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## Culture

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## **Culture**

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### **Abstract**

This article summarizes the definitions, means, and research of adapting psychotherapy to clients' cultural backgrounds. We begin by reviewing the prevailing definitions of cultural adaptation and providing a clinical example. We present an original meta-analysis of 65 experimental and quasi-experimental studies involving 8,620 participants. The omnibus effect size of  $d = .46$  indicates that treatments specifically adapted for clients of color were moderately more effective with that clientele than traditional treatments. The most effective treatments tended to be those with greater numbers of cultural adaptations. Mental health services targeted to a specific cultural group were several times more effective than those provided to clients from a variety of cultural backgrounds. We recommend a series of research-supported therapeutic practices that account for clients' culture, with culture-specific treatments being more effective than generally culture-sensitive treatments.

*Keywords:* psychotherapy outcomes, ethnic minority groups, culture, meta-analysis, evidence-based practice, treatment adaptation

The psychotherapist-client relationship is highly dependent on context. Factors such as the therapy format (e.g., family, individual therapy), clinical setting (e.g., group home, wilderness retreat), and personal characteristics of the participants (e.g., age, gender, culture) influence the content and process of therapy. Mental health treatments adapted to these contexts and supported by available research constitute evidence-based practice (EBP), defined by the American Psychological Association (APA) Presidential Task Force on Evidence-Based Practice (2006) as “the integration of the best available research with clinical expertise in the context of patient characteristics, *culture* [emphasis added] and preferences.” (p. 273). Professional standards and guidelines across the mental health professions recognize the centrality of cultural contexts. The Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations (APA, 1993) unequivocally state that culture and language impact psychological services. The more recent Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (APA, 2003) specify that psychologists apply culturally appropriate skills in psychological practice, taking cultural context into account at all times. Recognizing and aligning with client culture is not only best practice but ethical practice (APA, 2002; Bernal et al., 2009; Smith, 2010).

Despite the clear professional mandates to account for client culture, the implementation of these standards appears limited. Engagement into mental health services for ethnic minorities has been low (U.S. Surgeon General, 2001) and continues to be so (Gonzalez et al., 2010). Some scholars have argued that this low engagement is a result of incongruous therapy-client match (Dumas, Moreland, Gitter, Pearl, & Nordstrom, 2008) and low relevance of available treatments to ethnic minorities (Miranda, Azocar, Organista, Muñoz, & Lieberman, 1996). Other evidence

points to language, economic, and structural barriers, such as a lack of mental health clinics in ethnic neighborhoods (Alegría et al., 2002).

Disproportionately low rates of utilization and retention among ethnic minorities may also be related to practitioner demographics. In the United States, the vast majority of treatment professionals are White/European American, primarily English-speaking (APA, 2009; NSF, 2009). In a survey of psychologists, only 12% of respondents reported speaking a language other than English well enough to provide services in that language and 9% reported actually providing services in another language (APA, 2010). Meanwhile, nearly 20% of the US population speak a language other than English in the home (Shin & Kominski, 2010). Ethnic minorities represent roughly 25% of the population in the US and are expected to surpass 50% between 2040 and 2050 (Ortman & Guarnieri, 2009). While neither therapist ethnicity nor non-English language fluency imply cultural competence or lack thereof (Schwartz et al., in press), the demographic mismatch between therapists and clients may present challenges to client engagement in therapy.

In this paper, we consider cultural adaptations to psychotherapy – their definitions, measures, and examples. We present an original meta-analysis of culturally adapted mental health treatments. We conclude with probable moderators, limitations of the research reviewed, and recommendations for therapeutic practices based on the research evidence.

### **Definitions and Measures**

Although sometimes broadly considered *culture relevant* or *culture sensitive* (Hall, 2001; LaRoche & Christopher, 2009; Tanaka-Matsumi, 2008), the term *culturally adapted* treatments has been used frequently in the literature. A precise definition of cultural adaptation is “the systematic modification of an evidence-based treatment (EBT) or intervention protocol to

consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009, p. 362).

