

Factors Influencing Cognitive Behavioral Therapy Acceptance in Malaysian Hospital Settings: A Structural, Clinical, and Cultural Analysis

Faktor-Faktor yang Mempengaruhi Penerimaan Terapi Tingkah Laku Kognitif dalam Tetapan Hospital Malaysia: Analisis Struktur, Klinikal dan Budaya

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ABSTRACT

Cognitive Behavioral Therapy (CBT) is an evidence-based psychological intervention for depression, anxiety, and trauma-related disorders, yet its acceptance in Malaysian hospital settings remains limited despite its proven clinical effectiveness. Early diagnosis does not consistently translate into CBT engagement, and existing research has not sufficiently explained how structural, clinical, and cultural factors collectively shape this transition. Structural factors include resource availability, referral pathways, and institutional support. Clinical factors involve perceived effectiveness, delivery format, and therapeutic fit. Cultural factors encompass stigma, collectivist norms, religious beliefs, and power distance orientations. This review synthesizes evidence on how these three domains interact to influence CBT acceptance at the early diagnostic stage in Malaysian hospital settings, with specific reference to Hospital Canselor Tuanku Muhriz (HCTM), Universiti Kebangsaan Malaysia. Findings indicate that cultural safety and structural feasibility jointly condition whether clinical effectiveness translates into actual CBT uptake, pointing toward the need for an integrated, culturally grounded acceptance model for Malaysian healthcare.

Keywords: cognitive behavioral therapy; CBT acceptance; cultural factors; structural factors; early diagnosis; Malaysia

ABSTRAK

Terapi Tingkah Laku Kognitif (CBT) merupakan intervensi psikologi berasaskan bukti bagi gangguan kemurungan, kebimbangan, dan berkaitan trauma, namun penerimaannya dalam tetapan hospital Malaysia kekal terhad walaupun keberkesanan klinikalnya telah terbukti. Diagnosis awal tidak secara konsisten diterjemahkan kepada penglibatan CBT, dan kajian sedia ada tidak menjelaskan dengan mencukupi bagaimana faktor struktur, klinikal, dan budaya secara kolektif membentuk peralihan ini. Faktor struktur merangkumi ketersediaan sumber, laluan rujukan, dan sokongan institusi. Faktor klinikal melibatkan keberkesanan yang dirasakan, format penyampaian, dan kesesuaian terapeutik. Faktor budaya merangkumi stigma, norma kolektivistik, kepercayaan agama, dan orientasi jarak kuasa. Tinjauan ini mensintesis bukti tentang bagaimana ketiga-tiga domain ini berinteraksi untuk mempengaruhi penerimaan CBT pada peringkat diagnosis awal dalam tetapan hospital Malaysia, dengan rujukan khusus kepada Hospital Canselor Tuanku Muhriz (HCTM), Universiti Kebangsaan Malaysia.

Kata kunci: terapi kognitif tingkah laku; penerimaan CBT; faktor budaya; faktor struktur; diagnosis awal; Malaysia

INTRODUCTION

Mental health disorders represent a growing public health burden in Malaysia, with the National Health and Morbidity Survey reporting that prevalence among adults rose from 10.7% in 1996 to 29.2% in 2015, yet fewer than 10% of affected individuals receive formal psychological treatment (Institute for

Public Health 2015; Munawar et al. 2022; Mohd Noh et al. 2022). Cognitive Behavioral Therapy (CBT) is internationally recognised as a first-line, evidence-based intervention for depression and anxiety, with meta-analytic evidence confirming consistent moderate-to-large effect sizes across diverse clinical populations (Hofmann et al. 2012; Cuijpers et al. 2023). Despite this strong efficacy evidence, real-world uptake of CBT in Malaysian hospital outpatient settings remains critically low, indicating that clinical effectiveness alone does not ensure acceptance or engagement.

CBT acceptance in Malaysia is shaped by a complex interaction of structural, clinical, and cultural conditions that existing research has typically examined in isolation (Algumaei et al. 2025). Structurally, uneven hospital distribution and a limited number of CBT-trained practitioners restrict access to evidence-based psychological care. Clinically, high caseloads and limited specialised training further constrain consistent and culturally competent delivery. Culturally, mental health stigma, collectivist family norms, religious coping orientations, and high power distance orientations reduce willingness to engage, particularly during the early stages of help-seeking (Koon et al. 2023; Subhas et al. 2021). As a result, a persistent gap exists between early diagnosis and actual engagement with CBT. The primary objective of this review is to analyze these structural, clinical, and cultural factors and to examine how their interaction shapes CBT acceptance at the early diagnostic stage within selected Malaysian hospital settings, with particular reference to Hospital Canselor Tuanku Muhriz (HCTM), Universiti Kebangsaan Malaysia.

