CHAPTER

2

What Do We Mean by Culturally Adapting Psychotherapy?

The movement is contagious, and the people in it are the ones who pass on the spirit.—***Yuri Kochiyama (1921–2014)***

In this chapter, I define and highlight the importance of cultural competency, differentiate the more generic notion of cultural competency from the more specific skill set of culturally adapting therapy, and identify some of the extant models and frameworks for culturally adapting treatments. I also review the treatment outcome literature on culturally adapted therapies, discuss methodological biases and limitations associated with conducting this type of work, and provide recommendations for the future.

INSTITUTIONAL SUPPORT FOR CULTURAL COMPETENCY

Numerous agencies, including the American Psychological Association (APA), the Surgeon General's Office, and the Institute of Medicine have put out forth calls and guidelines on culturally competent practice—thus highlighting the importance of effectively treating those from diverse backgrounds (American Psychological Association, 2003; Institute of Medicine, 1999; President's New Freedom Commission on Mental Health, 2003; United States Department of Health and Human Services, 2001a, 2001b). For example, in 1986 the APA Committee on Accreditation included cultural diversity as a component of effective training, a factor also included in the more recent guidelines (American Psychological Association, 1986). These efforts recognize the importance of cultural and individual differences and diversity in the training of clinical, counseling, and school psychologists.

The most effective educational environments for the development of multicultural competence integrate diversity into all components of training and service. As a result, the training councils of many disciplines now incorporate and document the ways they have included diversity in educational goals, faculty, and student body. The publication of the Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists by the American Psychological Association (2003) also mandates the development of practitioner competence in working with many facets of diversity, including culture, race, ethnicity, religion, gender, sexual orientation, and socioeconomic class.

In addition, the American Psychological Association's Ethical Principles and Code of Conduct (2010) also highlighted the necessity for culturally competent psychologists to be sensitive to diversity factors. There are five principles to which psychologists aspire to: beneficence and nonmaleficence, fidelity and responsibility, integrity, justice, and respect for people's rights and dignity. The latter includes a culturally grounded understanding of age, gender, sexual orientation, race, ethnicity, national origin, language, religion, socioeconomic status, and disability, as well as the multiple identities that stem from the potential intersection of these factors.

In regards to psychological testing and assessments, standards have also been set forth that require psychologists to account for cultural, linguistic, situational, and personal differences that may affect test scores and interpretations (American Psychological Association, 2010a, 2010b). Practitioners and researchers are encouraged to use diagnostic and other research instruments that have been found to be reliable, valid, and culturally

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equivalent across diverse populations. In their assessments, interpretation, and subsequent treatment of clients, psychologists should consider multiple aspects of diversity mentioned above, including socioeconomic status, literacy, ableism, ageism, sexual orientation, and ethnicity.

The guidelines are based on the premise that the US population is extremely diverse, and that students, research participants, clients, and workforce staff are increasingly more likely to come across people from many different cultural backgrounds. Although these guidelines often help practitioners understand the importance of cultural competency, they are aspirational in nature, often too general and do not provide advice that is concrete enough to help therapists become more culturally effective. Specifically, many professionals who want and need cultural competence are not provided with skills that they can implement into actual practice. In order to provide quality psychological services to diverse populations, mental health providers must be able to understand and account for multiple world views and perspectives. This is not an easy task and requires awareness, experience, continuing education, and training. Although diversity is a significant content area for psychologists to develop and understand, it is also important to consider the institutional context in which this training occurs. The organizational climate and context of the training program may influence the training experience and the development of multicultural competence.

The importance of cultural competence is also supported by the National Institute of Health, where the funding of a variety of research projects on diversity issues has increased (United States National Institutes of Health, 2011). Furthermore, tracking of the proportion of ethnic minorities participating in studies is now mandated (United States National Institutes of Health, 2011). A National Center for Cultural Competence has also been established, which provides recommendations for policies, works to increase the effectiveness and cultural competency of current health projects, and provides information for families, professionals, and organizations who want to be more culturally aware and competent (Cohen & Goode, 1999).

Although a great number of programs have begun incorporating diversity training requirements, many undergraduate and graduate training programs still do not require diversity courses. Despite being a good first step, taking diversity courses is only the beginning of one's journey to becoming more culturally competent. This strategy alone does not provide the requisite knowledge and skills necessary to be effective in treating diverse populations in real life. Cultural issues need to be integrated into all aspects of psychology training programs in order to adequately prepare young professionals to work with our rapidly diversifying population. Improved acceptance, understanding, and competence when working with diverse groups is an important endeavor as we continue building a world that accommodates and respects cultural differences. Scientists, managers, policymakers, and the public would benefit from supporting and researching the diverse populations, identities, and viewpoints of all of our people. With increasing globalization and internationalization, culturally informed and competent mental healthcare providers and researchers can help raise awareness and promote a healthy and diverse society.

CULTURAL COMPETENCY DEFINED

Cultural competency, or the ability to work effectively with people of different backgrounds, is a critical component of effective health and mental care (Hwang, 2006). However, in order to become culturally competent, we need to understand what it is, broadly and deeply. We also need to understand the difference between race, ethnicity, and culture. Barnouw (1963) defined culture broadly as a set of attitudes, values, beliefs, and behaviors shared by a group of people. Culture is transmitted from one generation to the next through the retention of language and cultural values. Rohner (1984) notes that culture, which consists of a highly variable system of meanings, is learned and can be shared. Moreover, culture consists of belief systems and value orientations that influence customs, norms, practices, languages, caretaking practices, organizations, media, education, and social institutions (Fiske, Kitayama, Markus, & Nisbett, 1998). Triandis (1980, 1994) highlights that culture consists of both objective and subjective elements that have helped increase the probability of survival for those who share a common language and geographic location—there is a physical culture (eg, food, clothing, buildings, and artwork) as well as subjective elements of culture (eg, attitudes, values, beliefs, and social norms for communication styles, parenting strategies, and emotional expression). According to Matsumoto and Hwang (2013), culture is an information system shared by a group that provides tools for the group to meet basic needs of survival, and for the group to find happiness and meaning in life. As can be seen by these multiple definitions, culture is highly complex and consists of many different components.

The notion of the need for cultural competence arose from the civil rights movement of the 1960s and 1970s, but did not really begin to gain momentum until the 1990s (Saha, Beach, & Cooper, 2008). There are a number of overlapping and distinct cultural literatures that have characterized cultural competence in a number of ways, utilizing terms such as cultural sensitivity, cultural awareness, cultural acceptance, and becoming culturally informed. Hwang and Wood (2007) note that being culturally sensitive and aware is a necessary component but different from cultural competency. Specifically, cultural competency goes beyond sensitivity and includes clinical flexibility and skills that improve rapport and increase effectiveness when working with people from diverse backgrounds. Cultural competency is a very broad term that is hard to define and even more difficult to teach. In the field of psychology, the most widely accepted definition of cultural competency refers to the development of awareness (eg, cultural self-awareness), knowledge (eg, of other groups), and skills that facilitates delivery of effective services to ethnically and culturally diverse clientele (Sue, Arredondo, & McDavis, 1992; Sue et al., 1982).

The first component of this cultural competency triarchy is cultural self-awareness, which requires a significant amount of personal growth, self-reflection, and ethnic identity development. Because of cultural differences and/or experiences with prejudice and discrimination, many people of color grow up being forced to think about their race and ethnicity; whereas, many White Americans do not. For example, when I teach diversity classes, many of my White students report having had the privilege of never having to think about issues of culture and race while growing up. Developing cultural self-awareness includes understanding issues of privilege that many White Americans have not had to think as much about because growing up White and being American has often been confused with being synonymous to being American or even a culture-universal human experience.

For many students of color, experiences with overt racism, covert prejudice, racial microaggressions, and lack of White privilege often remind them that they are different (McIntosh, 1998; Rothenberg, 2005; Wise, 2011). For some, this includes alienation and the idea that non-Whites are not Americans because of their skin color. Many ethnic minorities are also culturally different from mainstream American culture and are often reminded of their cultural differences by the media. Cultural self-awareness requires much more internal work, and reflection about one's own prejudices and biases. For White Americans, this also requires them to be cognizant and reduce the concept of White emotional fragility (eg, being less sensitive and reactive when talking about issues of race). A central focus of a cultural competency training program should be on intra- and interpersonal growth and development. This necessitates becoming aware of the different lenses that we grow up with and understanding how our upbringing influences our perceptions and interpretations of the world.

The second component of the triarchy is cultural knowledge, which refers to the learning and understanding of other groups. This is perhaps the easiest to accomplish because there are many books, ethnic studies classes, culture and mental health courses, and continuing education workshops available that focus on specific ethnocultural groups. In addition, a number of books have been written to provide greater instruction on addressing clinical issues relevant to specific populations, including women of diverse identities (Comas-Diaz & Greene, 1994), minority families and children of color (McGoldrick, Giordano, & Pearce, 1996; Webb, 2001), those with diverse sexual orientations (Perez, DeBord, & Bieschke, 2000), the elderly (Duffy, 1999), and the poor (Acosta, Yamamoto, & Evans, 1982). Although the study of other groups is critical, a sole focus on this dimension oversimplifies the complexity of what it means to be culturally competent. In fact, some have even criticized this nonparticipatory and historical emphasis of studying other groups as being too observational, likening it to watching animals at the zoo or only caring about ethnic food and music. In order to become fully culturally competent, a person needs to have both the requisite knowledge of other groups, and also a good understanding of one's own prejudice and bias. It is important that as mental health professionals, we do not make the common but problematic assumption that cultural competency is merely learning about people from different cultural backgrounds—which reinforces ethnocentrism and the assumption that the White population should be the standard group for which all other group should be compared.

Although the first two components of cultural competency are challenging to learn in their own right, the most elusive of the three components of cultural competency is the third component (ie, developing the practical skills needed to work effectively with people of diverse backgrounds). This is the most difficult component of this cultural competency triarchy because actual skills development and implementation (although more vague and ambiguous) is what will make the biggest difference in the therapy room. Many practitioners who want and need cultural competency struggle with knowing what to do and how to do it, even after they have evaluated their own biases and obtained knowledge of other groups.