A less structured conceptualization of cultural adaptation considers mental health treatments tailored to clients' cultural beliefs and values, provided in a setting considered "safe" by the client, and conducted in the clients' preferred language (Miranda, Nakamura, & Bernal, 2003; Whaley & Davis, 2007). For instance, mental health clinics provide culturally adapted services when they regularly consult with cultural group representatives, provide language appropriate resources, or modify their intake procedures to help orient clients unfamiliar with psychotherapy.

Guidelines for adapting therapy to clients' cultures have emerged in recent decades. A synthesis of the work of several international scholars with expertise in cross-cultural psychotherapy identified common themes regarding cultural adaptation:

- ◆ therapists must practice flexibly
- ◆ services must be meaningful within the cultural context that they are delivered
- ◆ assessments should be conducted prior to implementing treatment
- ◆ therapists must remain open to what clients bring to therapy
- ◆ traditional treatments should not be dismissed but rather used as existing resources
- ◆ therapists must communicate empathy with clients in a culturally appropriate manner
- ◆ therapists should not interpret cultural differences as deficits (Draguns, 2008).

Themes like these can be clinically actualized by eight elements of culturally adapted treatments: (a) language, (b) persons (client attributes), (c) metaphors, (d) content, (e) concepts, (f) goals, (g) methods, and (h) context of the intervention or services (Bernal & Sáez, 2006). A

*language* appropriate service refers to not only the use of clients' preferred language but also to understanding the meaning of particular uses of language by different groups such as adolescents. *Person* factors include characteristics such as race and ethnicity. Studies consistently show that clients prefer therapists matched to their race, ethnicity, and native language (Coleman, Wampold, & Casali, 1995). Infusion of cultural *metaphors*, symbols, and overarching cultural concepts, can align therapy with existing client heuristics. For instance, cultural sayings can be used in therapy to more clearly convey meaning or insight. Attending to the cultural *content* of a psychotherapy can enhance alignment with client worldviews. For example, some groups are more collectivistic than others, so notions such as individuation, differentiation, and dependence may need to be contextualized so as to not pathologize clients with a collectivistic worldview. The categories of *goals* and *methods* imply the consideration of customs and cultural values in setting treatment goals and establishing suitable procedures to reach those goals. And finally, by the consideration of *context*, broader issues such as the social and economic realities come into focus that may include acculturative stress, migration, availability of social supports, etc. In brief, explicit consideration of these eight elements can help the psychotherapist align treatment with the client rather than presuming that the client will accommodate to the psychotherapy.

When deciding when and how to culturally adapt treatments, psychotherapists should recognize the tension between population fit and treatment fidelity. If a traditional intervention such as cognitive therapy is adapted in content and format with an Asian American client by infusing the Buddhist principle of mindfulness, for example, there comes a point at which the causal explanations of cognitive therapy may no longer predominate in the adapted treatment

(therapy may facilitate meditative relaxation/awareness over the explicit refutation of irrational thoughts).

The research contains a broad spectrum of opinions about maintaining traditional treatment fidelity when working with ethnic minority clients. Some call for the creation of new therapies specific to each cultural group that are explicitly aligned with their beliefs, values, and practices (Comas-Diaz, 2006; Gone, 2009), yet others propose implementing traditional EBTs with minimal or no alterations (Chambless & Ollendick, 2000). Many scholars, however, seem to opt for an integrated or hybrid model of cultural adaptation that takes into account both fidelity and fit (Castro, Barrera, & Martinez, 2004).

These scholars recommend adaptation of existing evidence-based therapies for cultural fit while retaining the original mechanisms of behavioral change or symptom reduction. For example, a Parent Management Training–Oregon (PMTO) intervention (Domenech Rodríguez, Baumann, & Schwartz, in press) with Spanish-speaking Latino families maintained behavioral therapy principles, such as applying immediate contingencies for desired behaviors. However, the specific behaviors thought to be desirable, the specific contingencies used, the context in which they are presented, the frames or metaphors used to explain the concepts to parents (or other caregivers), and the therapeutic process were all changeable and hence adapted to the clients' culture.

