

COMMENTARY

Aboriginal Practitioners Offer Culturally Safe and Responsive CBT: Response to Commentaries

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We appreciate the valuable commentaries that have been provided for our paper “Can CBT be effective for Aboriginal Australians? Perspectives of Aboriginal practitioners trained in CBT.” The international authors identify how CBT, with adaptations by culturally responsive practitioners can be of value for non-Western and Indigenous peoples. The commentary by Australian psychologists Dudgeon and Kelly questions the value of CBT for Indigenous Australians, terming it a “Western therapy” that is “culturally unresponsive” and “culturally blind.” They also critique the methodology of the study. We argue that CBT can be adapted by culturally competent practitioners to be culturally safe in Australia, as elsewhere. Cultural safety is mostly a function of the therapist, not the therapy. In the Bennett-Levy et al. (2014) study, CBT was delivered in a culturally responsive way by Aboriginal counsellors within their own communities. CBT is a particularly adaptable and versatile therapy, and embodies principles of empowerment and self-determination that are central to Indigenous social and emotional well-being. We are concerned that CBT, which has strong empirical support and has been adapted elsewhere for a range of cultures, including Indigenous cultures, may be being denied to Indigenous Australian clients. There is considerable opportunity to evaluate the effectiveness and versatility of CBT, and variations of its mode of delivery, for all Australians.

Key words: CBT; CBT training; culturally responsive CBT; cultural safety; social and emotional well-being; Indigenous mental health

The combined authorship of “Can CBT be effective for Aboriginal Australians? Perspectives of Aboriginal practitioners trained in CBT” thank all the commentary authors for their contributions and the editor of the *Australian Psychologist* for providing this forum. We welcome the opportunity to reply to the commentaries.

First, we wish to thank the international experts Pamela Hays, Simon Bennett and Duncan Babbage, and Torrey Creed for their informed and thought provoking discussions (Bennett & Babbage, 2014; Creed, 2014; Hays, 2014). Both Hays and Bennett and Babbage provide a cross-cultural context for our research, positioning the article within the context of international research on CBT and Indigenous peoples, and the need to develop evidence-based psychological therapies for Indigenous clients. Creed points out that CBT’s focus on supporting clients to build their own skills is highly consistent with the Aboriginal and Torres Strait Islander focus on self-determination and empowerment.

Bennett and Babbage (2014, p. 18) make the salient point: “We suggest that what is known about best psychological treatment for Australia’s indigenous people has fallen behind other

countries in which clinical psychology is a well-established profession, a challenge it is important to address.” For this reason, our research sought to address the important task of evaluating a therapeutic approach with empirical support, which may make a positive difference for Aboriginal and Torres Strait Islander Peoples.

In the study, we looked at the potential usefulness of two forms of CBT: high-intensity (face-to-face) CBT, closely based on the cognitive therapy of Aaron T. Beck (Beck, Rush, Shaw, & Emery, 1979), and low-intensity CBT. The core text for the high-intensity “Beckian” CBT training was Westbrook, Kennerley, and Kirk (2007, 2011), which places a particular emphasis on the B in CBT. The counsellors received 9 days’ training and follow-up supervision in high-intensity CBT.

Following this training, at the request of the counsellors, a further 1-day workshop on “low-intensity CBT” (Bennett-Levy et al., 2010) was provided. Low-intensity CBT uses self-help materials that can be apps, Internet-based programs, or written materials, usually supported by a practitioner (often termed “guided self-help”). Because the “therapeutic expertise” is in the materials, the low-intensity practitioner does not need to be a specialist CBT therapist. Their primary role is to support, encourage, and problem-solve. Support can be provided remotely by phone, short message service (sms), or email. Because many Aboriginal and Torres Strait Islanders live in remote locations and cannot necessarily attend weekly therapy sessions, and because there are often no trained counsellors in more remote regions, we were interested to explore whether

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Accepted for publication 22 October 2013

doi:10.1111/ap.12041

low-intensity CBT might be one way to extend mental health services to clients for whom high-intensity CBT might not be feasible or acceptable. The study therefore encompasses high- and low-intensity CBT, and its application with Aboriginal and Torres Strait Islander clients.

