SHORT COMMUNICATION

Lost in translation? Cultural adaptation of treatment content for Japanese internet-based cognitive therapy for social anxiety disorder

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Abstract Studies that look to disseminate psychological therapies in different countries often discuss whether and how much cultural adaptation may be required. However, most do not provide sufficient descriptions of how language translation and cultural adaptations were performed, and rarely give examples of specific changes. This makes it hard to understand how much the adapted treatment differs from the original, causing difficulty when comparing studies. This study aimed to describe the translation and cultural adaptation process used to generate a Japanese version of a UK-developed online psychological therapy for social anxiety. It aimed to evaluate the translated and adapted content with a case series of Japanese patients. Following translation and back-translation, incorporating cultural adaptations where appropriate, the new Japanese content was reviewed and a list of adaptations collated and categorised. The Japanese treatment material was then evaluated using a guided self-study approach with six Japanese patients with social anxiety. Four categories of adaptation were identified: Linguistics and Metaphors, Social Systems, Social Behaviours, and Familiarity. Assigning instances of adaptation into these categories showed good interrater reliability (0.78). The Japanese materials showed excellent treatment efficacy (pre-post Hedges' g = 2.31). Patient feedback highlighted areas of strength, and further suggestions to improve suitability for Japanese settings.

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The clinical outcomes observed suggest that the translation and adaptation procedures were effective. Ways of further improving the adaptation based on patient feedback were identified. It is hoped that the translation procedure and adaptation categories described in this study may help other clinicians/researchers working to disseminate both online or in-person psychological therapies cross-culturally.

Introduction

When seeking to disseminate psychological therapies widely, it is important to consider whether and how much translation and cultural adaptation of the treatment is required in order to be meaningful and effective for those undertaking it. There is meta-analytic evidence to suggest that treatments adapted to the culture and context of those receiving the treatment show moderate efficacy (Griner & Smith, 2006). A recent systematic review found that culturally adapted treatments did not differ from 'conventional' cognitive behavioural therapies (CBTs) in terms of effectiveness or retention (Hernandez Hernandez, Waller, & Hardy, 2020). Importantly, both of these large reviews made the point that most of the reviewed studies did not clearly specify the exact processes of adapting treatment and details of the adaptations made.

The extent of cultural adaptation required may depend on the nature of the clinical problem being treated. In social anxiety for example, it has been suggested that culture may influence the norms and standards about what signs of anxiety are publicly acceptable in social situations (Hofmann, Asnaani, & Hinton, 2010; Okawa et al., 2021), and could suggest that social anxiety disorder (SAD) may manifest differently between Asian and Western settings. Despite such cultural difference in SAD pathology, evidence from treatment studies has also shown that with a small amount of cultural adaptation, Western-developed therapies for SAD can be highly effective when delivered in Japan (Yoshinaga, Kobori, Iyo, & Shimizu, 2013; Yoshinaga et al., 2016, 2019). Whilst this is a promising finding, social anxiety is a common difficulty in Japan (Ishikawa, Kawakami, & Kessler, 2016) and it can be difficult to access evidence-based psychological therapy. Using an online format of treatment delivery has significant potential to address this issue.

Internet-based Cognitive Therapy for Social Anxiety Disorder (iCT-SAD) is a therapist guided online psychological therapy developed in the UK (Stott et al., 2013). It is an online adaptation of the face-to-face Cognitive Therapy protocol (Clark et al., 2006; Warnock-Parkes et al., 2020) that is the primary treatment recommendation by the UK National Institute for Health and Care Excellence (National Institute for Health and Care Excellence, 2013) for adults with social anxiety, based on evidence from multiple randomised controlled trials (Clark et al., 2003, 2006; Ingul, Aune, & Nordahl, 2014; Leichsenring et al., 2013; Mörtberg, Clark, Sundin, & Wistedt, 2007; Nordahl et al., 2016; Stangier, Heidenreich, Peitz, Lauterbach, & Clark, 2003; Stangier, Schramm, Heidenreich, Berger, & Clark, 2011; Yoshinaga et al., 2016). The iCT-SAD programme has a number of potential advantages for patients, such as

flexibility in where and when they work on their treatment, as well as benefits for services in that a course of treatment requires less therapist time compared to face-to-face therapy. In terms of international dissemination, internet interventions have an advantage in that the core treatment manoeuvres are written into the programme and are delivered in a consistent manner to different patients. They are therefore likely to be easier to translate and implement at scale in settings where they are needed compared to face-to-face interventions, while also ensuring that treatment is delivered consistently with high fidelity to the original treatment protocol (Thew, 2020). The English-language iCT-SAD programme has shown promising results when evaluated in Hong Kong in a largely unadapted form with English-speaking Chinese patients (Thew et al., 2019). While there are examples of culturally adapted internet interventions in the literature, which generally report good clinical outcomes (Gallego, Emmelkamp, van der Kooij, & Mees, 2011; Jakobsen, Andersson, Havik, & Nordgreen, 2017; Kishimoto et al., 2016; Tulbure et al., 2015), such studies generally provide limited information on the procedures followed to translate and adapt the online intervention, or examples of the changes made.