In fact, one of the biggest complaints of practitioners is that the recommendations given by cultural competency training are too general, focus too much on demographic descriptors, and provides only stereotypical information. They are left wondering what to do in therapy, and yearn for concrete advice that they can integrate into

clinical practice. This problem is compounded by the complexity of cultural issues, which oftentimes cannot be simplified and narrowed down into a simple right or wrong answer. In fact, sometimes cultural issues are ambiguous and difficult to detect, often deeply intertwined with clinical and personality issues. As a result, most mental health professionals who want and need cultural competence may feel like they get little additional insight on how to make concrete clinical modifications. Developing concrete skills is one of the differences between cultural competency and the ability to culturally adapt psychotherapy—the latter of which has a more pragmatic focus. Increasing the number of training programs that emphasize how to culturally adapt and modify treatments may be a more practical solution for those who want and need more concrete advice and practical clinical recommendations, which is a central focus of this book.

In addition to Sue's (Sue et al., 1982, 1992) original triarchy, several others have expanded what we know about cultural competency and how we define it. For example, Lo and Fung (2003) add that it is also important to distinguish between generic and specific cultural competencies, or the knowledge and skill set needed in any cross-cultural encounter versus that which is necessary to work with a specific ethnocultural group. The importance of an interactional perspective between the client and the provider has also been stressed (Hardy & Laszloffy,1995; Hwang, 2006). Specifically cultural competency requires the therapist to understand his/her cultural self in relation to others, as well as a substantive understanding of the client. Hardy and Laszloffy (1995) developed a cultural genogram to help clinicians become more aware of their cultural identities. This genogram consists of (1) understanding the influence that culture can have on the family system, (2) helping therapists identify the groups which contribute to the formation of their cultural identity, (3) identifying and challenging culturally based assumptions and stereotypes, (4) helping therapists uncover their culturally based triggers or conflicts, and (5) encouraging therapists to explore how their cultural identities influence their therapeutic style and effectiveness.

Also emphasizing an interactional perspective, Sue, Ivey, and Pedersen (1996) proposed a theory of Multicultural Counseling and Therapy (MCT) composed of six propositions each with multiple corollaries. Abbreviated here, the propositions include (1) MCT is a metatheory of psychotherapy that takes culture into account, (2) both client and therapist identities are formed and embedded within a cultural context and multiple levels of experience, (3) therapist and client identities influence attitudes and self−other relations, (4) therapy outcomes are likely to improve if the therapist uses modalities and defines goals which are consistent with the cultural values and life experiences of the client, (5) helping roles should be defined broadly and multiple resources should be utilized, and (6) a liberation of consciousness and an improved understanding of self−other relations should be a basic goal. These corollaries were developed to help provide a framework for the multicultural counseling movement, which has been labeled the fourth force among therapy movements (Pedersen, 1990).

Cultural competency training programs that focus on interactional issues have also been developed. For example, Pedersen (1988, 1997) developed a program that focuses on awareness and understanding of the culture-centered context and developing and implementing culture-centered skills. Key to understanding interactional perspectives is the ability to identify and address hidden messages in therapy dialogue. Pedersen (2000) proposed a Triad Training Model composed of understanding the verbal exchange between the two parties, including the therapist and the client's internal dialogue. He emphasized that culturally competent therapists strive to hear the positive and negative messages that their clients are thinking, but not necessarily saying.

Although a number of training programs and initiatives have been established to improve cultural competency, there continues to be little empirical research on cultural competency and actual therapy outcomes. Part of the problem is a measurement issue. Specifically, how do we objectively assess cultural competency when the extant measures are based on subjective self-reports—which are inherently biased and influenced by social desirability or the need to appear competent and accepting of others. What little we do know focuses on cultural competency training programs that help increase a therapist's self-reported confidence and awareness of others (Sue, Zane, Hall, & Berger, 2009). One way to assess cultural competency is to use objective measurements, such as recording therapy sessions and having independent raters code cultural competence. This would be very time-consuming and require a sophisticated coding and measurement system, but is nevertheless sorely needed.

HOW IS CULTURALLY ADAPTING THERAPY DIFFERENT FROM CULTURAL COMPETENCY?

Following the cultural competency movement, more recent endeavors to meet the needs of ethnic minorities in the United States have focused on culturally adapting health and mental health services. It is important to note

that cultural competence and cultural adaptations of therapy are related, but distinct, concepts. In regards to mental health services, culturally adapted treatments have been referred to as culturally adapted psychotherapy. The importance of culturally modifying and adapting psychotherapy to meet the needs of ethnic minorities is an important new "hot topic." Because of access, utilization, and mental health outcome disparities among ethnic minorities (Institute of Medicine, 1999; United States Department of Health and Human Services, 2001a, 2001b), the term has traditionally referred to the adaptation of services for underserved ethnic populations in the United States. However, the term has also been applied to adapting services for other forms of diversity (eg, gender, age, sexual orientation, and specific clinical issues). Because the cultural competency movement left many people who want and need to be more culturally competent feeling like the ideas and principles were too vague and ambiguous, culturally adapted treatments have traditionally focused on modifying evidence-based treatments (EBTs) and practices.

A number of culturally adapted treatment definitions have arisen over the years. Bernal, Jiménez-Chafey, and Domenech Rodríguez (2009, p. 362) defined cultural adaptation as "the systematic modification of an 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." Here, the emphasis is on a strategic and comprehensive approach to modifying EBTs in particular, which is where the culturally adapted psychotherapy movement originally came from. The purpose of cultural adaptations, according to Bernal et al. (2009, p. 362), is to "[increase] the congruence between the client's ethnocultural worldview and EBTs" by changing aspects of the psychotherapy. Specifically, they stress the desire and need to modify EBTs and to compare its efficacy and effectiveness with "nonadapted services." This emphasis on the comparative efficacy of EBTs was stressed by funding agencies to anchor the cultural adaptation movement into something that is evidence-based, fundable, and testable such that modified treatments can also be effectively disseminated.

Hwang (2006, 2012) provided a broader definition of cultural adaptation. Specifically, the modification and tailoring of services for people of different backgrounds, or the need to adapt treatments so that they are congruent with the client's background and belief system in order to better meet the needs of diverse clients, increase consumer satisfaction, and improve treatment outcomes. Hwang (2006) also highlighted the need to develop models and frameworks for adaptation so that more concrete illustrations and examples could be offered. Because great diversity exists internationally as well as within the United States, finding a way to culturally adapt psychotherapy to improve treatment engagement and outcomes is of critical importance (Hwang, 2006). Improving the effectiveness of mental health treatments for people of non-European backgrounds is especially important given that three-fourths of the world is collectivistic and possesses belief systems that are distinctly different to the Western world.

Although different terms have been developed to describe the adaptation of services, the most commonly used term is culturally adapting psychotherapy—the basic idea being that we need to modify services to make them more efficacious and effective for diverse clientele. The term "cultural attunements," which focuses on synchronizing treatment to better match ethnic cultures and the social contexts in which clients live, has also been used (Falicov, 2009). The Office of Minority Health refers to culturally appropriate services as "health care services that are respectful of and responsive to cultural and linguistic needs" (United States Department of Health and Human Services, 2001a, 2001b). The Center for Addiction and Mental Health in Canada describe adaptation as "the process of adjusting health messages to the intended audience by incorporating their cultural heritage, language, and ethnicity… [by] finding cultural equivalents so that information is accurate but is also relevant and understandable to a different cultural audience" (Center for Addiction and Mental Health, 2007).

One important point of note is that cultural adaptations can be simplistic, or more complex and deeply ingrained into the treatment. Resnicow, Braithwaite, Ahluwalia, and Baranowski (1999) discussed two types of cultural sensitivity that can help improve treatment for ethnic minorities. Surface structure adaptations include providing ethnically matched therapists, conducting therapy in a client's native language, designing clinics to be culturally aesthetic, and locating clinics in neighborhoods that are easily accessible. In contrast, deep structure involves incorporating the ideas, beliefs, and values into the treatment. This type of adaptation is much harder to understand and implement, but has the potential to increase cultural congruence between psychotherapy and the client's background, consequently improving treatment acceptability and outcomes. Although there has been a lot of research conducted on surface structure adaptations (eg, ethnic and language match studies), research on deep structure adaptations has been quite limited. In addition, it is important to keep in mind that we can also make structural adaptations to treatments, such as modifying the length of a therapy session. For example, why does a therapy session need to be 45–50 min? In modifying treatments for populations that are less familiar with therapy or more collectivistic, would they benefit from longer sessions where they have more time to become comfortable, adjust, and develop a stronger interpersonal relationship with their therapist?

A REFORMULATED CULTURALLY ADAPTED TREATMENT DEFINITION

In this book, I offer a more comprehensive and expanded definition of culturally adapted treatments that builds upon my previous work as well as the work of others. This broader definition allows for and is inclusive of both health and mental health services. Specifically, culturally adapted treatments are those that focus on modifying and tailoring services for people of different backgrounds. The primary goals of cultural adaptation are to individualize treatments so that they are more culturally acceptable, congruent, and syntonic with the client's cultural values and belief systems. Culturally adapted treatments focus not only on improving therapeutic outcomes, but also on increasing client engagement, knowledge and buy-in of treatment processes and methods, consumer satisfaction, reducing premature dropout, and improving therapeutic relationships. Because cultural adaptations focus on modifying extant treatments, it is important to make an effort and to be wary of the potential disadvantages in removing already established therapeutic factors, mechanisms, and active ingredients that have been identified as being empirically efficacious. This does not mean that extant therapeutic mechanisms or specific active ingredients cannot be differentially packaged, emphasized, or rebalanced to include additional therapeutic ingredients that were not part of the original treatment. Nevertheless, research studies should focus on identifying which adaptations are therapeutically helpful and empirically validating their benefits.