### **Clinical Examples**

In a broad sense, all mental health treatments are informed by cultural contexts. What have been termed “traditional” Western treatments are inextricably interwoven with European/European American culture, so much so as to render the cultural influences nearly



invisible (Smith, Richards, Granley, & Obiakor, 2004). Yet, in an increasingly multicultural society, culture cannot remain invisible.

There are a number of ways in which cultural centering of mental health interventions can be achieved (Barrera & González Castro, 2006; Hwang, 2009; Lau, 2006; Leong & Lee, 2006; Whitbeck, 2006). These can better serve ethnic minority clients by: providing additional or ancillary services (e.g., child care, home visits, referrals for legal or medical assistance), supporting consultation/collaboration with community/family (e.g., religious clergy and indigenous healers such as *curanderos* or *santeros*), and providing outreach services that move beyond the traditional patient-therapist office visit to facilitate access to services by disadvantaged populations.

Successful cultural adaptation has been demonstrated in an innovative study conducted in Australia with Aboriginal people suffering from chronic mental illness (Nagel, Robinson, Condon, & Trauer, 2009). The treatment development invited both Aboriginal mental health workers and recovered patients as key informants to understand indigenous views of mental illness. Group and individual in-depth interviews were conducted as well as field observations. The themes that emerged were the importance of the family, strength derived from cultural traditions, and the value of storytelling to share information. These themes were used to inform the process and content of the assessment, treatment, and ancillary materials. The resulting culturally adapted psychotherapy was subsequently compared to treatment as usual. In all, 49 patients were randomly assigned and outcomes were evaluated at baseline, 6-, 12-, and 18-month follow-ups. The culturally adapted therapy produced better outcomes in well-being, health, and substance dependence with changes maintained over time. Conducted in a remote indigenous area of Australia with a historically underserved population, this served as an excellent example

of collaboratively accessing experiential phenomena and then directly applying that understanding to the treatment rendered.

### **Previous Meta-Analyses**

Evidence has slowly accumulated regarding the efficacy and effectiveness of culturally adapted treatments. In a comprehensive analysis of a decade of the randomized clinical trials (RCT) conducted with NIH funds, less than 50% of the studies reported any data specific to client culture, and all groups except White/European Americans and African Americans were underrepresented (Mak, Law, Alvidrez & Pérez-Stable, 2007). Previous reviews have indicated that psychotherapy with ethnic minority clients is equally effective as that with White/European Americans (Hall, 2001; Miranda, et al., 2005; Sue, 1988; Zane et al., 2004), but these reviews cite a limited number of RCTs.

Two meta-analyses of culturally adapted psychological treatments, one specific to children and youth (Huey & Polo, 2008) and another with clients of all ages (Griner & Smith, 2006), found average effect sizes of moderate magnitude ( $d = .44$  and  $d = .45$ , respectively), although the results of both meta-analyses were moderated by several factors. The positive meta-analytic findings have been somewhat surprising, given the lack of direct measurement of cultural adaptation and sparse information available on how cultural adaptations were implemented.

### **Meta-Analytic Review**

#### **Methods**

**Inclusion and exclusion criteria.** We included in our meta-analysis those studies that provided quantitative data regarding clients' experiences in mental health treatments that explicitly accounted for clients' culture, ethnicity, or race. We included treatments for mental

illness, emotional distress/well-being, family problems, and problem behaviors (such as physical aggression but not pregnancy or sexual behavior). Substance abuse treatments or prevention programs were excluded unless they also targeted psychological variables (e.g., depression, self-concept). We excluded studies that accounted for generic contextual/ecological factors (such as poverty or family systems) or other client characteristics (such as gender) unless they explicitly accounted for culture, ethnicity, or race (e.g., Latina women). Selection of ethnic minority clients or assignment of clients to therapists of the same ethnic group or native language (ethnic or language matching) were insufficient criteria for inclusion; some aspect of the content, format, or delivery of the intervention had to be purposefully changed to align with clients' culture, ethnicity, or race. We extracted effect size data from psychological and behavioral outcomes but not educational, substance abuse, or physical health outcomes if reported. We restricted this meta-analytic review to studies using quasi-experimental and experimental designs.