This study aimed to document the processes involved in translating and culturally adapting iCT-SAD from English to Japanese. It aimed to categorise the types of cultural adaptations made in the hope this may provide a point of reference for clinicians and researchers undertaking similar work. Lastly, it aimed to provide an initial evaluation of the translated and adapted content, reporting the treatment outcomes and module feedback of a pilot series of six participants with SAD.

Method

Translation and cultural adaptation procedure

The procedure for translating and culturally adapting the iCT-SAD treatment content occurred in four stages, as described in Table 1.

Procedure for categorisation of cultural adaptations

To permit an analysis of all the cultural adaptations made to the programme, the translated text of all modules was reviewed, and instances of cultural adaptation were highlighted and collated. These were then reviewed by a Japanese clinical psychologist (OK) who lived in the UK for 8 years. The instances were grouped into categories, and

Table 1 Description of translation and cultural adaptation stages.

Stage	Description	Performed by
1	Initial English to Japanese translation (literal translation)	Independent professional translator
2	Review of initial translation, and initial cultural adaptation	Japanese mental health professionals (English-speaking) (NY & OK)
3	Back-translation into English	Second independent professional translator
4	Comparison of original and back-translated English; review and resolution of discrepancies	UK clinical psychologist (GT); review by the wider project team

a brief definition of each category was developed. Two of the other authors (YH and GRT) then independently categorised each instance of cultural adaptation based on these definitions, to allow the estimation of interrater reliability.

Pilot case series

Participants

We collected clinical outcome data from six participants with SAD (2 female; mean age 26.0 years [SD = 5.0]; mean duration of SAD 9.3 years [SD = 7.5]; 3 students, 1 full-time employment, 1 homemaker, 1 sick leave from work) at the psychiatry outpatient clinic in Japan for this pilot evaluation between January and December 2019. The diagnostic assessment was performed by an experienced psychiatrist at the study institution. The therapist also confirmed the diagnostic assessment based on DSM-5 (including comorbidity) at the initial assessment. All the participants met a primary diagnosis of SAD according to the fifth edition of DSM (DSM-5) (one participant was classified as the performance-only subtype). Two participants had a comorbid major depressive disorder. Five participants were taking psychotropic medication at baseline.

Treatment procedure

The treatment was provided by the first author (NY), a psychiatric nurse and a certificated public psychologist, with ten years of experience providing individual face-to-face CT for SAD in Japan. To evaluate the Japanese module content and obtain feedback before conducting a pilot study, treatment used a guided self-study approach, where electronic versions of the Japanese modules were emailed and used independently by participants between in-person treatment sessions, in which the module topics were discussed and related activities and behavioural experiments planned. The iCT-SAD consists of core modules completed by all patients (e.g. Feeling Self-Conscious, Safety Behaviours), and optional modules linked to specific concerns that are selected by the therapist to tailor treatment to the patient (e.g. Sweating, Feeling Boring) (Stott et al., 2013). Typically, the in-person sessions were conducted in 14 weekly 15-30 minute sessions.

Outcomes

Participants completed outcome assessments at week 0 (Pre), week 8 (Mid), and week 14 (Post). The primary outcome was the severity of social anxiety, measured using

the self-report version of the Liebowitz Social Anxiety Scale (LSAS) (Baker, Heinrichs, Kim, & Hofmann, 2002). Secondary self-reported outcomes included general mood and functioning measures: the Patient Health Questionnaire-9 item (PHQ-9) (Kroenke, Spitzer, & Williams, 2001), the Generalized Anxiety Disorder-7 item (GAD-7) (Spitzer, Kroenke, Williams, & Löwe, 2006), and the EuroQol-5 Dimensions (EQ-5D) (Tsuchiya et al., 2002). An independent assessor also evaluated the Clinical Global Impression of Severity/Improvement (CGI-S/I) (Guy, 1976).

For classifying participants as treatment responders and/or remitted social anxiety, we used the criteria described in the original iCT-SAD case series in the UK (Stott et al., 2013). Response to treatment was defined as an improvement greater than 31% on the LSAS between Pre and Post. Remission was defined as a drop of at least 12 points on the LSAS between Pre and Post combined with a Post score at or below the clinical threshold of 38 points.

Ethical review

The study protocol was reviewed and approved by the Institutional Review Board of the University of Miyazaki (O-0442).

Results

Categories of cultural adaptation

All the modules were reviewed to identify cross-cultural adaptations made during the translation process. As a result, 31 items were identified, and grouped into 4 categories: Linguistics and Metaphors, Social Systems, Social Behaviours, and Familiarity. Table S1 presents the definitions, frequencies, and examples. The inter-rater agreement (Kappa coefficient) was 0.78 between two independent raters (YH and GT), suggesting substantial agreement (Landis & Koch, 1977).

Pilot case series

No participants dropped out of treatment. On average, patients had 13.7 sessions (SD = 0.8) over 14.0 weeks (SD = 3.6). One participant finished treatment earlier than planned at session 12, following recovery.