Cultural adaptations can be made to both health and mental health services. They can occur at an individual therapist or treatment provider level, or be systematically integrated into EBTs and practices. Efforts should be made to select treatments that are evidence-based and empirically supported because a primary goal of cultural adaptations is to improve outcomes, client engagement, and to reduce premature treatment dropout. In addition, cultural adaptations can also be made to not only both manualized and nonmanualized treatments. Cultural adaptations can be systematic and comprehensive, or they can be targeted and focused on specific issues and factors. Cultural adaptations can be simplistic, superficial, or focused on surface structure issues such as clinic location, appearance, accessibility, and ethnic or linguistic match. However, comprehensive or deep structural adaptations that focus on bridging therapeutic aspects of treatment with the client's cultural background, values, ideas, and beliefs should be the higher aspiration.

In addition, it is important to note that cultural adaptations are not ethnic or racial adaptations. Specifically, culture is constantly changing, malleable, and is in flux; whereas, race and ethnicity are constant and fixed. Cultural adaptations need to address and be open to the changing nature of culture (eg, immigration and acculturative changes between the culture of origin and the host culture, or even addressing modernization and globalization changes that influence treatments within a country). Because of the history of oppression, modern racism, and socioeconomic differences with the White population, when adapting treatments for ethnic minorities, cultural adaptations often also need to take into account issues of poverty, education, and health disparities.

Because of the emphasis on studying the comparative effectiveness of culturally adapted versus nonadapted treatments associated with the development or the culturally adapted therapy movement, I would like to propose the establishment of a more consistent vocabulary and establishment of acronyms. For example, when comparing nonadapted cognitive-behavioral therapy (CBT) with culturally adapted CBT, I would recommend using the following label and acronym CBT versus CA-CBT. Another illustrative example using the terminology would be interpersonal psychotherapy (IPT) versus culturally adapted interpersonal psychotherapy (CA-IPT). Using a more consistent terminology is beneficial because the advent of too many different words to describe similar processes may lead to confusion and ambiguity.

FRAMEWORKS FOR CULTURALLY ADAPTING THERAPY

In order to culturally adapt treatments, guidelines and frameworks need to be developed (Hwang, 2006). Even in ethnic-specific centers, where clinicians are more likely to be bilingual and have had some training on cultural sensitivity and awareness, training mechanisms may not have systematically provided specific skills or frameworks for incorporating cultural issues into treatment. Despite the advances that have been made, there is still no uniform methodology or framework for adapting treatment interventions for ethnic minority groups, or for implementing such modifications into widespread practice (Hwang, 2006). Currently, few such frameworks exist and much of the historical emphasis on culturally adapting therapy was focused on the more generic notion of cultural competency.

Most of the work on this area was developed simultaneously and by different scientist-practitioners who studied different populations. However, less of this work has focused on systematically modifying an EBT. A number of

scholars have provided recommendations for increasing cultural effectiveness when working with diverse populations. For example, Rogler, Malgady, Costantino, and Blumenthal (1987) recommend that consumer-oriented practical approaches be taken, such as increasing accessibility to bilingual/bicultural staff, selecting therapy orientations that are congruent with the client's cultural background, and modifying treatments to fit the needs of the client. Sue and Sue (1990) suggested targeting three major domains to improve client–therapist relationships when treating ethnic minorities, including culture-bound communication styles, sociopolitical facets of nonverbal communication, and counseling as a communication style. These recommendations highlight understanding and improving subtleties in communication that may interfere with the therapeutic process. Leong's cultural accommodation model (Leong & Lee, 2006) provides a three-step framework for thinking about these issues. The first step is to identify "cultural gaps" that prevent existing treatments from being fully effective in different cultures. The second step is researching the culture in question in order to fix those gaps. The third and final step is to compare the adapted treatment to the original one in order to check whether it is indeed more effective for the clients.

A number of approaches to adapting evidence-based psychotherapies have also been proposed. For example, Lau (2006) recommended an evidence-based approach that (1) prioritizes selectively targeting problems and identifying communities that would most benefit and (2) using direct data outcomes to justify adaptations. In a response to Lau, Barrera and Castro's (2006) commentary recommended a sequence involving (1) information gathering, (2) preliminary adaptation design, (3) preliminary test of the adapted treatment, and (4) adaptation refinement. Domenech Rodríguez and Wieling (2005) proposed a Cultural Adaptation Process Model, consisting of three phases: (1) focusing on the iterative process among all those involved in the adaptation process, (2) selection and adaptation of evaluation measures and continual exchange between the community and those creating the adaptations, and (3) integrating the observations and data gathered in phase two to create a new intervention. These models argue that community-based approaches will increase the ecological validity of adaptations by increasing community participation.

Few comprehensive frameworks have been proposed for conducting deep structure adaptations. Two frameworks in particular have been widely utilized to create and test culturally adapted treatments by clinical researchers. The first comprehensive framework was developed by Bernal, Bonilla, and Bellido (1995), and was a framework for developing culturally sensitive interventions for Latinos. They suggest considering eight different dimensions, including language, persons, metaphors, content, concepts, goals, methods, and context when adapting therapy for culturally diverse clientele. For example, the dimension of "persons" involves addressing ethnic/racial similarities and differences between the client and the clinician. Issues of "content" involve cultural knowledge and information about the values, traditions, and customs of the culture. The principle of "context" involves consideration of changing contexts that might increase risk to acculturative stress problems, disconnect from social supports and networks, and reduced social mobility. This framework has been used to guide adaptations in cognitive-behavioral and interpersonal treatments for depressed Puerto Rican adolescents and these adapted treatments have been shown to be efficacious in randomized controlled trials (RCTs) (Rossello & Bernal, 1996, 1999).

My own work started off by first identifying principles for cultural adaptation (Hwang, Wood, Lin, & Cheung, 2006), then utilizing a comprehensive theoretical framework to organize domains, principles, and rationales for adaptation (Psychotherapy Adaptation and Modification Framework, PAMF; Hwang, 2006), which then culminated in a community-participatory approach that integrates bottom-up formative processes and top-down knowledge-based and theoretically driven approaches to inform and drive adaptations (Formative Method for Adapting Psychotherapy, FMAP; Hwang, 2006, 2011; Hwang & Wood, 2009; Hwang et al., 2015). These approaches were utilized to create a culturally adapted 12-session manualized cognitive-behavioral treatment (CA-CBT) for depressed Chinese Americans, which was then tested against nonadapted CBT and an RCT funded by the National Institute of Mental Health (NIMH) (Hwang et al., 2015). In addition, these frameworks are meant to be practical and consumer-driven. As such, they are meant to have increased clinical utility for practitioners who want and need cultural competency, and want to make the shift between cultural awareness to cultural effectiveness through conducting applied cultural adaptations. Even though many of my examples focus on providing not only breadth of awareness, but also deep structural understanding through application to a specific ethnoracial group and ethnic group (eg, Asians and Chinese Americans), these frameworks have broad clinical utility and can be readily applied to culturally adapting therapy for other groups. These frameworks are meant to be flexible and allow for additional modifications and tailoring to the specific needs of particular groups. In addition, they can also be used to tailor health services. For example, we are currently working on a project to culturally adapt diabetes interventions for Chinese Americans.

When I first started thinking about cultural adaptations, I developed 18 principles for culturally adapting CBT for Chinese Americans. These principles were applied to a clinical case study so that practitioners could concretely see what is meant by culturally adapting treatment (Hwang et al. 2006). The particular clinical case

involved a 12-year-old, Chinese American boy suffering from medically unexplained retrograde amnesia, drop attacks, social phobia, and apparent loss of consciousness for several minutes followed by confusion and agitation lasting an hour. Eighteen therapeutic principles for culturally adapting therapy were explained and then applied to this particular case. See Hwang et al. (2006) for a more extensive discussion of the clinical case. These 18 principles include:

Principle 1: Initially educating clients about psychotherapy may increase their understanding, familiarity, and satisfaction with therapy, decrease the likelihood of premature treatment dropout, and improve treatment outcome.
Principle 2: Treatment outcomes for clients will improve if a therapist makes an effort to learn more about their client's cultural background.
Principle 3: Establishing goals for treatment and identifying markers of improvement early on in therapy is likely to reduce confusion about treatment, improve the client–therapist relationship, and facilitate treatment outcome.
Principle 4: Focusing on the psychoeducational aspects of mental health treatment and reinforcing client efforts to learn may help empower Chinese American clients and reduce stigma and misconceptions about mental illness.
Principle 5: Another way to adapt CBT to better meet the needs of Chinese American clientele is to engage in "cultural bridging" of CBT concepts to Chinese cultural beliefs and traditions.
Principle 6: Therapists can gain credibility by presenting themselves as expert authority figures who can help the client resolve problems.
Principle 7: Carefully defining and addressing client–therapist roles and expectations for therapy will increase client understanding and satisfaction with treatment.
Principle 8: Understanding cultural differences in communication and expression toward authority figures will help reduce misinterpretations of client's intents and behaviors.
Principle 9: Spend more time joining and engaging the client by finding out more about them, their migration histories, and their family backgrounds.
Principle 10: Chinese culture is family-oriented, and when warranted, families may be asked to collaborate in the treatment process.
Principle 11: When working with Chinese clients, be aware of the shame and stigma associated with having a mental illness.
Principle 12: Chinese clients may not feel as comfortable talking about their feelings with their therapist.
Principle 13: Be sensitive and aware of push–pull feelings and culture-related role inconsistencies that may exist between the client's culture of origin and the culture of therapy.
Principle 14: Finding ways to integrate extant cultural strengths and healing practices into the client's treatment plan is one way to modify CBT to be more culturally sensitive and effective.
Principle 15: Awareness of ethnic differences in expression of distress can improve diagnostic accuracy and treatment planning.
Principle 16: Chinese clients also experience emotional and cognitive symptoms of depression (not just somatization).
Principle 17: It may be helpful to teach clients the relationships between biomedical and psychosocial models of disease development to facilitate their understanding of and identification with the treatment.
Principle 18: It may be helpful for therapists to align with traditional forms of healing, target physical symptoms, and reformulate behavioral treatments to help engage clients in healthy behaviors and exercise.