**Search strategies.** We included studies identified in prior meta-analyses and reviews (Griner & Smith, 2006; Hall, 2001; Huey & Polo, 2008; Miranda et al., 2005; Smith, 2010; Zane et al., 2004). We subsequently searched for additional published and unpublished studies that had appeared from January 2004 to July 2009 using several electronic databases: Academic Search Premier, Dissertation Abstracts, Mental Health Abstracts, and PsycINFO. Search terms included a list of root words relevant to psychotherapy (*clinic, counsel, intervention, psychotherapy, service, therapy, and treatment*) that were crossed with combinations of the root terms *culture/cultural, ethnic, multicultural, and race/racial* that were crossed with root terms *adapt, appropriate, consonant, compatible, competent, congruent, focused, informed, relevant, responsive, sensitive, skill, and specific*. Three undergraduate research assistants sequentially reviewed retrieved titles then abstracts and full texts of apparently relevant reports. One of these

assistants manually examined the reference sections of past reviews and of studies meeting the inclusion criteria to locate articles not identified in the database searches. Finally, we sent personal email requests to several colleagues and posted general solicitations on several professional listservs: APA Division 12 Section VI: Clinical Psychology of Ethnic Minorities; APA Division 45; Association of Black Psychologists; National Latino/a Psychological Association; and the Society of Indian Psychologists.

**Coding procedures.** Coders were six undergraduate and four graduate students with prior experience and training in meta-analytic coding. To increase the accuracy of coding and data entry, two team members coded each article. Subsequently, two different team members coded the same article. Coders extracted several objectively verifiable characteristics of the studies, including participants' age, gender, and race; the outcome evaluated; and components of the research design and intervention. Discrepancies across coding pairs were resolved through further scrutiny of the manuscript to the point of consensus.

**Statistical methods.** Data within studies were transformed to the metric of Cohen's *d*. Across all studies we assigned positive *d* values to indicate beneficial results and negative *d* values to comparatively worse results for the culturally adapted intervention.

When multiple effect sizes were reported within a study (e.g., across different measures of outcome), we averaged the several values (weighted by *N*) to avoid violating the assumption of independent samples. Aggregate effect sizes were calculated using random effects models following confirmation of heterogeneity.

## **Results**

Statistically non-redundant effect sizes were extracted from 65 studies that evaluated culturally adapted interventions using quasi-experimental or experimental designs. These studies

and their ESs are reported in detail elsewhere (Smith, Domenech Rodríguez, & Bernal, 2011). Data included 8,620 participants, with an average age of 24.4 years (range = 5 to 73; SD = 16); 55% of the participants within studies were female. Of the total, 39% were Asian American, 32% were Hispanic/Latino(a), 20% were African American, 4% were Native American, 1% were White/European American, and 4% indicated “other” affiliations including ethnic groups outside North America.

Across all 65 studies, the weighted average effect size was  $d = .46$  (95% CI = .36 - .56). By conventional benchmarks, a  $d$  of .46 represents a medium effect size, indicating that patients receiving culturally adapted treatments typically experienced superior outcomes than patients in control groups. Effect sizes ranged from -.97 to 2.80, with substantial heterogeneity across studies ( $I^2 = 74\%$ ;  $Q_{(64)} = 247$ ,  $p < 0.001$ ). No extreme outliers were observed.

We calculated Orwin’s fail-safe N, the number of hypothetically “missing” studies with null results needed to render negligible the present results. The resultant value was 103, which left open the possibility of publication bias. Egger’s regression test reached statistical significance ( $p < .001$ ), and our examination of the funnel plot of the effect sizes by their standard error indicated approximately 15 “missing” studies on the left side of the distribution, where statistically non-significant results would be located in the expected funnel-shaped distribution. When we re-estimated the average weighted effect size using “trim and fill” methodology (Duval & Tweedie, 2000), the recalculated value was  $d = .27$  (95% CI = .16 to .38).