Fig. 1 shows a graph of the participants' LSAS scores over time. All participants met criteria to suggest a response
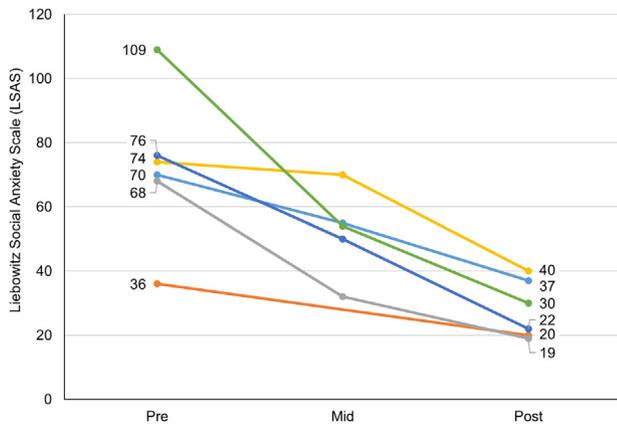
Figure 1 Scores on the Primary Outcome Measure (Liebowitz Social Anxiety Scale) Across Treatment for the Pilot Cohort.

Table 2 Pre- and post means and standard deviations on the secondary outcome measures.

Measure	Pre Mean (SD)	Post Mean (SD)	Effect Size (Hedges' g)
PHQ-9	9.7 (4.6)	2.0 (0.9)	2.13
GAD-7	12.8 (6.7)	3.2 (1.6)	1.83
EQ-5D	0.768 (0.057)	0.915 (0.094)	1.78

PHQ-9: Patient Health Questionnaire-9 item; GAD-7: Generalized Anxiety Disorder-7 item; EQ-5D: EuroQol-5 Dimensions. Effect sizes calculated using the pooled standard deviation and corrected for small sample sizes.

to treatment, with 83% meeting the criteria for remission. However, it should be noted that the one participant with the performance-only subtype had a baseline LSAS score which was below the clinical threshold at the start of treatment. The mean LSAS score at baseline was 72.2 (SD = 23.3) and at posttreatment was 28.0 (SD = 9.1). The Pre-Post within-group effect size (Hedges' g) was 2.31.

Results from the secondary outcome measures indicated that the treatment was associated with reductions in depression and generalised anxiety symptoms, and an improvement in quality of life (Table 2). The ratings on the CGI-S indicated that all participants were considered to be in the nonclinical or borderline clinical range at the end of treatment. Ratings on the CGI-I classified all participants as 'much improved' or 'very much improved'.

A summary of participants' feedback and actions taken is given in the supplementary materials (Appendix S1).

Discussion

The present results suggest that overall, the iCT-SAD treatment content was successfully translated and culturally adapted using the procedures described. This is evidenced by both the feedback provided by pilot participants and the excellent clinical outcomes obtained in treatment using the Japanese iCT-SAD modules (Hedges' g = 2.31), which are comparable to those obtained in the English-language programme (Stott et al., 2013). The translation and adaptation procedure employed here was particularly thorough, and

represents a strength of the present work. However, this approach is time-consuming, particularly for programmes such as iCT-SAD where a range of optional treatment modules is available to help personalize treatment to each patient. Depending on the nature of the treatment programme and the extent of cultural/linguistic differences between the original and target treatment settings, there may be ways to shorten the procedures required, but there remains a balance to be struck between speed and quality. Our view is that the back-translation step was critical to the overall quality of the procedure, given that it specifically identifies areas where meanings may have changed or that have moved away from the clinical focus of the original material.

It is notable that only a small number of changes were deemed necessary to adapt the treatment for the Japanese context, most of which were relatively minor. However, fuller evaluation of the translated and adapted content would be helpful, using larger samples, and having the content embedded into a full Japanese iCT-SAD online programme to permit better integration of audio and video material. This work is currently underway. The present study also sought to categorise the cultural adaptations made. The examples presented in Table S2 may offer some helpful clinical implications for when a therapist from either the UK or Japan is treating a client from the other cultural context. For example, a common behavioural experiment in the UK is to have a conversation about blushing (or a different concern) while on a bus or train, to see how others respond. However, in Japan it is culturally inappropriate to talk on public transport, so adapting the experiment to take place while waiting for the bus or train is more acceptable. Table S2 also highlights how English idioms such as 'shaking like a leaf' would not be fully understood by Japanese patients, and that referring to 'moving branches' is more appropriate. As the categories themselves are not specific to UK-Japan comparisons, it is suggested that these may be of use to those working to translate and adapt other treatments.

This study has described the process of translating and culturally adapting iCT-SAD from English to Japanese, and the initial evaluation of the new Japanese content. We hope that the descriptions of translation procedures and categorisation of cultural adaptations made in this study may prove helpful for other clinicians and researchers working to disseminate both online or in-person psychological therapies cross-culturally (e.g. Okawa et al., 2021; Vera, Obén, Juarbe, Hernández, & Pérez-Pedrogo, 2021; Wright, Reisig, & Cullen, 2020).

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Disclosure of interest

The authors declare that they have no competing interest.

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Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at https://doi.org/10.1016/j.jbct.2021.05.004.

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