Subsequently, and while trying to figure out how to organize and present cultural adaptations in a manner that would be most clinically useful for scientists and practitioners, I reorganized and expanded upon these adaptations by creating the Psychotherapy Adaptation and Modification Framework (PAMF; Hwang, 2006). This reorganization added breadth and depth to thinking about cultural adaptations, and also provided clinical reasons for why and how such modifications can be beneficial. The PAMF is a three-tiered approach to cultural adaptations. It provides a more accessible, user-friendly, and flexible approach that can be easily modified for use with multiple populations. The three tiers consist of domains, principles, and rationales. Broader domains identify general areas that practitioners should think about when modifying their approach for treating their clients. More specific therapeutic principles provide detailed instruction on the types of adaptations that may be important to make for a particular group. Corresponding rationales help the practitioner understand why some of these modifications should be made and how they might be beneficial.

The PAMF consists of 6 therapeutic domains, 25 therapeutic principles, and corresponding rationales (Hwang, 2006). The domains include: (1) dynamic issues and cultural complexities, (2) orienting clients to psychotherapy and increasing mental health awareness, (3) understanding cultural beliefs about mental illness, its causes, and what constitutes appropriate treatment, (4) improving the client–therapist relationship, (5) understanding cultural differences in the expression and communication of distress, and (6) addressing cultural issues specific to the population. This framework was utilized to justify how cultural adaptations would be made in the funded NIMH R34 grant application that funded the culturally adapted treatment manual included with this book. The initial conceptualization of the domains, principles, and rationales are presented below.

Domain 1: Dynamic Issues and Cultural Complexities

Principle 1: Be aware of dynamic sizing (eg, knowing when to generalize and when to individualize treatments on the basis of client characteristics). (Rationale: *Helps reduce stereotyping and cook-book approaches to treating diverse clientele; reduces therapeutic rigidity, increases therapist flexibility, and individualizes treatments.*)
Principle 2: Be aware of and address clients' multiple identities and group memberships. (Rationale: *Helps therapist understand that minority status is not a simplistic category (eg, clients have multiple and dynamic identities and group memberships); helps therapists understand the complexities in treating diverse clientele.*)

Domain 2: Orientation

Principle 3: Orient clients to therapy. (Rationale: *Decreases stigma, increases familiarity, increases comfort, and reduces premature dropout.*)
Principle 4: Establish goals and structure for therapy early in treatment. (Rationale: *Is congruent with goal-driven aspects of Asian culture; reduces ambiguity and provides markers of improvement.*)
Principle 5: Orient clients to a biopsychosocial or holistic approach model of disease development. (Rationale: *Facilitates client understanding and is congruent with the holistic and mind–body integration extant in Asian culture.*)

Domain 3: Cultural Beliefs

Principle 6: Focus on psychoeducational aspects of treatment. (Rationale: *Is consistent with educational emphasis in Asian culture, empowers clients and provides them with a sense of mastery; decreases stigma and misconceptions about mental illness.*)
Principle 7: Use cultural bridging to relate CBT concepts to Asian beliefs and traditions. (Rationale: *Facilitates understanding and adherence to treatment; provides cultural context for learning and reduces culture shock to foreign psychological concepts.*)
Principle 8: Find ways to integrate extant cultural strengths and healing practices into the client's treatment. (Rationale: *Capitalizes on aspects of the client's culture that may facilitate the healing process; uses methods of healing that are culturally congruent.*)
Principle 9: Align with traditional/indigenous forms of healing. (Rationale: *Integrates treatment services; improves physical functioning and engagement in healthy behaviors.*)
Principle 10: Understand how cultural beliefs have influenced help-seeking patterns for your client. (Rationale: *Underscores stigma against mental illness, client's level of discomfort in seeking care, and severity of distress at point of entry.*)

Domain 4: Client–Therapist Relationship

Principle 11: Teach therapists about the cultural background of their clients. (Rationale: *Facilitates development of understanding and empathy; increases therapist sense of confidence and efficacy.*)
Principle 12: Therapists should be professional and present themselves as an expert authority figure. (Rationale: *Consistent with hierarchical traditions in Asian culture; provides assurance to clients that they are receiving expert care.*)
Principle 13: Client–therapist roles and expectations for therapy should be clearly addressed. (Rationale: *Helps clients understand their role and the therapist's actions and behaviors; facilitates development of realistic expectations.*)
Principle 14: Join and engage the client by assessing family background and migration history. (Rationale: *Facilitates building of working alliance and bonding with therapist; provides important contextual information on experiences of client.*)
Principle 15: Therapist cultural self-awareness and self-identity should be thoroughly explored. (Rationale: *Improves therapist understanding of self and cultural issues; facilitates building of positive working relation with clients; encourages therapists to take responsibility for client care; alleviates feelings of anxiety and tension related to working*

with culturally similar or culturally diverse clients; improves understanding of ethnocultural transference and countertransference.)
Principle 16: Interactional and relational models of therapeutic relations should be understood. (Rationale: *Helps therapists realize that cultural competence requires awareness of client issues, therapists' cultural awareness, understanding of biases, and a unique interaction of client–therapist dynamics; increases understanding of individualistic and professional biases evident in psychotherapy*).

Domain 5: Cultural Differences in Expression and Communication

Principle 17: Understand that the notion of psychotherapy and talking about one's problems as a method of treatment is culturally foreign to Asian clients. (Rationale: *Asian clients may need more time to become comfortable with talking about their feelings and discussing their problems*.)
Principle 18: Understand cultural differences in communication styles. (Rationale: *Reduces miscommunication and misunderstanding; facilitates understanding of verbal and nonverbal behaviors*.)
Principle 19: Understand and address ethnic differences in expression of distress (eg, somatization vs worry). (Rationale: *Reduces stigma associated with mental illness by targeting somatic symptoms; increases cultural congruency by providing greater mind–body balance; improves diagnostic accuracy; increases understanding of the meaning of symptoms; prepares clients to discuss cognitive and affective symptoms*.)
Principle 20: Address cognitive and affective symptoms of Asian clients. (Rationale: *Although clients may veer away from talking about feelings and thoughts, discussing them in a culturally sensitive manner can improve treatment outcomes*.)

Domain 6: Cultural Issues of Salience

Principle 21: Be aware of shame and stigma issues that may influence the treatment process. (Rationale: *Tempers loss-of-face issues and stigma associated with having a mental illness; addressing these issues may reduce premature treatment dropout.)*
Principle 22: Address and be aware of push–pull feelings and culture-related role inconsistencies that may exist between the client's culture of origin and the culture of therapy. (Rationale: *Reduces confusion and discomfort and normalizes feelings when clients are asked to behave in a stereotypically culturally incongruous manner (eg, pushing an Asian client to be more independent and individualistic and autonomous)*.)
Principle 23: Collaborating with family and/or spending more time understanding family relationships may be necessary. (Rationale: *Is congruent with Asian culture, which values family relationships; increases understanding of development and communication styles*.)
Principle 24: Be aware of and understand life experiences that may act as additional stressors or place clients at additional risk for mental illness (eg, acculturative stress, racism, linguistic difficulties, social mobility problems, feelings of nostalgia, loss of interpersonal networks, intergenerational family conflict). (Rationale: *Addressing issues of salience in clients' lives will help them feel more understood and satisfied with therapy; many of these issues are overlooked when therapists do not understand or can't relate to what their clients are experiencing*.)
Principle 25: Therapists should understand how social class and privilege interact and affect the treatment process. (Rationale: *Improves understanding of dynamic social and class dynamics and biases; helps therapists become more responsive to working with disadvantaged diverse populations; decreases blaming and increases appreciation for the hardships and disadvantages that some groups face*.)

After receiving NIMH funding to culturally adapt CBT for depressed Chinese Americans, the more extensive work of implementing and expanding our understanding began. In order to further guide adaptations and provide more specificity and concreteness to developing an empirically based intervention, I proposed and developed an integrative and comprehensive bottom-up and top-down framework for culturally adapting therapy (Hwang, 2009, 2011). Specifically, I wanted to involve the consumers and experts in the field who may potentially use the treatment manual in the future to be involved in the process of developing a community-based intervention. The FMAP framework is a community-participatory bottom-up approach for culturally adapting psychotherapy and consists of five phases: (1) generating knowledge and collaborating with stakeholders, (2) integrating generated information with theory and empirical and clinical knowledge, (3) reviewing the initial culturally adapted clinical intervention with stakeholders and revising the culturally adapted intervention, (4) testing the culturally adapted intervention, and (5) finalizing the culturally adapted intervention. The FMAP integrates the more theoretically driven and top-down Psychotherapy Adaptation Modification Framework (PAMF) in the second phase. This combined framework has the advantage of integrating theory, research, and community knowledge of what we know from clinical practice when working with Asian American populations.

Each of the FMAP stages and concrete illustrations of how the culturally adapted intervention was developed is discussed in greater detail in chapter "The Formative Method for Adapting Psychotherapy."

As part of the iterative process of the FMAP, revisions were made to the existing 25 PAMF theory-driven therapeutic principles, and additional principles were also added. These add-ons were made as a result of the formative processes used to develop the culturally adapted treatment manual used to help depressed Chinese Americans. Specifically, they arose during the process of conducting focus groups with practitioners, indigenous healers, and through additional reflections by myself while writing the culturally adapted manual (see Hwang, 2009). However, these modifications do not yet include what we learned through implementing the treatment manual in the clinical trial, which will be discussed later on in this book when I review the treatment manual. The revised principles and corresponding rationales have been expanded to now include a total of 48, and are listed below (Hwang, 2009).

