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The theory, process, and outcomes of culturally adapted psychotherapy and psychosocial interventions

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THE THEORY, PROCESS, AND OUTCOMES OF CULTURALLY ADAPTED PSYCHOTHERAPY AND PSYCHOSOCIAL INTERVENTIONS

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by

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DEDICATION

This dissertation is dedicated to Eden Sorenson and Ivy Sorenson—my North Stars, and to Corey Sorenson, who is the Earth itself.

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ABSTRACT

Massive demographic changes have coincided with rise of the importance of evidence-based treatment across the health sciences and widespread awareness of the failure of psychology to address and serve the mental health needs of historically underrepresented groups. Researchers, theorists, and clinicians demand that empirically supported treatments be adapted to better address and better "fit" clinical needs. Based on existing approaches in the literature, this dissertation presents a four-part model of cultural adaptation of psychological interventions and reviews 101 current culturally adapted empirically supported treatments through the lens of this model. The dissertation project comprehensively describes the current state of the field in terms of the theoretical bases, processes, and outcomes of culturally adapted psychotherapy and psychosocial interventions in the context of evidence-based practice, provides suggestions, and illuminates implications for future research and practice.

Chapter 1: Introduction

The eye forms the world / The world forms the eye.

--Marvin Hill

Mainstream psychology is inextricably intertwined with a cultural worldview that can be described as Euro-North American, English-speaking, and formally educated (Benish, Quintana, & Wampold, 2011; Carpenter-Song et al., 2010; Harrell, 2015). As the demographics of the United States rapidly change (Bernal, Bonilla, & Bellido, 1995; Hwang, 2006b; United States [US] Census, 2015) and globalization and technology bring far-flung cultures into contact with one another, the limitations of that worldview have become increasingly obvious. As cultural psychologists have been warning for decades, if psychology does not adapt to meet the demands of a multicultural 21st century (and beyond), it runs the risk of being left behind as a technology that no longer applies (Harrell, 2015; Marsella, 2015; Sue & Sue, 1972). Mainstream psychology has been slow to embrace cultural inclusivity; more than *twenty years* after codification and articulation of multicultural guidelines by cultural psychologists, it was only in 2003 that the American Psychological Association finally expressly called for multicultural competence as the only ethical practice (American Psychological Association [APA], 2003; Gallardo, Johnson, Parham, & Carter, 2009; Sue, Arredondo, & McDavis, 1992). In 2017, the APA updated the Multicultural Guidelines to reflect the significant growth in research and theory within multicultural psychology since 2003 (APA, 2017). The updated guidelines not only articulate an intersectional, ecological approach to psychological conceptualization, research, and practice, but also expressly state that "Psychologists seek to promote culturally adaptive interventions and advocacy within and across systems, including prevention, early intervention, and recovery," a remarkable expansion from the original guidelines (APA, 2017, p. 4).

Psychology bears the legacy of over one hundred years' of utilization of psychological science to support and condone racism, sexism, and homophobia. Early psychological thought was heavily influenced by the accepted social science concepts of the day, which included phrenology (Smedley, 1998), eugenics (Guthrie, 1998), and the concept of polygenism, the theory that different races developed from different genetic origins (Keel, 2013). These ideas, widely accepted by foundational psychologists including Sir Francis Galton (credited with developing psychological testing), served to provide support for the enslavement, mistreatment, and degradation of Native Americans, African Americans, some European-descended individuals like Eastern European Jews and Italians, and people of Asian ancestry (Guthrie, 1998).

While contemporary psychologists claim to study human behavior broadly, the vast majority of psychological research is produced by American psychologists and explores American subjects exclusively (Arnett, 1998). Kelley and Blashfield (2009) argue that, "science is subject to the same preconceptions, sociopolitical pressures, and passions that influence other human constructions" (p. 122). Both the historical origins of the field, as well as current practices contribute to and manifest Eurocentric bias in psychological research (Mandler, 2011; Watkins, 2012), diagnostic conceptualization (Whaley & Hall, 2008), therapy techniques, counseling styles (Sue et al., 2007), and theory (Lillard, 1998). Scientists purport objectivity and empiricism, yet research bias exists in the form of publishing (Mahoney, 1977; Rennie, Watson, & Monteiro, 2002), institutional support (Moore, Acosta, Perry, & Edwards, 2010), sampling bias (Mandler, 2011; Watkins, 2012), and methodological bias (Kral, 2008; Ponterroto, 2005). Therapist bias occurs in the form of overt discrimination and subtle microaggressions (Sue et al., 2007) towards (to name a few) women, people of color (Thompson, Bazile & Akbar, 2004),