We freely acknowledge that our study is a modest start, relying on the perceptions of a small group of Aboriginal counsellors trained in CBT. Bennett and Babbage, Hays, and Creed have suggested a number of ways to build on these humble beginnings. In line with the recommendations of the Interdivisional Task Force of the American Psychological Association, these authors all emphasise the importance of the therapeutic alliance and cultural responsiveness (Norcross, 2011). After establishing a trusting relationship, Hays recommends a focus on the *helpfulness* of thoughts (rather than validity or rationality). Creed emphasises the value of individualised case formulation, and Bennett and Babbage highlight the importance of the spiritual dimension in cultural adaptations. We support all these suggestions.

We reserve the vast majority of our response for addressing the commentary of the prominent Australian Aboriginal academic, Professor Pat Dudgeon and Kerrie Kelly (Dudgeon & Kelly, 2014 this volume). We acknowledge the contributions of Dudgeon and Kelly over many years. During the past decade and more, they have done much to articulate the effects of colonisation on Indigenous Australians, the historical response of government and health services, the impact of social determinants on mental health, the development of a social and emotional well-being framework for Indigenous Australians, and have advocated for better services for Indigenous Australians. We appreciate the work they have done and of course share their perspective on the extremely deleterious effects that colonisation and social determinants have had on the well-being of Australia's Indigenous community. As we shall discuss below, Dudgeon and Kelly have opened up a dialogue that is important in the context of enhancing the mental health and social and emotional well-being of Aboriginal and Torres Strait Islander Peoples.

For all the reasons that Dudgeon and Kelly give, it is not surprising that the state of Aboriginal social and emotional well-being, including mental health, is dire. Effective solutions have been in short supply. The main part of Dudgeon and Kelly's commentary is oriented to their historical analysis of the impact of colonisation. Our focus is necessarily different. We are counsellors who work at the coalface everyday. We see, feel, and treat the ongoing impact of genocide, removal, assimilation, colonisation, and racism. We work hard to empower and equip our clients to deal with the ongoing pain of intergenerational trauma and the influence of immense grief and loss that our families live with everyday. It was our desire to provide better mental health practices and to build capacity in our people by providing techniques that are flexible, informative, and safe that was the driver behind our participation in this research. Our experience is summarised by a quote from one of the counsellors in our article (Bennett-Levy et al., 2014; this volume):

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.

(Hays, 2014; this volume) makes a similar point. She notes that in her work with native and non-native people in rural Alaska, individuals who have experienced trauma typically come in for help with everyday problems. Longer-term therapy is often not possible or desired. As counsellors working with Aboriginal and Torres Strait Islander clients, it is our job to assist with self-identified presenting problems. We do this by focusing on things that they can control rather than things that they cannot. This is where we found "Beckian CBT" to be so effective. To expand on another quote from one of the counsellors, part of which was included in our earlier article:

I'm not dealing with the community, they haven't come in for a session. One person has. So a lot of all this other stuff is the impact on the community. CBT keeps it within the person's feelings and—it's about them and that's what counselling's about. We can't counsel a community. We can work and advocate and all that stuff within a community, but in counselling you're on your own. 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.

Dudgeon and Kelly's perspective on CBT is one we have encountered many times, but have never seen articulated so fully in print. It was because of a negative prevailing view of CBT amongst our Indigenous colleagues that we decided that it was important to engage with this study. We wanted to know whether the CBT approach, which currently has the strongest evidence base for treating a range of mental health problems, was as unsuitable and culturally unresponsive as Dudgeon and Kelly suggest.

We turn now to Dudgeon and Kelly's critique of our study, which we divide into two main categories: first, their critique of CBT as a Western therapy of questionable value for Aboriginal and Torres Strait Islander people; and second, their critique of the study methodology. Our response addresses these critiques in the following two sections and ends with some concluding comments.