Domain 1: Dynamic Issues and Cultural Complexities

Principle 1: Learn when to individualize, when to generalize, and when to examine the complexities of cultural issues (eg, thought records do not work with Asian Americans vs thought records work better with more educated and more acculturated Asian Americans). (Rationale: *Cultural issues may be moderated by other factors such as level of education or level of acculturation*.)
Principle 2: Individualize statements made to client (eg, rather than say "Family is really important to Chinese people," say, "You seem to really care a lot about your family"). (Rationale: *Helps clients feel validated rather than stereotyped*.)
Principle 3: Adaptations made for specific Asian groups may not work with other Asian groups (eg, modifications that involve incorporating Buddhist concepts may not equally apply to Filipino Americans because of religious differences among these groups). (Rationale: *Although racially similar, those from different ethnic and cultural backgrounds have different beliefs, histories, philosophies, and religious beliefs*.)
Principle 4: Differentiate emic (culture-specific) and etic (culture-general) constructs when providing psychoeducation (eg, assertive communication may not carry the same benefits when used in cultures in which it is less normative, perceived as being too direct and disrespectful, and can potentially exacerbate relationship problems). (Rationale: *What is normative or effective in one culture may be abnormal and socially ineffective in another culture*.)

Domain 2: Therapy Orientation

Principle 5: Provide a longer and more detailed orientation to therapy. (Rationale: *Asian American clients are less familiar with and have less understanding of how psychotherapy works*.)
Principle 6: Spend some time getting to know each other and understanding why the client is seeking therapy at this time. (Rationale: *Social relationships are very important for those from collectivistic backgrounds. Reduces awkwardness of talking with someone they do not know*.)
Principle 7: Establish goals and markers of treatment progress that is periodically reviewed. (Rationale: *Helps reduce ambiguity of therapy and is consistent with the problem-focused nature of clients seeking treatment. Also helps clients who are less comfortable being in therapy confirm the benefits of attendance*.)
Principle 8: Educate clients about the course of therapy (eg, what their experience is going to be like the first few weeks, several weeks thereafter, and in the long run). (Rationale: *Helps increase comfort and reduce ambiguity by normalizing experiences and providing realistic expectations*.)
Principle 9: Client–therapist roles and expectations for therapy should be clearly addressed at the beginning of therapy. (Rationale: *Helps client understand their role as well as therapist's actions and behaviors. Facilitates clients' development of realistic expectations and normalizes their experiences*.)
Principle 10: Address premature dropout and educate clients about healthy therapy termination. (Rationale: *Helps normalize clients' feelings and increases the likelihood that they will be open and honest with the therapist*.)
Principle 11: Directly address why clients may feel like they are not receiving as much benefit during the first few weeks of therapy (eg, gathering of background information and accurate understanding of the client and their problems results in more effective problem solving). (Rationale: *Helps reduce premature treatment dropout and normalize feelings of why they feel like they are doing most of the talking and why the therapist is not giving as much direct advice near the beginning of treatment*.)
Principle 12: Focus on psychiatric symptoms, but do not avoid discussing the psychiatric diagnosis. (Rationale: *Focuses on clients' presenting problem rather than psychiatric labeling. Acknowledges and normalizes clients' difficulties and uses helpfulness of diagnostic information without reinforcing cultural stigmas and taboos about discussing mental illness*.)

Principle 13: Distinguish psychological and somatic symptoms of psychiatric diagnoses at the beginning of treatment. (Rationale: *Highlights that psychiatric disorders are not just "mental" problems and acknowledges interrelationship of mind and body. Consistent with holistic and somatic emphasis in Asian culture and reduces stigma associated with seeking mental health treatment*.)

Domain 3: Cultural Beliefs

Principle 14: Reduce the emphasis on cognitions and changing the way a person thinks. Instead, focus on helping clients think in more effective and healthy ways. (Rationale: *Focusing on changing one's way of thinking is less in line with client goals of solving their problems. Too much emphasis on cognitive biases and changing negative thinking patterns may alienate clients, whereas a positive reframe of helping clients think more effectively and healthily is more congruent with their goals*.)

Principle 15: Increase emphasis on problem solving and behavioral activation. (Rationale: *Aligns with clients' problem-solving focus and is congruent with physical health and holistic nature of Asian culture*.)

Principle 16: Increase emphasis on resolving social conflicts and relational problems. (Rationale: *The primary problems of many clients from collectivistic cultural backgrounds tend to be family or relational problems. The process of immigration and the acculturation gap between parents and children also tends to exacerbate family difficulties*.)

Principle 17: Highlight consequences of not properly addressing one's problems. Focus on advantages and disadvantages of different actions. (Rationale: *Consistent with problem-focused and practical nature of Asian culture and philosophy*.)

Principle 18: Provide psychoeducation on unfamiliar topics. (Rationale: *Improves client understanding of topics that they may have had little previous exposure to. Consistent with educational focus of client culture, and facilitates concrete understanding of important issues*.)

Principle 19: It takes more time to work through therapy materials for people who have less prior knowledge or exposure. In addition, Asian American clients have less exposure to therapy and are more likely to be intimidated by large manuals. (Rationale: *If using a manualized treatment, reduce the amount of different materials you cover in each session, and focus on applying the most relevant materials to the client's situation. Also, try to reduce the bulkiness of the manual (eg, number of pages, not number of sessions) so that the treatment does not seem too overwhelming*.)

Principle 20: Simplify and consolidate topics into the basics when several variations of similar categories exist (eg, instead of discussing 15 different types of cognitive biases, focus on a few of the most common biases). (Rationale: *Reduces confusion, improves learning of the materials, and makes psychotherapy less intimidating*.)

Principle 21: For adults and children, use terms such as exercise, practice, or strengthening rather than homework. (Rationale: *Although one may think that a strong emphasis on education in Asian culture is congruent with assigning homework, some children and adults may have an aversive reaction to being assigned homework in therapy. Children already have too much homework to do, and adults were pressured to study in the past. Terms such as exercise, practice, or strengthening are more in line with the goal, hard work, and health emphasis in Asian cultures*.)

Principle 22: Make sure the examples used are culturally salient and meaningful. When using a manualized treatment, make sure that artwork and layout design are also culturally appealing. (Rationale: *Using more relevant examples helps the client understand therapy concepts and more quickly acquire skills that are being taught. Culturally appealing artwork and layout increases the manualized treatment's aesthetic appeal*.)

Principle 23: Use cultural bridging techniques to relate therapy concepts to Asian beliefs and traditions (eg, bridging qi and balance of energy to cultivating balanced cognitions and healthy behaviors to improve mood). (Rationale: *Facilitates understanding and adherence to treatment. Provides cultural context for learning and reduces culture unfamiliarity with foreign psychological concepts*.)

Principle 24: Use metaphors to relate mental health treatment to physical health treatment (eg, psychotherapy is like physical therapy, and both require exercises and practice). (Rationale: *Helps reduce stigma related to seeking psychological services, and helps client see the importance of practice and commitment to achieve gains*.)

Principle 25: Understand how cultural beliefs influence help-seeking and change the nature of the client you are treating (eg, because of stigma, Asian American clients tend to delay treatment and by nature are more severe when they do come into treatment. This, compounded with unfamiliarity and cultural barriers, leads to longer therapy response times). (Rationale: *Helps therapist understand client concerns and also helps therapist develop realistic treatment progress expectations of their clients*.)

Principle 26: Modify worksheets so that they are more culturally congruent and translate esoteric therapy terminology into common language and understanding (eg, add a goals column to "thought records" and call it "goal analysis" or reformulate "chaining" into "climbing the mountain to reach your goals.") (Rationale: *Helps clients better understand and align with the purpose of each worksheet or exercise. Also helps clients better understand culturally unfamiliar terminology and concepts*.)

Domain 4: Client–Therapist Relationship

Principle 27: Use proper cultural etiquette (eg, offer clients some tea to drink and ask them how they have been doing). (Rationale: *Helps clients feel more comfortable, increases feelings of social connectedness, and decreases feelings of awkwardness associated with talking to a stranger about one's problems.*)
Principle 28: Teach therapists about the cultural background of their clients. (Rationale: *Helps therapist understand and empathize with their clients. Increases therapist confidence and feeling of self-efficacy.*)
Principle 29: Join and engage with clients by assessing family background and migration history. Clarify the role that family or caregivers will have in therapy. (Rationale: *Facilitates building of working alliance and bonding with therapist. Provides important contextual information on clients' experiences. Respects clients' privacy and rights but also acknowledges family and caretakers who may have brought clients to treatment.*)
Principle 30: Therapists should be professional and present themselves as experts who can help clients solve their problems. (Rationale: *Consistent with respect for authority figures in collectivistic traditions in which caregivers are experts who can help resolve their problems.*)
Principle 31: Therapist cultural self-awareness and self-identity should be thoroughly explored. (Rationale: *Improves therapist understanding of self and cultural issues. Facilitates building of positive working alliance with clients, and encourages therapists to take responsibility for client care. Alleviates feelings of anxiety and tension related to working with culturally dissimilar or similar clients.*)
Principle 32: Interactional and relational models of therapeutic relations should be understood. (Rationale: *Facilitates understanding that cultural competence requires knowledge of client issues, therapist cultural self-awareness, and understanding of how the two interact to affect therapy processes. Increases understanding of professional biases and ethnocultural transference and countertransference.*)
Principle 33: Because of cultural stigma toward mental health services and unfamiliarity with therapy, increase emphasis on normalizing client feelings. Case examples may also be helpful. (Rationale: *Helps reduce stigma, increase level of comfort, and increase feelings of being supported and understood. Helps clients relate their experiences to those of others and feel less alone.*)
Principle 34: Make an active effort to provide emotional support, encouraging words, optimistic statements, and positive feedback to clients. Validate clients when they share difficult-to-talk-about experiences. (Rationale: *Helps increase feelings of comfort and support. This is especially important because there is a greater emphasis on receiving support and feedback from one's social network rather than developing positive self-statements. In Asian cultures it is more common for people to say positive things about you than for you to say positive things about yourself.*)
Principle 35: Help therapist develop realistic expectations for client progress. Have more patience when clients are trying to learn new skills and improve at a slower rate (eg, learn new hobbies and self-care activities vs revisiting old hobbies or previously practiced health activities). (Rationale: *Many Asian clients delay treatments and as a result are more severely ill when they come to treatment. Compounded with cultural barriers and unfamiliarity with therapy, clients are likely to exhibit slower treatment progress, and it may take longer to develop a strong working relationship. Having realistic expectations will help normalize therapist feelings, increase clients' sense of self-efficacy, and develop more patience for client progress.*)