### **Moderators**

Given the substantial heterogeneity in the omnibus effect size estimate, we evaluated what factors may have accounted for the variation. Analyses of effect size moderation were

conducted using random effects weighted correlations for continuous level variables and random effects weighted analyses of variance for categorical variables.

We first evaluated the association between effect sizes and the following characteristics of study participants: gender composition (percentage of females), average age, mental health status (normal community members, at-risk group members, clients in clinical settings), and racial composition. Participants' average age was strongly associated ( $r = .39, p < .001$ ) with the magnitude of effect sizes within studies. Investigation of the associated scatterplot revealed that studies with adult participants over age 35 tended to have effect sizes of larger magnitude than studies with children, adolescents, and young adults.

Differences were observed between studies using participants of different races ( $Q_{(3, 48)} = 12.8, p = .005$ ). Specifically, 7 studies with Asian American participants ( $d = 1.18, 95\% \text{ CI} = .79$  to  $1.60$ ) had an average effect size of more than twice that of 14 studies of African American participants ( $d = .47$ ), 26 studies of Hispanic/Latino(a) participants ( $d = .47$ ), and 5 studies of Native American participants ( $d = .22$ ). Differences were also found between studies using culturally homogeneous samples (i.e., all participants were of the same culture) and culturally heterogeneous samples ( $Q_{(1, 63)} = 5.2, p = .02$ ). Mental health treatments delivered to a specific cultural group were much more effective ( $d = .51, 95\% \text{ CI} = 0.40$  to  $0.63$ ) than interventions delivered to mixed groups ( $d = .18, 95\% \text{ CI} = -.08$  to  $.44$ ).

We next evaluated the association between effect sizes and several characteristics of study design: random assignment, control group condition, type of outcome evaluated, and the time of outcome assessment administration (number of sessions completed at post-test). None of these variables were found to be associated with effect size magnitude ( $p > .10$ ). However, there was a statistically significant difference observed across the source of the outcome

evaluation ( $Q_{(2, 108)} = 6.7, p = .04$ ); outcome evaluations provided by therapists tended to be associated with effect sizes of much lower magnitude ( $d = .09$ ) than those provided by the clients ( $d = .45$ ) or external observers ( $d = .45$ ).

We next evaluated whether authors included descriptions of treatment components that aligned with the eight points of Bernal's model (Bernal, Bonilla, & Bellido, 1995; Bernal & Sáez, 2006). Each of the eight components was assigned a binary value (yes = 1, no = 0), which we summed to obtain a total number of culturally adapted components described within each study. This total value was positively associated with effect sizes ( $r = .28, p = .007$ ), indicating that studies describing more cultural adaptations tended to be more effective than studies describing fewer cultural adaptations. To ascertain which types of cultural adaptations were most associated with effect size magnitude, we simultaneously entered into a random effects weighted multiple regression the eight binary variables of language matching, ethnic matching, metaphors, content, conceptualization, goals, methods, and context (described previously). The resulting model explained 20% of the variance in effect sizes ( $p = .03$ ); the two variables that reached statistical significance were descriptions of therapeutic goals that explicitly matched clients' goals ( $b = .29, p = .02$ ) and descriptions of using metaphors/symbols in therapy that matched client cultural worldviews ( $b = .37, p = .02$ ).

### **Limitations of the Research**

Psychotherapy outcome research has accumulated over several decades, with now thousands of research reports and hundreds of meta-analyses. By comparison, the research investigating culturally adapted treatments is miniscule. The amount and pace of clinical outcome research specific to clients' cultural backgrounds have remained consistently low. The studies included in this review appeared at a steady rate of about two per year since 1981.

Because the long-term success of any initiative depends on the consistent replication of supportive findings, the single greatest need of the research on culturally adapted interventions is for more evidence to accumulate.