CBT as a "Culturally Blind" Western Therapy of Questionable Value for Aboriginal and Torres Strait Islander People

Dudgeon and Kelly frame CBT as a Western technique that is "culturally unaware" or "blind" and "not culturally responsive." They say that "some Aboriginal healing models that have come from a grounded Indigenous base may use techniques drawn from Western therapies at appropriate stages of the healing journey"; and at another point, they suggest that CBT "can provide a useful tool when working with Aboriginal and Torres Strait Islander people." However, they warn that "these need to be deployed with care otherwise there may be a risk of repeating the mistakes of the past, of an assimilation of Aboriginal and Torres Strait Islander reality and the well meaning

imposition of Western psychological concepts that ultimately undermine the social and emotional wellbeing of Indigenous people."

As we reported in our article, at the start of the study, our own attitudes to CBT ranged from scepticism to curiosity. Our approach to the research project and to the high- and low-intensity CBT training was that if you want to understand and critique a therapy, it is first of all important to know what it is, how it works, and to try it out in practice. Our desire was to see if a Beckian style of CBT, influenced by culturally responsive practices, would enhance mental health outcomes.

Dudgeon and Kelly call CBT "culturally unaware" and "not culturally responsive." They are right to the extent that, as Hays (2014; this volume) indicates, the needs of non-Western cultures may not have originally been in the minds of the developers of evidence-based practices. However, as Hays, Bennett and Babbage, and Creed illustrate, internationally there are those who have a different view of the cultural responsiveness of CBT. Two books (Hays & Iwamasa, 2006; Naeem & Kingdon, 2012) and a number of other recent articles show that CBT has been successfully adapted for a range of non-Western cultures including Indigenous Maori, Native Americans, Alaska Native people, Canadian First Nation communities, Middle Eastern cultures, Bangladesh, Pakistan, and China. So two of our key questions were: Is CBT useful for Aboriginal Australians? And another was: Can CBT be adapted for Aboriginal Australians? Based on our experience, the answer to both questions was yes, with the form of the adaptation being specific to client characteristics (e.g., from different urban, rural, or remote communities), rather than indigeneity *per se*.

From our study, our understanding of adaptation is that it is more about the therapist than the therapy. This view is consistent with the conclusions of the Interdivisional Task Force of the American Psychological Association (Norcross, 2011). Of course, some elements of CBT practice and some techniques do need to be adapted or set aside for use in different cultures, as Hays, Bennett and Babbage, and Creed have noted, but we would suggest that the more important issue is whether the therapists are culturally competent or incompetent and have the understanding to adapt Western therapies. As Aboriginal counsellors, we respected and recognised the need to build on what we already know about our own diverse culture, language, and social and emotional well-being, and incorporated the new CBT knowledge into this. Our view is that, in the right hands, some Western therapies including CBT can be adapted by culturally competent therapists and that, as Hays (2006) has written, the level of adaptation needed will be different depending on the bicultural competence of the client.

Dudgeon and Kelly do at times acknowledge that "CBT can provide a useful tool when working with Aboriginal and Torres Strait Islander people"—but we are unclear on what basis they say this? Certainly not an empirical one. The lack of available evidence was one of the main reasons that we did the training and research. At another point, they questioned why the trainers did not deliver CBT training in a culturally adapted form. Again, this was one of the purposes of the study. CBT cannot and should not be offered in adapted form if we do not know what kind of adaptations would be of benefit. The study

required us to use CBT over the next year and reflect on what kind of adaptations we had found to be most beneficial.

Our experience—and that of many others—suggests that CBT is a successful therapy precisely because it embodies a number of psychological principles that may have general applicability to human beings. For example, goal setting, problem solving, identifying negative thoughts and images, linking thoughts with emotions, testing out thoughts in everyday life to see if they hold true (behavioural experiments), transforming negative images, and creating positive images are strategies that appear to be helpful across cultures and quite possibly have universal value. Competently delivered face-to-face CBT encompasses key therapeutic elements of empathy, goal setting, collaborative relationships, positive regard, genuineness, and getting client feedback, which, as well as being empirically supported relational elements in their own right (Norcross, 2011), are among the most important factors in determining outcomes in cross-cultural therapies (Smith, Domenech Rodriguez, & Bernal, 2011).