Domain 5: Cultural Differences in Expression and Communication

Principle 36: Psychotherapy and talking about one's problems as a way to resolve them may seem culturally foreign to those from cultures that focus more on problem solving through actions rather than words. (Rationale: *Clients may need more time to understand the benefits of therapy and to become comfortable talking about their feelings and problems with someone they do not know. In addition, they may need more psychoeducation to differentiate their thoughts from their feelings.*)
Principle 37: Understand cultural differences in communication styles (eg, direct vs indirect, verbal vs nonverbal, and different meanings associated with being assertive, aggressive, and passive in different cultures). (Rationale: *Helps therapist teach communication skills that are more effective given the client's cultural context. Reduces the pushing of ethnocentric values that may be countertherapeutic or counterproductive to clients given their cultural environment. Improves understanding and reduces miscommunication between client and therapist.*)
Principle 38: Understand and address ethnic differences in expression of distress (eg, differential emphasis on mind vs body). (Rationale: *Validates somatic expression of psychiatric distress and helps the therapist normalize clients' experiences. Increases understanding of clients' level of distress and improves diagnostic accuracy. Helps therapist develop more holistic treatment plans that target somatic symptoms as much as they focus on cognitive reframing.*)
Principle 39: Address and differentiate cognitive and affective experiences of client. (Rationale: *Helps clients differentiate their thoughts from their feelings, which is especially important for those from more holistic cultural orientations in which there is less differentiation between the two. Although clients may veer away from talking about their thoughts and feelings, discussing them in a culturally sensitive manner can improve treatment outcomes.*)

Domain 6: Cultural Issues of Salience

Principle 40: Be aware of and understand life experiences that may act as additional stressors or place clients at additional risk for mental illness (eg, acculturative stress, racism, linguistic difficulties, social mobility problems, feelings of nostalgia, loss of interpersonal networks, and intergenerational family conflict). (Rationale: *Addresses issues salient to clients' life and increases the likelihood of feeling understood and being satisfied with treatment. Also addresses topics that are sometimes overlooked by therapists who are not aware of culture-specific experiences*.)

Principle 41: Understand how immigration and acculturation affect individual and family relationships across different generations. (Rationale: *Acknowledges unique roles, needs, and situations of immigrants as a culture in transition. Helps clients understand their identity and development in an appropriate cultural context. Also helps clients understand how cultural transition and immigration issues affect their and their family's cultural values and ability to communicate*.)

Principle 42: Understand how social class and privilege interact and affect the treatment process. (Rationale: *Improves understanding of social and class dynamics and biases. Also helps the therapist become more responsive to working with disadvantaged diverse populations, and decreases blaming and increases appreciation for the hardships and struggles that certain groups face*.)

Principle 43: Address and be aware of push–pull feelings and culture-related role inconsistencies that may exist between clients' culture of origin and the culture of therapy. (Rationale: *Reduces confusion and discomfort and normalizes feelings when clients are asked to behave in a culturally incongruous manner (eg, pushing an Asian client to be more independent, individualistic, and autonomous)*.)

Principle 44: Address clients' individual rights, but also integrate this understanding with the realities of their roles and responsibilities. Discuss how one's rights, roles, and responsibilities change when others do not act in appropriate ways. (Rationale: *Contextualizes one's rights within a social context of one's roles and responsibilities. Helps highlight the importance of meeting one's own needs while at the same time reducing feelings that one is being selfish. Helps clients understand how obligations, actions, and moral responsibilities change when the family or social system is unhealthy*.)

Principle 45: Be aware of and address shame and stigma issues that may influence treatment progress. (Rationale: *Helps improve clients' comfort level, helps therapist be more empathetic and supportive to client, and helps reduce treatment failure and premature dropout*.)

Principle 46: Align with traditional–indigenous forms of healing, medicine, religions, or philosophies. (Rationale: *Better coordinates treatment services and helps promote collaboration between caregivers*.)

Principle 47: Find ways to integrate extant cultural strengths into clients' treatment. (Rationale: *Capitalizes on aspects of clients' culture that may facilitate the healing process and that are culturally congruent with clients' goals (eg, increasing focus on family strengths and improving social relationships, integrating cultural strengths related to Buddhism and acting in the right way to achieve one's goals, highlighting the importance of cause and effect or karma, and incorporating popular cultural metaphors and stories that help people live in healthier ways)*.)

Principle 48: For manualized treatments, be more flexible in the ordering of sessions and also on the speed with which you move through them (eg, whether you spend more time and repeat some sessions). (Rationale: *Helps ensure that the topics that you are focusing on are consistent with clients' problems and goals. Also ensures that clients sufficiently learn materials and reduces cursory exposure to information that will not be effectively used*.)

EXAMPLES OF CULTURALLY ADAPTED INTERVENTIONS

A number of researchers have already begun culturally adapting psychotherapy and studying its benefits. Below I provide a brief review of some of the interventions that target different areas, including adaptations for specific ethnic groups, modifications to psychotherapy that address immigration and bicultural effectiveness, as well as indigenous treatments that have developed from their cultures of origin (which tend to be significantly different from traditional Western psychotherapies). However, it goes beyond the scope of this book to review all of the research that has or is currently being conducted in this arena. However, a recently edited book written by Bernal and Domenech Rodríguez (2012) provides an excellent overview of efforts to culturally adapt psychotherapy for a number of ethnocultural groups. This book serves as an excellent resource to understand how various scientist-practitioners have begun to address this challenging but important endeavor. (See Bernal & Domenech Rodríguez, 2012 for a more extensive review of recent projects.)

One of the first studies was a culturally adapted cognitive-behavioral and interpersonal treatment for depressed Puerto Rican youth, which has been shown to be efficacious in RCTs (Rossello & Bernal, 1996, 1999). Kohn, Oden, Munoz, Robinson, and Leavitt (2002) adapted a manualized group CBT intervention for use with low-income African American women. They utilized both structural change (eg, limiting the group to African American women, adding experiential meditative exercises, changing some of the language used to describe CBT) and didactic adaptations (eg, attending to four issues salient to this group: creating healthy relations, spirituality, African American family issues, and African American female identity) in modifying the treatment outcomes. Kumpfer, Alvarado, Smith, and Bellamy (2002) have used various approaches to adapt the Strengthening Families Program for use with multiple ethnic groups.

Others have developed interventions to target specific issues that acculturating immigrants might encounter. These approaches address diversity issues related to the culture of origin as well as issues related to adjustment, acculturation, and cultural transitions to the United States. Because many immigrants encounter adaptation and acculturation problems, instead of focusing solely on cultural differences with the client's culture of origin, adapted treatments need to be flexible in addressing cultural changes over time. This is especially important since many minorities share a similar immigration experience that could be targeted in prevention and treatment programs.

These programs include Bicultural Effectiveness Training (BET) and Family Effectiveness Training (FET) that target intergenerational conflicts exacerbated by acculturation and adaptation problems (Szapocznik, Santisteban, Kurtines, Perez-Vidal, & Hervis, 1984; Szapocznik et al., 1989) and the Strengthening of Intergenerational/Intercultural Ties in Immigrant Chinese American Families (SITICAF) (Ying, 1999). FET was tested among a Hispanic population and was able to both reduce child behavior problems and improve general family functioning and interactions compared to a control condition (Szapocznik et al., 1989). Among Cuban American families, BET was found to be just as effective as a preexisting therapy for dealing with adolescent conduct disorder and social maladjustment (Szapocznik, Rio, Perez-Vidal, Kurtines, Hervis, & Santisteban, 1986). Though tried among a smaller sample, SITICAF was also found to be effective in improving intergenerational relations, and for parents, a sense of responsibility and control (Ying, 1999).

Some scholars have also begun developing treatment modalities that favor the particular values and traditions embedded in the culture of origin. These programs are not direct cultural adaptations, but interventions that have developed out of cultural healing systems. For example, "cuento" or folktale therapy for Puerto Rican youth involves telling and then discussing fables that are culturally and developmentally relevant (Costantino, Malgady, & Rogler, 1988). Cuento therapy has been shown to have a positive psychological effect on Hispanic/Latino children and adolescents, especially with regards to decreasing anxiety (Costantino & Malgady, 1996; Costantino, Malgady, & Rogler, 1986; Ramirez, Jain, Flores-Torres, Perez, & Carlson, 2009).

In addition, Morita therapy and Naikan therapy for the Japanese both focus on repairing the interpersonal relationships that are key to Japan's collectivist society (Morita, Kondo, & LeVine, 1998; Reynolds, 1980). Morita therapy was developed in the early 1900s to soothe neurotic interpersonal anxieties, while Naikan therapy became popular a few decades later as an extension of Buddhist thought (Hedstrom, 1994). However, very few outcome studies have been conducted, and those that have are not always methodologically rigorous nor do they implement RCT methodologies. Still, there is some evidence that Naikan therapy can help patients with depression (Sengoku, Murata, Kawahara, Imamura, & Nakagome, 2010). Morita therapy has also been used to some effect in conjunction with pharmacological treatments to treat obsessive-compulsive disorder in China (Jie, Jian-Qing, & Qiang, 2005; Mei, Zhu, & Chen, 2000). Also in China, Zhang and colleagues combined elements of cognitive therapy with Taoist philosophy and developed Chinese Taoist Cognitive Psychotherapy for Chinese clients with generalized anxiety disorder (Zhang et al., 2002).

OVERALL, WHAT DO WE KNOW ABOUT CULTURALLY ADAPTED TREATMENTS AND OUTCOMES?

