda setting, client feedback, use of time) as keeping the focus on key agreed issues, which they felt creates containment and safety.

CBT is a really safe kind of intervention, I find. And 'cause, particularly with our guys, they're so volatile, you know, with anger issues and really poor impulse control and I find it really safe.

5 CBT is empowering and promotes self-agency.

The goal of CBT is to teach clients skills to use in their own lives during and after therapy, and to focus on aspects of life over which they can exert control. The counsellors perceived this as highly consistent with Aboriginal aspirations.

CBT helps me bring it back to your thoughts and what have you done, what are you feeling about it—which you can control. You can't control your grandfather down the block.

6 CBT techniques work well with Aboriginal clients.

Through their experience with CBT, counsellors consistently noted a number of techniques that worked well for Aboriginal clients. These included pictorial formulations, psychoeducation, Socratic questioning techniques, agenda setting, goal setting, problem solving, assertiveness skills training, homework, collaborative relationship, identifying and testing negative thoughts, and behavioural experiments. Clients would often share these techniques with family or community who had not attended the sessions.

The visual quality of diagrams was seen to be particularly helpful with Aboriginal clients. For instance, one counsellor remarked: "CBT really lends itself to diagrams, whereas a lot of other therapies don't." The collaborative nature of the CBT relationship was another plus: "The collaborative process was brilliant; I found that worked really well with nearly everything."

What Adaptations Might Make CBT Effective, or More Effective, with Aboriginal Australians?

The ARG gave examples of where the language and formal structure of high intensity CBT (e.g., see "formulation" in Table 3) would have to be adapted to suit social and cultural conditions. The group agreed that being fluid and considering factors such as indigeneity, ethnicity, literacy, and age was more appropriate than making across-the-board recommendations.

While not unique to CBT, one of the findings from the study was the importance of doing therapy opportunistically in "informal spaces" (e.g., outdoors, walking, sharing tea), where Aboriginal people often feel more comfortable. "Therapy" might not even be conceived of by the client as "therapy," as in the following example of a low-intensity intervention in the workplace:

I see them in the hallways, out in the yard, that sort of stuff and I go, "How's it going?" And they go, "Fine I don't need to see you," and I go, "Okay, tell me why you don't need to see me," "Well I have nothing wrong with me." "Okay, so what's not wrong with you?" "Well, I'm not sleeping but that's not a problem."

Discussion

The present research, designed to address the question of whether CBT "works" for Aboriginal people, breaks new ground in the Aboriginal mental health literature. Aboriginal counsellors trained in CBT perceived CBT to be efficacious in treating psychological distress in Indigenous Australian clients. In particular, they noted the value of its adaptability, structure, safety, and practical utility of its techniques. The qualities of this therapy style were especially useful in containing complex client presentations (helping to focus therapy) and for empowering clients as agents of change in their own lives. Specific techniques were seen as being easily transmitted to clients, and encouraging a simple and collaborative problem-solving approach to problems. This study is significant in that it encourages a move towards evidence-based best practice in Aboriginal mental health, rather than the current practice, which tends to be based on anecdotal evidence.

Three issues emerged that may have particular significance for mental health services for Aboriginal Australians. First, low-intensity CBT interventions were strongly endorsed by the counsellors. In many situations (e.g., irregular visits to remote communities), it is not possible to see Indigenous clients consistently for multiple sessions. Therapeutic interventions may have to be opportunistic. Low-intensity interventions, which can be delivered in informal spaces, or can be supported remotely (e.g., by phone, internet, or mobile apps), may be one way to address this problem (Bennett-Levy et al., 2010; Nagel et al., 2011). Furthermore, the training requirements to support low-intensity interventions for Aboriginal people are far less onerous than to deliver specialist "high-intensity" CBT.

Second, the ARG group contrasted CBT with trauma-focused "healing" approaches, which participants suggested might actually be harmful and counterproductive *without longer term therapeutic involvement*. This perspective is quite consistent with other CBT and psychotherapy literature, which emphasises that trauma and abuse issues of long-standing origin should only be addressed in the context of longer term interventions where therapeutic relationships are firmly established (Beck, 2005; Taylor & Harvey, 2010). When there are limited opportunities for therapist involvement, this lesson may sometimes get lost.

Third, CBT was seen to be of particular value for the counsellors themselves, not only for its impact on their skills, but also in reducing their stress levels and protecting them from burnout. Job stress and burnout are major issues for Aboriginal health workers (Dollard, LaMontagne, Caulfield, Blewett, & Shaw, 2007; Williams, 2003). The counsellors reported that CBT was helpful to address their own cognitions, and that the CBT's focus on clients' here-and-now thoughts was helpful in orienting sessions towards issues that are potentially changeable. If future studies confirm that CBT is "burnout-protective," this is an important finding.

The duration of CBT training and the depth of reflection undertaken by the ARG was a strength of the study. A year's immersion meant that the counsellors understood the strengths and weaknesses of CBT. The limitations of the study are that only five counsellors were involved, and they were a group specifically selected as university graduates who all worked within a specific geographical region. A further issue is that the data concerned *counsellors' perceptions* of CBT's usefulness, and were experiential and qualitative. It would be desirable if future studies could include quantitative measures of *client outcomes*.

It is also possible that the data suffer from confirmatory bias: that having invested time and energy in training, the counsellors were biased towards validating the therapy. However, it is notable that prior to the programme, they were undecided about the value of CBT. Furthermore, in a 1-year follow-up currently underway, all counsellors report that they have continued to integrate CBT into their professional and personal lives.

Finally, we cannot know to what extent the results generalise to other Aboriginal and Torres Strait Islander Peoples. Since it is clear that there is a huge cultural, social, geographical, and educational diversity across Australian Aboriginal and Torres Strait Islander communities, caution should be exercised in overgeneralising from the study. At this stage, it can be concluded that the study adds to a small but growing body of evidence that CBT might be effective in Indigenous contexts,

both in Australia and internationally (Hays & Iwamasa, 2006; Nagel et al., 2009).

Future studies should determine how best to adapt or adopt CBT into Aboriginal and Torres Strait Islander mental health therapeutic frameworks. In the meantime, an ideal outcome from this project would be that practitioners sensitively use CBT with Aboriginal and Torres Strait Islander clients, and be guided by their clients and their own estimations about its suitability and usefulness. Quantitative studies will be needed to determine the relative merits of the different adaptations of CBT, and whether there are objective gains in counsellor expertise, as well as objective gains in client outcomes.

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