Across the history of psychotherapy, there have been multiple cycles wherein a new treatment attains popularity following initial research support but then enthusiasm and implementation decline when subsequent research fails to replicate the initial positive results. Researcher allegiance effects, in particular, have been identified as a confound in comparisons of specific therapies. Even though our analyses indicated that ratings of client outcomes provided by therapists were of lower magnitude than those provided by clients or external observers, researcher allegiance to culturally adapted interventions may nevertheless be associated with outcomes of the studies included in our review.

A third limitation of the research concerns the heterogeneity of the adapted treatments. Studies included in this review used a variety of means to align mental health interventions with clients' cultures, with an average of four of the eight components (Bernal & Sáez, 2006) being explicitly described by authors within studies. Specifically, 74% described providing therapy in the clients' preferred language, 53% matched clients with therapists of similar ethnic/racial backgrounds, 42% utilized metaphors/objects from client cultures, 77% included explicit mention of cultural content/values, 37% adhered to the client's conceptualization of the presenting problem, 14% solicited outcome goals from the client, 43% modified the methods of delivering therapy based on cultural considerations, and 55% addressed clients' contextual issues. In our analyses these variables explained 20% of effect size variation, and the more of these adaptations described within studies, the more effective was the associated treatment.



Another limitation of the research base was the lack of systematic measurement of cultural adaptation within studies. All interventions in this review were developed by Western-trained professionals, with mention of consultation with indigenous healers or cultural experts in 30 of 51 studies (59%). Many authors adapted traditional (Western) mental health interventions, but evaluation of the fidelity to the causal mechanisms assumed by the traditional intervention was rare. In short, existing clinical outcome research of cultural adaptations has inconsistently achieved high levels of methodological rigor.

### **Summary and Therapeutic Practices**

Mental health treatments typically yield patient outcomes of similar magnitude, irrespective of differences in content (Lambert, 1999). Bona fide comparisons of client outcomes across different therapies usually average between a  $d$  of .0 and .15, with an upper limit of  $d < 0.20$  (Wampold et al., 1997). By comparison, the omnibus effect size obtained in this meta-analysis ( $d = .47$ ) exceeds those expected values. Even if we interpret only the omnibus effect size adjusted for possible publication bias ( $d = .27$ ), these results remain important. Culturally adapted mental health therapies are moderately superior to those that do not explicitly incorporate cultural considerations and should be considered EBPs.

The rationale for culturally adapted psychotherapy remains strong and is more widely accepted than ever. Movement from nominal acceptance of the principles underlying culturally adapted practices to their widespread application and subsequent evaluation is supported by available empirical evidence.

Based on the research, we advance the following research-supported practices:

◆ Clients will tend to benefit when psychotherapists make attempts to align treatment with clients' cultural backgrounds. This was particularly the case for Asian American clients and

adult clients, who tended to benefit most from culturally adapted treatments relative to clients of other groups and younger ages.

◆ Because both age and Asian American culture are likely associated with acculturation status (integration with mainstream Western society vs. maintaining ancestral cultural worldviews), therapists should attend to how client age and acculturation interact with their treatments.

◆ Whenever feasible, conduct psychotherapy in the client's preferred language.

◆ Culturally adapted treatments should address multiple components (Bernal et al., 1995). The greater number of these components incorporated into the cultural adaptations, the more effective the treatment. Rather than exert treatment-specific effects, it is possible that culturally adapted interventions influence common factors, such as the therapeutic alliance and client preferences (see Swift, Callahan, & Vollmer, this issue). Thus, the specific procedures taken to align therapy with client culture may matter less than the fact that therapists attempt to make the alignment (Smith, 2010).

◆ Culturally adapted treatments were much more beneficial when they were specific to clients of a given race than when they were provided to a conglomerate of clients from many racial groups. That is, the more specific to clients' cultural backgrounds, the more effective is the therapy. The more culturally focused and specific the treatment, the more effective it will probably prove.

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