RELATED WORK

At the structural level, Malaysian evidence consistently identifies workforce shortages, fragmented referral pathways, and unequal service distribution as primary barriers to CBT uptake. The Ministry of Health Malaysia (2022) documented that existing mental health policies support service provision structurally but do not directly address patient or clinician readiness to use psychotherapy, while workforce capacity constraints reduce clinician confidence and recommendation rates (Muda & Ahmad Raphaie 2025). Sam et al. (2022) demonstrated that embedding CBT within primary care settings and reframing it as practical stress management substantially reduced stigma and improved engagement, attributing success to accessible and low-stigma institutional framing. Saw et al. (2020) similarly reported that school-based CBT delivered in Bahasa Malaysia with relationship-oriented group activities achieved high retention and sustained depressive symptom reduction, highlighting how structural embedding and workforce readiness jointly determine feasibility. Sadali et al. (2025) further confirmed that integrating CBT-informed protocols within audiology services improved both clinician confidence and patient acceptability, reinforcing that structural conditions set the outer boundary of possible acceptance.

At the clinical level, therapeutic fit, guidance intensity, and perceived effectiveness function as core determinants of sustained CBT engagement in Malaysian settings. Keng et al. (2021) reported that graded emotional intensity and skills-focused delivery approaches enhanced participation, particularly when confrontational techniques were moderated to align with local norms of emotional restraint. Lian & Mathialagan (2025) demonstrated that culturally adapted schema therapy produced higher acceptability than standard Trauma-Focused CBT because it accommodated preferences for indirect emotional processing and family-oriented therapeutic framing. These findings are consistent with broader evidence showing that protocol structure, pacing, and therapist cultural competence independently mediate the relationship between structural access and actual treatment engagement (Algumaei et al. 2025). Without clinical scaffolding aligned to local cultural expectations, even structurally accessible services fail to sustain patient participation.

Cultural determinants represent the most consistently documented barriers to CBT acceptance in Malaysia. Koon et al. (2023) measured Hofstede-aligned cultural values in a Malaysian sample and found that collectivism and power distance significantly shaped help-seeking attitudes, with family endorsement and clinician authority functioning as the dominant cues to action. Subhas et al. (2021) documented that standard Western CBT protocols are frequently perceived as culturally misaligned, particularly when they require direct emotional confrontation inconsistent with Malaysian norms of indirectness and emotional restraint. Rahimah Samsudin et al. (2024) further reported that collectivist

family structures and community endorsement independently conditioned patients' willingness to engage with psychological interventions. These cultural dynamics do not merely add to structural and clinical barriers — they moderate how patients interpret and respond to them, making cultural safety a prerequisite condition for acceptance rather than an optional enhancement. Table 1 summarizes the three determinant domains, their key components, and their typical influence on CBT acceptance.

TABLE 1. Structural, Clinical, and Cultural Determinants of CBT Acceptance in Malaysian Hospital Settings.

Domain	Key Components	Influence on CBT Acceptance
Structural	Limited CBT-trained practitioners; fragmented referral pathways; unequal urban-rural service distribution; cost and time burden; weak policy implementation	Determines who can access CBT; weak structure blocks uptake regardless of clinical quality or patient willingness
Clinical	Perceived effectiveness; therapist cultural competence; pacing and emotional intensity; protocol structure; therapeutic alliance; modality fit; guidance intensity	Shapes engagement quality and retention once access is achieved; misaligned clinical delivery leads to premature disengagement
Cultural	Mental health stigma; collectivist family norms; religious and spiritual coping; high power distance; emotional restraint norms; fear of social judgement	Governs perceived relevance, credibility, and trust; conditions whether patients disclose symptoms and initiate treatment
Interaction	Structural feasibility $\times$ clinical scaffolding $\times$ cultural safety	Acceptance is conditional and multi-level; strong clinical design cannot compensate when cultural safety or structural access is inadequate

METHODOLOGY

This study employs a sequential explanatory mixed-methods design conducted at Hospital Canselor Tuanku Muhriz (HCTM), Universiti Kebangsaan Malaysia. In Phase 1, a cross-sectional quantitative survey will be administered to 200 outpatient participants selected through systematic random sampling, a sample size determined via G*Power analysis for SEM with medium effect size ($f^2 = 0.15$), 80% power, and seven predictors. The survey instrument was developed and validated using the Content Validity Index ($CVI \geq 0.80$) across ten domain experts in mental health, public health, and information systems.