The question of whether culturally adapted treatments can be beneficial is an important question. Although no one treatment outcome study can provide us the answer to this question, there is some evidence that cultural adaptations can be beneficial for treating mental health problems (Griner & Smith, 2006). One major limitation of the culturally adapted treatments literature is that it is still in its infancy, and has not yet been able to unequivocally demonstrate that cultural adaptations lead to superior treatment outcomes. Specifically, most studies on cultural adaptation are not RCTs, which are considered to be the gold standard in this field. This involves comparing two active treatments, which in this case would involve comparing the effectiveness of nonadapted versus adapted

interventions with the same primary theoretical orientation. Unfortunately, the majority of studies using cultural adaptations have a number of methodological limitations including very small sample sizes, nonrandom assignment to groups, comparison to waiting list control condition, or comparison to treatment as usual (which is often a mixed bag of different therapy modalities that makes it difficult to draw comparative conclusions).

Although the existence of some studies is better than no studies, head-to-head comparisons of adapted versus nonadapted treatments are still few and far between. Kazdin (1993) indicated that there is little empirical support for the superiority of adapted treatments to justify the additional cost it would take to develop and train mental health practitioners to deliver such services. Moreover, Lau (2006) also highlights the importance of testing cultural modifications and notes that including untested cultural modifications could also inadvertently lead to suboptimal outcomes if core components of EBTs are left out (eg, core therapeutic mechanisms and intervention components are compromised).

In addition, it is important to note that the term "cultural adaptation" has been used loosely, with few studies clearly articulating and defining how they went about adapting and modifying treatments. Many studies are described as culture adaptations, but in reality they are based on demographic matching, or are surface structure adaptations that do not systematically or specifically denote what cultural adaptations were made. For example, many involve ethnic and/or linguistic matching, the assumption being that if clients' ethnic or linguistic background matches the therapist's, some level of cultural adaptation must be occurring. Interestingly, these studies are often included in cultural adaptation meta-analyses, which use statistics to compare results across a variety of studies in order to find overall results. However, ethnic and linguistic match is not a true test of cultural adaptations, and including "ethnic match" study in meta-analyses changes the nature of the comparison being made and skews the results. A separate literature already exists for linguistic and ethnic match, which should be different than the cultural adaptation literature, or at most characterized as surface structure adaptations.

For some of these demographic and matching descriptors, previous research has already shown that treating clients in a more culturally sensitive manner (ie, providing client–therapist ethnic matching and treatment at ethnic-specific services) can reduce premature treatment failure (Flaskerud & Liu, 1991; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Takeuchi, Sue, & Yeh, 1995). However, some of this research also shows that ethnic matching is not more important than treating clients in a culturally competent and effective manner. Other studies may go beyond ethnic and linguistic matching, but focus more on other surface structure adaptations, and/or do not clearly define how treatments were modified.

Although recent reviews and meta-analyses have found that cultural adaptations, broadly defined, can be therapeutically beneficial, there continue to be few rigorously conducted RCTs comparing culturally adapted versus nonadapted ESTs of the same therapeutic modality (Benish, Quintana & Wampold, 2011; Griner & Smith, 2006; Huey & Polo, 2008; Miranda et al., 2005; Smith, Rodríguez & Bernal, 2011). In addition, a major problem with the studies included in these meta-analyses is the loose definition for what is considered to be a cultural adaptation study (eg, providing therapy in the client's native language, addressing cultural values, consultation with individuals from the client's culture, receiving services at an ethnic-specific treatment center, cultural sensitivity training of staff, providing extra services such as child care and administration of written materials for illiterate clients). Moreover, including the surface structure adaptation studies into these meta-analyses and not disaggregating types or levels of adaptations (eg, deep structure adaptations) is problematic because it interferes with our ability to accurately interpret and separate out the findings.

Many of the cultural adaptation studies included in these meta-analyses also have other methodological biases such as very small sample sizes, differential use of therapeutic modalities, providing additional treatment for clients in the culturally adapted arm, unfair comparisons of ethnic languages utilized in the adapted condition but English used in nonadapted condition, and ethnic match utilized in the adapted condition but not in the nonadapted condition (Benish et al., 2011). Lack of methodological vigor and use of RCT methodology (eg, nonrandom assignment to groups, small sample sizes, use of simplistic structural or single-point adaptation strategies) and less than optimal comparison treatments (eg, comparison with treatment as usual—which is not a direct comparison of the benefits of adaptation) weakens the conclusions that can be drawn from extant studies.

The first meta-analysis on cultural adaptations was conducted by Griner and Smith (2006). Across 76 studies, they found a weighted effect size of 0.45, indicating that cultural adaptations provide a moderately strong benefit to improving outcomes. It is important to note that many of these studies did not provide detailed information about how interventions were modified or how adaptations were developed. As mentioned above, there are some methodological issues that may influence the result of the study as what was considered to be a cultural adaptation in these studies was not clearly defined. For example, 41% of the studies included were simply clinics that explicitly served clientele from diverse backgrounds (eg, ethnic-specific service clinics). Being treated at an ethnic-specific service clinic does not automatically mean that treatment is being culturally adapted

systematically or at a deep structural level. At a surface structure and basic level, services provided at these clinics engage in linguistic matching and more often than not overlap with ethnic matching. As a result, it is unclear as to what extent adaptations are occurring, and making assumptions that systematic and deeper structural adaptations are being made by treatment providers may be erroneous.

Since then, a number of other meta-analyses have been published. For example, Smith et al. (2011) reconducted the previous meta-analysis using refined criteria. Specifically, they restricted the meta-analytic review to only studies that used quasi-experimental and experimental designs. In addition, unlike the previous meta-analysis, studies involving only ethnic and language matching were excluded. Moreover, some aspect of the content, format, or delivery of the intervention had to be purposefully modified to address issues of culture, race, or ethnicity. Results indicated that studies that incorporated some form of cultural adaptation evidenced a moderate effect size (d) of 0.46, indicating that they did much better for patients than control groups. These results indicate that culturally adapted therapies are moderately superior to those that do not make cultural adaptations. However, a major limitation of these meta-analyses is that the control group is loosely defined (eg, wait list control) and studies with direct comparisons of culturally adapted versus nonadapted treatments are still lacking. Specifically, most tests of culturally adapted treatments compare culturally adapted therapies against waiting list control conditions or treatment as usual, but do not utilize a comparison of adapted versus nonadapted evidence-based therapies.

Benish et al. (2011) also conducted a meta-analysis. To help address the "file drawer problems" (eg, the idea that statistically significant findings are more likely to be published, and that studies that do not find significant results are less likely to be published—which could potentially bias meta-analytic findings), their study included both published and unpublished direct comparison studies. They found that culturally adapted psychotherapy is more effective by an effect size of 0.32 than unadapted, but bona fide psychotherapy. In this meta-analysis, however, bona fide psychotherapy did not refer to a cultural adaptation of the same evidence-based practice or empirically supported treatment within the same therapeutic modality (eg, culturally adapted CBT versus nonadapted CBT), which again limits the conclusions that can be drawn. In addition, the cultural adaptation studies had similar methodological weaknesses and/or biases, such as very small sample sizes (eg, oftentimes with numbers in the single digits or less than 20 participants per treatment condition), providing additional treatment for clients in the culturally adapted arm (resulting in unfair comparisons of lengthier adapted treatments vs shorter nonadapted treatments), conducting therapy in ethnic languages for the adapted condition but English in the nonadapted condition (resulting in participants of differing acculturative levels being treated in each condition), and client−therapist ethnic match biases (utilizing ethnic match in the adapted condition but not in the nonadapted condition) (Benish et al. 2011). This limitation further highlights the need for more clinical trials that provide direct head-to-head comparisons. Although still in its infancy, more resources and funding are needed to explore the therapeutic benefits and identify cultural mechanisms that may mediate or moderate outcomes. For example, Pan, Huey, and Hernandez (2011) found that acculturation levels moderated whether a one-session culturally adapted phobia treatment was more effective than a nonadapted treatment.

In regards to the child literature, Huey and Polo (2008) conducted a meta-analytic review of EBTs for ethnic minority youth. This meta-analysis was not one comparing culturally adapted versus nonadapted, but more of a mainstream outcome literature review. Using the same criteria that were used by Chambless et al. (1996, 1998) and Chambless and Hollon (1998), they found that across a variety of clinical problems (eg, depression, anxiety, ADHD, problems, substance abuse, and PTSD), treatments tested on ethnic minority youth were identified as being only probably or possibly efficacious, rather than well-established. This indicates that the treatments that we know work best with White adolescents, have not been commonly provided or tested on ethnic minority youth, thus limiting our knowledge of how effectively well-established treatments generalize to diverse groups. In addition, studies that did include ethnic minority youth tended to have small sample sizes and limited numbers of less acculturated youth, resulting in low statistical power and questions about applicability to immigrant youth. Moreover, Huey and Polo (2008, 2010) highlight that there have been few cultural adaptation studies conducted in the youth literature. Initial findings on the culturally responsive treatments indicate that it may not be more beneficial than standard treatments for ethnic minority youth.

Even if some studies were to find that culturally adapted treatments may be less beneficial for diverse child and adolescent populations than adults, we would still need to examine the complexities of this important issue. Interpretations of the benefits of adaptations need to be done with caution. For example, there could be many moderators that affect the level of impact of culture adaptations, such as level of acculturation. Specifically, adaptations may be more beneficial for those who are less acculturated and who identify less with mainstream American culture. Because adolescents growing up in the United States are likely to be more Americanized than youth and

adults who immigrated during or after their formative years, fewer cultural adaptations may be needed for this population, and it makes sense that these adaptations would be less effective for more acculturated youth. Age of immigration or the developmental period in which one integrates (eg, coming here for high school or college versus growing up here since elementary school) may also be another moderating factor that influences outcomes. Future studies should identify and test moderating and mediating factors of outcome for culturally adapted treatments (eg, language, cultural value orientation, ethnic identity, and internalized racism).