Dudgeon and Kelly highlight the importance of empowerment and self-determination for Indigenous Australians. As we have found from our experience, CBT is an empowering therapy, which fits well with the idea of promoting self-agency. This was one of the things that appealed to us about CBT. CBT focuses on setting your own goals and finding your own solutions to problems via guided discovery and Socratic questioning. Nowhere is this more evident than in the recent development of low-intensity CBT, which can be delivered by variety of means (e.g., apps, computer, pictorially, and books) and may be used for preventive or treatment purposes (Bennett-Levy *et al.*, 2010). Low-intensity CBT interventions can be guided or self-guided. Because the "therapeutic expertise" is in the materials, low-intensity interventions can be supported by practitioners without specialist therapy training (e.g., by Aboriginal Health Workers). For Aboriginal and Torres Strait Islander people living in urban or remote communities, low-intensity CBT interventions have the potential for cultural safety, including anonymity. They can be accessed anywhere, anytime, provided that the recipient has a mobile phone, computer, or access to pictorial or written low-intensity materials. In one of the only examples of an empirically supported mental health strategy for Indigenous Australians, Nagel and colleagues have demonstrated the value of low-intensity CBT in remote Indigenous communities (Laliberte, Nagel, & Haswell, 2010; Nagel, Robinson, Condon, & Trauer, 2009).

In summary, far from CBT "ultimately undermin(ing) the social and emotional wellbeing of Indigenous people," we see its considerable potential to increase access to effective mental health strategies for Indigenous Australians, even for those living in remote communities with little or no access to trained therapists. CBT is extraordinarily versatile, currently much more so than any other therapy. Furthermore, its self-empowerment philosophy and focus on skill acquisition is consistent with the Indigenous principles of self-determination, recovery from adversity, and resilience.

The Methodological Critique

Dudgeon and Kelly's methodological critique includes what was an unfortunate misconstrual of the researcher roles, perhaps

coupled by a lack of familiarity with CBT clinical practice. In this section, we address five issues that they have raised: the role of the researchers, the "invisibility" of the clients, the place of community consultation, research ethics, and whether the study constituted participative action research.

Dudgeon and Kelly's interpretation of the role of the researchers was unfortunately incorrect:

A non-Indigenous CBT practitioner recruited and trained five tertiary trained Aboriginal counsellors to deliver CBT interventions to Aboriginal and Torres Strait Islander people over a 12 month period ... The report suggests different roles were set down for the non-Indigenous and Indigenous co-researchers. For example, the role of the non-Indigenous co-researcher was to deliver a 10 day CBT training program (theory) to the Aboriginal co-researchers and then to gather and theme data provided by the Aboriginal co-researchers as they applied CBT theory in their counselling practice. The role of Aboriginal co-researchers was to accept the training (without adaptation to suit application with Aboriginal and Torres Strait Islander peoples), to deliver CBT interventions to their Aboriginal clients, and to report what this was like to the non-Aboriginal co-researcher.

How Dudgeon and Kelly drew these conclusions is not clear, and we wonder if they considered the implications of their representation of us as data gatherers for the non-Aboriginal researcher. The research design and ethics proposal were created by four of the research team: two Aboriginal associate professors, an Aboriginal author of a book on Indigenous research methods, and the non-Indigenous CBT trainer. It should also be noted that recruitment was undertaken by the Aboriginal members of the research team, not the non-Indigenous researcher. In addition, the initial gathering and theming of the project data across the whole project was undertaken by three researchers, and the CBT programme had been previously evaluated in other practice contexts.