Seven hypotheses (H1–H7) guide the quantitative analysis, examining the determinants of CBT acceptance and their cultural moderating roles. Structural Equation Modelling (SEM) using SmartPLS 4.0 will assess measurement model reliability (Cronbach's α , composite reliability, AVE) and structural path coefficients. To further analyse the structural, clinical, and cultural factors influencing CBT acceptance, evidence was drawn from Malaysian and regional literature identified through Scopus, Web of Science, PubMed, and PsycInfo. Search terms included cognitive behavioral therapy, CBT acceptance, mental health Malaysia, cultural factors, structural barriers, clinical engagement, and early diagnosis. Studies were considered if they reported empirical or conceptual findings relevant to CBT acceptance at patient, provider, or service levels, with priority given to Malaysian hospital and community contexts published between 2015 and 2025. Identified determinants were organized across three interacting domains — structural, clinical, and cultural — to examine how their interaction shapes CBT acceptance during the early diagnostic stage in Malaysian hospital settings.

RESULTS AND DISCUSSION

The evidence indicates that structural, clinical, and cultural factors each address a distinct and non-substitutable dimension of CBT acceptance, while leaving critical gaps when examined in isolation. At the structural level, Malaysia's mental health service system faces well-documented challenges

including a national shortage of clinical psychologists and CBT-trained practitioners, with services concentrated in urban centres such as Kuala Lumpur (Ministry of Health Malaysia 2022). Referral pathways between primary care, outpatient services, and specialist mental health clinics remain fragmented, and limited implementation monitoring means that even existing policies do not consistently translate into clinician readiness or patient access (Sam et al. 2022). These structural conditions set the outer boundary of possible acceptance — they determine who can reach CBT but do not explain why patients with access still disengage or avoid treatment.

Clinical factors operate within the point of service delivery and shape the quality of engagement once structural access is achieved. The reviewed evidence shows that CBT delivered without cultural adaptation is frequently experienced as emotionally confrontational, inconsistent with Malaysian norms of indirect communication and emotional restraint (Subhas et al. 2021; Lian & Mathialagan 2025). Therapist cultural competence, graded pacing, and skills-focused protocol design are critical mediators of sustained participation. Patients who experience CBT as coherent, emotionally safe, and practically relevant to their daily lives are significantly more likely to continue beyond initial sessions, while those who encounter direct emotional exposure or culturally unfamiliar therapeutic demands tend to withdraw prematurely (Keng et al. 2021). This positions clinical scaffolding quality as a necessary complement to structural access — without culturally sensitive delivery, even accessible services fail to retain patients.

Cultural determinants emerge as the most powerful and consistent moderators of CBT acceptance, operating both independently and in interaction with structural and clinical conditions. In Malaysia's collectivist and high power-distance society, the decision to seek psychological treatment is rarely an individual act — it is negotiated through family approval, community norms, and deference to authority figures including clinicians and religious leaders (Koon et al. 2023; Rahimah Samsudin et al. 2024). Stigma associated with mental illness, fears of social judgement, and religious interpretations of psychological distress collectively suppress perceived susceptibility and inflate perceived barriers (Munawar et al. 2022), the two constructs most strongly associated with treatment non-initiation. As illustrated in Table 1, acceptance is therefore a conditional, multi-level outcome: structural feasibility enables access, clinical scaffolding sustains engagement, and cultural safety governs perceived relevance and willingness to disclose. None of these domains is independently sufficient, and their interaction — rather than any single factor — determines whether early diagnosis leads to sustained CBT engagement at HCTM and across Malaysian hospital settings.

CONCLUSION

This review synthesized evidence on the structural, clinical, and cultural factors influencing CBT acceptance during early mental health diagnosis in Malaysian hospital settings. The central finding is that acceptance is not determined by any single domain but emerges from their interaction: structural feasibility enables access, clinical scaffolding sustains engagement, and cultural safety governs perceived relevance and trust. These three domains operate simultaneously and conditionally — a finding consistent with the broader literature on CBT implementation in multicultural and resource-constrained settings (Algumaei et al. 2025). No existing framework fully captures this three-domain interaction for CBT acceptance in the Malaysian hospital context, highlighting the need for an integrated, culturally grounded model that explicitly incorporates structural, clinical, and cultural determinants within a unified analytical framework. Future research should develop and empirically test such a model to improve early mental health intervention outcomes and support the equitable delivery of CBT across Malaysia's diverse hospital system.

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