In sum, it seems reasonable to assume that if more systematic and empirically guided therapy adaptations and trainings of cultural competence are developed, even larger therapeutic effects would be expected. If more systematic and deep structure adaptations are implemented, the effect size and treatment benefits may become more evident. Unfortunately, many studies have yet to implement and describe in detail deep structure adaptations in a systematic way. These adaptations are more difficult to accomplish, and few frameworks exist for guiding such modifications. Nevertheless, deep structure adaptations have more potential for improving outcomes and individualizing treatment to account for the client's background. Fortunately, there are a number of cultural adaptation programs targeting many diverse populations under way, indicating that scientist-practitioners, who are experts in the field, perceive a need to culturally tailor interventions to better engage ethnic clients and improve outcomes.

WHY IS CULTURALLY ADAPTING TREATMENT IMPORTANT?

The goal of culturally adapting treatment is to individualize and tailor services for people of diverse backgrounds. This is an overarching assumption and goal of psychotherapy that should not be taken lightly. The importance of individualizing care is also underscored in Gordon Paul's (1967) quote "*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, and under *which* set of circumstances?" It is also important to understand that Western psychotherapy has already been culturally adapted and tailored for White and European Americans, and that the goal of all psychotherapy is to provide individually tailored services. The problem here is that for White or European American patients, therapy has already been culturally adapted to meet their broader cultural needs. This is not to say that additional adaptations to match different White subcultures are not needed. However, it is important to recognize that ethnic minorities are at a disadvantage in regards to receiving equitable care because psychotherapy has not been specifically developed for them, and treatment providers do not have equitable knowledge about how to provide effective services for diverse populations—again highlighting the importance of culturally tailoring services.

Moreover, although the emphasis in the above quote is placed on several different aspects (eg, what treatment, by whom, this individual, what specific problem, and which set of circumstances), some of these issues have been underweighted or largely ignored, and others are heavily emphasized. For example, during our graduate training, there is a logical and important emphasis on what treatment. Specifically, most of us received supervision on various therapeutic modalities and read dozens of books regarding "what treatment?" We learned about psychodynamic/psychoanalytic therapies, we learned about cognitive-behavioral therapies, we learned about humanistic therapies, and some of us went even further and learned about different family therapies (eg, structural and strategic) and different types of couples' therapy. If you recall different conference programs and talks, you will probably remember the plethora of workshops and trainings on learning different therapeutic modalities. Learning about the effectiveness of various treatments and how to implement them appropriately is, of course, important.

In addition, most of our training has also placed a significant emphasis on "that specific problem." That is, every time we were assigned a client that was diagnosed with a specific psychiatric diagnosis or exhibited a particular type of problem, we would go and read a number of books on this topic so that we would feel more prepared and competent in helping our clients effectively deal with their specific problem. Moreover, many of us have attended conference workshops and trainings that specialize in the emphasis of both of the aforementioned issues (eg, interpersonal therapy for depression, CBT for anxiety disorders, motivational interviewing for dual diagnoses, eye movement desensitization and reprocessing for post-traumatic stress disorder, or dialectical behavioral therapy for borderline personality).

Less ubiquitous in our training is the emphasis on "*this* individual" and "*which* set of circumstances?" For instance, there are typically fewer workshops, trainings, and readings that emphasize how to address the context and circumstances, as well as intra- and intrapersonal issues related to the cultural diversity of the individual.

Specifically, when you read over conference proceedings, there are often fewer workshops offered on how to understand and improve the treatment for people from a variety of neighborhood contexts (eg, poverty, rural communities, and single-parent families). Interpersonal and intrapersonal factors are part of the human equation. Ethnic, racial, and cultural issues are an inseparable component of the human equation. Many therapists have not attended workshops or attended a number of trainings on treating people from a variety of specific racial groups (eg, trainings on working with American Indians, African Americans, Latinos, or Asian Americans). There are even fewer trainings and books that go beyond racial competency and offer and tailor services for specific ethnic groups rather than the larger Asian heritage umbrella term (eg, conducting therapy with Chinese Americans, Vietnamese Americans, or Hmong Americans).

Despite the tendency to attend trainings and read as many books as possible to prepare ourselves when we start treating clients with particular diagnoses, the tendency to do the equivalent for diverse clients when they walk into our office is often aspirational, and certainly not acted upon to the same degree. For example, we can ask ourselves, how many of us read a number of books on Filipino culture when we began treating our first Filipino American client? I would assume that very few or none of us actually do. Many practitioners also make the mistake of expecting their clients to teach them about their culture and how it influences client problems. Most clients have no idea how to answer this question, especially when they are the ones hoping that the therapist will have ideas on how to help them. They often leave treatment prematurely, complaining that their therapist did not know how to help them, that it's not their responsibility to teach therapists about their culture or their problems, and that they feel like they are not receiving the help they need. It is important to note that we typically never put this responsibility onto White Americans or ask them to teach us about their cultural backgrounds. This question just never pops into our head because the culture of psychotherapy and White American culture is so integrally intertwined that we already unconsciously or consciously understand that psychotherapy is already tailored for White nonimmigrant populations.

Similarly, we can also ask ourselves as how many of us tried to educate ourselves about the Mexican American experience when we had our first Mexican American clients. How many of us researched specific issues such as internalized racism when a young African American girl came to us with low self-esteem and feeling unattractive because, like the classic Clark and Clark (1939) experiment, she believes that she is less attractive than White people? How many of us feel like we can effectively address these issues and feel that we can comfortably say that we are providing the best care possible without continuing to further our knowledge in these arenas? These issues are problematic because, as treatment providers, we have an ethical and moral responsibility to provide effective care in an equitable or equal opportunity manner. The ability to provide equitable services to people from diverse backgrounds should not only be a concept that we aspire toward, but also be a higher standard that we should boldly and actively pursue. In order to achieve this goal, we must make active efforts to learn about our client's cultural backgrounds, values, beliefs, and historical experiences.

In addition, we need to be open to understanding our own intrapersonal processes and biases, as well as have a good understanding of how to be able to be interpersonally effective when working with diverse groups. This interactive perspective is very important to be able to bridge cultural and clinical issues so that the treatments are easily understood by the client. Finally, we cannot expect clients to change their cultural beliefs and values in order to align with the cultural value system of psychotherapy or the therapist. Mental health practitioners need to be able to provide equal opportunity in care. In order to do so, we need to bring the "individual" back into the equation, so that we can truly tailor treatment to the specific needs of our diverse clientele and fulfill our ethical and moral responsibilities to provide parity in care. Cultural adaptations are essential to good therapy and ignoring them violates our professional responsibility (American Psychological Association, 2010a, 2010b; American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006; Bernal & Domenech Rodríguez, 2012).

Given that the majority of the world comes from a background that is non-Western and not familiar with psychotherapy as a form of mental health treatment, culturally adapting mental health services to better meet the needs of the world's population makes sense. Many clinical researchers have already begun culturally adapting psychotherapy, but much more work needs to be done to improve mental services and to ensure that all groups receive quality mental health care. By learning how to culturally adapt therapies in an effective way for people of different backgrounds, we also increase our awareness of cultural-universal and culture-specific issues, and effectively advance psychological science. This also has benefits for clinical science as a whole. For example, we may begin to learn how to integrate extant cultural strengths and healing mechanisms into psychotherapy and mental health treatment.

This integration has already begun with the mindfulness and psychotherapy movement. Specifically, the Eastern concepts of mindfulness, meditation, acceptance, and compassion, which have deep roots in Asian religions and philosophies, such as Buddhism, Taoism, Confucianism, Ayurvedic medicine, and Traditional Chinese

Medicine, have already begun to be integrated into many therapeutic modalities (eg, mindfulness-based cognitive therapy and dialectical behavioral therapy). In addition, conferences specializing in bridging psychotherapy with Eastern concepts of mindfulness, meditation, acceptance, compassion, and the integration of these concepts to neuroscience, relapse prevention, improving relationships, stress management, depression, anxiety, pain, and the healing of trauma have also become increasingly popular (eg, the FACES mindfulness conference that provides training multiple times a year).

Integrating Eastern healing systems with Western psychotherapy is a specific and concrete adaptation strategy. Infusing elements of Eastern philosophies and religions and utilizing core cultural constructs side-by-side with clinical strategies is also an important tailoring approach (eg, cognitive reframing and behavioral activation). Learning how to accept our thoughts and feelings, center ourselves, and create internal balance are all important aspects of managing and maintaining good mental health. At a neuroscience level, integration of Eastern medicines and meditations helps us downregulate our sympathetic nervous system so that we do not react with a fight-or-flight response when trying to make important decisions or effectively communicate with others. This also helps activate our parasympathetic nervous system to increase centeredness and balance.

Learning about the healing strengths of Eastern cultures is only one example of how studying culture can provide valuable information on how to improve mental health treatments. It is possible that by studying cultures from all around the world many more extant cultural strengths can be discovered and integrated into Western psychotherapy to improve its effectiveness and make it more accessible and culture-universal. Just as the study of psychological science informs clinical science, the scientific study of culture can also improve and guide our understanding of universal and culture-specific aspects of human behavior and the improvement of mental health. This aspirational goal also advances the clinical science of treating psychological disorders across diverse populations. The goal of this book is to provide concrete illustrations and examples of deep structural, cultural adaptations. In doing so, the reader is introduced to specific models and frameworks that will help improve understanding of how culture influences mental health, and how culture adaptations can be formulated and introduced into therapy. Moreover, readers will be provided a culturally adapted treatment manual and will be trained on how to implement the manualized treatment. The evidence-based manual will also be used to illustrate subtle and more obvious cultural adaptations. It is my hope that by reading this book, practitioners and research scientists will be able to improve services for diverse clientele and gain a deeper understanding and appreciation for the study and integration of culture into mental health treatment. It is important to remember that culturally adapted therapy is good therapy. As mental healthcare providers, this is a necessity and responsibility, not an option, if we are to provide equally efficacious care.

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