Dudgeon and Kelly also critiqued the study for not including feedback and input from the Aboriginal clients who received the CBT interventions. They questioned why "the current study has rendered those who received CBT invisible, with no information provided about who they were, why they sought help from the Aboriginal counsellors, how many received CBT interventions, the type of interventions delivered, or how useful the CBT interventions were to them."

The rationale for non-inclusion of the Aboriginal and Torres Strait Islander clients' perspectives in the dataset was based on a concern for client welfare. To involve them in a research process would be to add to the clients' burden. They have come in for help with a problem they have. As counsellors, we are focused on clients' spiritual, emotional and physical needs, and their presenting issue. Conceivably with a well-funded large-scale study, an independent qualitative researcher, strict criteria about seeking feedback only from clients with mild to moderate level disorders, and a large lead-up time for ethics approval, it might be possible to build direct client feedback into the process. As it is, we see clients with all kinds of problems, some of extreme severity. We exercise clinical judgment about when and how to use CBT strategies and seek clients' feedback whether the strategies are working for them as part of our normal clinical

practice. It is not as if CBT is an experimental therapy; the empirical justification for offering CBT to our clients is as strong or stronger than for any other therapy. For a small-scale research study such as ours to directly involve formal client feedback was neither practical nor appropriate.

As Dudgeon and Kelly state, the clients in our study were rendered invisible. This was purposely so. We had five counsellors in our study, working in specific settings, for example, drug and alcohol rehabilitation. With this few counsellors, to render the clients visible would be to identify the counsellor and comments about clients might be traced back to specific clients. It was for reasons of confidentiality that we focused on counsellors' perceptions not client difficulties or client outcomes. Such studies may come later, with appropriate numbers and study designs, as suggested by Bennett and Babbage, and Creed. In the absence of any relevant studies of CBT with Aboriginal and Torres Strait Islander Peoples, ours was a small first step, supported by a university ethics committee as a low-risk project. Involving client data would have meant an entirely different and altogether more complex level of ethics approval.

A further critique of Dudgeon and Kelly was that the study lacked community engagement. They suggested that this lack was in contravention of National Health and Medical Research Council (NHMRC) Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Research (NHMRC, 2003). In our article, we indicated that: "Consistent with recent guidelines for conducting research with Indigenous participants Aboriginal people participated in every stage of project, including its planning, implementation, observation, and evaluation." The preliminary consultative phase of the current project was substantial. Appropriate representatives from the Aboriginal Health and Medical Research Council, Cooperative Research Centre for Aboriginal and Torres Strait Islander Health, Division of General Practice, Southern Cross and Sydney Universities, Aboriginal Medical Services, North Coast Area Health Service Mental Health and Aboriginal Health, and the Australian Indigenous Psychologists Association were consulted and engaged in conversations focusing on how they would like the project to be conducted and about their levels of support. This phase took close to 12 months to complete. At a personal level, we consulted at different times with family, community, supervisors, service directors, and coordinators regarding this project, and had their full support. We chose not to establish a community reference group as the population of interest was practitioners and not community members. We acknowledge that we did not report the details of all these consultations in our article.

A final methodological point concerns Dudgeon and Kelly's assertion that our study constituted cooperative enquiry rather than participative action research (PAR). We will not take up journal space to discuss the finer points of this distinction, except to say that Dudgeon and Kelly's critique would be justified if the participants under study were the clients. But they were not. The participants were the counsellors, as in previous PAR research on counsellors' reflections (Bennett-Levy, Lee, Travers, Pohlman, & Hamernik, 2003; Bennett-Levy et al., 2001). To quote a key PAR writer (McTaggart, 1991), PAR is "research by particular people on their own work, to help them improve what they do, including how they work with and for others" (McTaggart, 1991, p. 181). We are satisfied that our

study clearly falls within the terms of this definition. There is, however, a distinction between PAR and Community PAR (Shalowitz et al., 2009). Our study was clearly PAR, not Community PAR. We agree with Dudgeon and Kelly that in other contexts, Community PAR is often a desirable research strategy with Indigenous Australians.

In summary, we consider that it would have been inappropriate to seek formal client feedback in the context of this small-scale study and a potential breach of confidentiality to give client details. Aboriginal people were involved at all stages of the research process in accordance with NHMRC Guidelines. Our study was a first step to establishing whether CBT in high- and low-intensity forms can be an appropriate therapy strategy with Aboriginal and Torres Strait Islander clients using PAR principles over the course of 10 research meetings. The contributions of the entire research team were critical to the success of the research enterprise.

Concluding Comments

Dudgeon and Kelly, Bennett and Babbage, Hays, Creed, the readership of the *Australian Psychologist*, and our research group would all agree that improving the mental health and social and emotional well-being of Aboriginal and Torres Strait Islander Peoples is paramount. It is clear that all the authors of these invited contributions feel passionately about enhancing the mental health of our Indigenous populations. We have the same basic motives even if at times our ideas about how this should be achieved may be different. The orientation of our research group has been to look at therapeutic approaches that have empirical support in other countries, including those with adaptations and evidence within Indigenous populations, and see if they may be effective with Indigenous Australians. To this end, we undertook an extensive training programme in CBT, followed by a 1-year research programme to evaluate its effectiveness through personal and professional experience in the context of a PAR study.

Our conclusion was that CBT in its high-intensity (Beckian) and low-intensity forms can be effective with Aboriginal and Torres Strait Islander Peoples and that, following this initial formative study, it is worthwhile to proceed with more formal efficacy studies, as suggested by Bennett and Babbage and Dudgeon and Kelly. It may also be an important step, as Hays, and Dudgeon and Kelly suggest, to seek the perspectives of Aboriginal and Torres Strait Islander clients who have engaged with CBT either in low intensity or higher intensity (face-to-face) form. There are ethical obstacles that will be need to be comprehensively addressed for this to happen. We have articulated why this step was not appropriate for the present study.

We acknowledge that CBT "done badly" can be culturally unresponsive. However, our experience is that, in the right hands with culturally competent practitioners, CBT "done well" is an adaptable, person-centred therapy; and as writers from other cultures have noted, it can easily be adapted for Indigenous and other non-Westernised communities. We suggest that there is no reason that CBT and its component elements cannot be successfully adapted for Aboriginal and Torres Strait Islander clients, as Nagel and colleagues have already done in the Northern Territory (Nagel et al., 2009). To dismiss CBT as a Westernised therapy,

which is not applicable to Indigenous Australians, risks doing our communities a disservice in denying them access to effective therapeutic approaches. Low-intensity CBT, which can be accessed remotely in self-help or guided self-help form, may be a particularly promising approach for Indigenous clients.

Of course, CBT has a number of limitations as any therapy does; and as Hays indicates, there are specific elements of CBT that limit its applicability in toto. We recognise that social determinants are a major impediment to social and emotional well-being and that, as Dudgeon and Kelly suggest, CBT can only be a part of the answer to population level change. We also recognise the value of other psychological therapies and that over time, they may achieve equal or superior outcomes to CBT.

We are well aware of the study's methodological limitations and agree with the suggestions of Bennett and Babbage, Creed, Hays, and Dudgeon and Kelly about the kinds of studies that may be appropriate as next steps. Our study is a modest start, but a start that has needed to happen.

References

- Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford.
- Bennett, S. T., & Babbage, D. R. (2014). Cultural Adaptation of CBT for Aboriginal Australians. *Australian Psychologist*, *49*, 18–20. doi:10.1111/ap.12029
- Bennett-Levy, J., Lee, N., Travers, K., Pohlman, S., & Hamernik, E. (2003). Cognitive therapy from the inside: Enhancing therapist skills through practising what we preach. *Behavioural and Cognitive Psychotherapy*, *31*, 145–163. doi:10.1017/S1352465803002029
- Bennett-Levy, J., Richards, D. A., Farrand, P., Christensen, H., Griffiths, K. M., Kavanagh, D., & Williams, C. (2010). *The Oxford guide to low intensity CBT interventions*. Oxford: Oxford University Press.
- Bennett-Levy, J., Turner, F., Beaty, T., Smith, M., Paterson, B., & Farmer, S. (2001). The value of self-practice of cognitive therapy techniques and self-reflection in the training of cognitive therapists. *Behavioural and Cognitive Psychotherapy*, *29*, 203–220.
- Bennett-Levy, J., Wilson, S., Nelson, J., Stirling, J., Ryan, K., Rotumah, D., Budden, W., & Beale, D. (2014). Can CBT be effective for Aboriginal Australians? Perspectives of Aboriginal practitioners trained in CBT. *Australian Psychologist*, *49*, 1–7. doi:10.1111/ap.12025
- Creed, T. A. (2014). Training Aboriginal Practitioners in Cognitive Behavioural Therapy. *Australian Psychologist*, *49*, 13–15. doi:10.1111/ap.12032
- Dudgeon, P., & Kelly, K. (2014). Contextual Factors for Research on Psychological Therapies for Aboriginal Australians. *Australian Psychologist*, *49*, 8–12. doi:10.1111/ap.12030
- Hays, P. (2014). An International Perspective on the Adaptation of CBT Across Cultures. *Australian Psychologist*, *49*, 16–17. doi:10.1111/ap.12027
- Hays, P. A. (2006). Cognitive-behavioral therapy with Alaska Native people. In P. Hays & G. Y. Iwamasa (Eds.), (2006): *Culturally responsive cognitive-behavioral therapy: Assessment, practice, and supervision* (pp. 47–71). Washington, DC: American Psychological Association.
- Hays, P. A., & Iwamasa, G. Y. (Eds.) (2006). *Culturally responsive cognitive-behavioral therapy: Assessment, practice, and supervision*. Washington, DC: American Psychological Association.
- Laliberte, A., Nagel, T., & Haswell, M. (2010). Low intensity CBT with indigenous consumers: Creative solutions for culturally appropriate mental health care. In J. Bennett-Levy, D. A. Richards, P. Farrand, H. Christensen, K. M. Griffiths, D. Kavanagh, C. Williams (Eds.), *Oxford guide to low intensity CBT interventions* (pp. 577–585). Oxford: Oxford University Press.

- McTaggart, R. (1991). Principles for participatory action research. *Adult Education Quarterly*, 41, 168–187.
- Naeem, F., & Kingdon, D. G. (Eds.) (2012). *Cognitive behaviour therapy in non-western cultures*. Hauppauge, NY: Nova Science Publishers.
- Nagel, T., Robinson, G., Condon, J., & Trauer, T. (2009). Approach to treatment of mental illness and substance dependence in remote Indigenous communities: results of a mixed methods study. *The Australian Journal of Rural Health*, 17, 174–182. doi:10.1111/j.1440-1584.2009.01060.x
- National Health and Medical Research Council (NHMRC) (2003). *Values and ethics: Guidelines for ethical conduct in Aboriginal and Torres Strait Islander health research*. Canberra: Commonwealth of Australia. Retrieved from: <http://www.nhmrc.gov.au/guidelines/publications/e52>
- Norcross, J. C. (Ed.). (2011). Evidence-based therapy relationships. *Psychotherapy (Chicago, Ill.)*, 48(1).
- Shalowitz, M. U., Isacco, A., Barquin, N., Clark-Kauffman, E., Delger, P., Nelson, D., & Wagenaar, K. A. (2009). Community-based participatory research: A review of the literature with strategies for community engagement. *Journal of developmental and behavioral pediatrics*, 30, 350–361.
- Smith, T. B., Domenech Rodriguez, M., & Bernal, G. (2011). Culture. *Journal of Clinical Psychology*, 67, 166–175. doi:10.1002/jclp.20757; In Session.
- Westbrook, D., Kennerley, H., & Kirk, J. (2007, 2011). *An introduction to cognitive behaviour therapy: Skills and applications*. London: Sage.