members of the lesbian, gay, bisexual, and transgender communities (Israel, Gorcheva, Walther, Sulzner, & Cohen, 2008), as well as, some argue, towards theists or religious people in general (Shelton & Delgado-Romero, 2013; Slife & Reber, 2009). Theoretical bias ignores culturally normative meaning-making narratives and understandings of self (Lillard, 1998; Markus & Kitayama, 2010). Assessment bias exists in the persistent use of measuring tools that, some argue, presuppose ethnocentric cultural fluency as the measure of intelligence (Kwate, 2001). Perhaps it is not surprising that psychologists themselves are overwhelmingly White, with psychologists from historically underrepresented groups joining the field in small numbers and in recent years. The first Latina to receive a doctorate in psychology did so in 1962, it was not until 1963 that the state of California licensed its first African American psychologist, and in 1971 there was exactly one Chinese American psychologist who held a faculty position in an APA-accredited clinical psychology program in the entire country (Rowe, 2015, personal communication; Sue, 2009). Despite efforts to diversify the field, the overall rate of ethnoculturally diverse doctoral students appears relatively flat (Shen, Forrest, & Elman, 2009). According to APA's "Graduate Study in Psychology 2017: Student Demographics" survey (APA, 2016), White students accounted for 73.7% of overall psychology graduate students in academic year 2003-2004 and fell to 70% in 2014-15. However, when doctoral programs are isolated from masters programs, White student representation is 72.4% (APA, 2016). The APA itself has faced and continues to face considerable criticism from affiliated and non-affiliated psychologists for its reluctance, even hostility, to multicultural issues (Obasi, Speight, Rowe, Clark, & Turner-Essel, 2012; Sue, 1992).

First, do no harm. That is the core of the public trust endowed to psychologists, physicians, and other helping professions. The APA ethics code clearly describes beneficence

and non-malfeasance as the primary and foundational ethical principles of the field (APA, 2003). Yet in 2001, the Surgeon General of the US produced a report on the mental health outcomes of ethnoculturally diverse populations in the US, documenting disparities in mental health services and research (i.e., lack of research on non-white subjects). The Surgeon General's report concluded that communities of color have less access to mental health services than do whites, are less likely to receive needed care, and when they receive care, it is more likely to be poor in quality (U.S. Public Health and Human Services, 2001). Additionally, given the checkered history of psychology in regards to non-White populations, it is unsurprising that research suggests that African Americans and Latinos often perceive mental health practitioners as insensitive to their experiences (Carpenter-Song et al., 2010; LaVeist et al., 2000; Thompson et al., 2004). Research indicates that people belonging to historically underrepresented groups face higher levels of everyday stressors along with stressors that are unique to their racial experience (Utsey, Payne, Jackson, & Jones, 2002). Racially based stressors and the effects of poverty are correlated with higher levels of depression, somatic illnesses, and lower perceived quality of life among African Americans and other minorities (Utsey et al., 2002). Available data indicates that ethnoculturally diverse people are less likely than White Americans to seek services from psychologists or other mental health professionals, that they are likely to attend fewer sessions of therapy when they do seek services, and to terminate treatment earlier (Lau, 2006; Sue & Sue, 1972; Sue et al., 2007; Thompson et al., 2004). Additionally, research suggests that stigma against mental health services and cultural differences in presentation of illness also negatively impact the likelihood of minorities, particularly immigrants, to seek out and receive appropriate mental health treatment and increase the likelihood that those who do seek psychological services will be more severely ill at the onset of treatment (Hwang, 2006b). The Surgeon

General, followed by the APA Multicultural Guidelines, strongly stated what multicultural psychologists and cultural psychologists have long-argued, despite being long ignored, culture counts in mental health treatment (APA, 2003; U.S. Public Health and Human Services, 2001).

While there is increasing agreement that culture should be incorporated into ethical psychological practice, there are differing approaches to how culture should be approached, specifically whether a cultural framework should be the starting point for psychological interventions, or whether existing psychological interventions may be adapted to incorporate culture. Numerous scholars and clinicians advocate a psychological practice in which culture-specific models are utilized (Harrell, 2015; Kwate, 2005; Nobles, 2013; Piper-Mandy & Rowe, 2010). While culturally specific models offer tremendous benefits, one of the challenges of contemporary psychological practice is the widespread emphasis on empirically supported treatments (ESTs) as the current standard of care. ESTs are specific interventions designed for use with specific disorders, the efficacy of which has been demonstrated through empirical research. ESTs become the standard of care through informal and formal "approval" processes that includes stakeholders such as insurance companies, the American Psychological Association (e.g., Division 12), and large healthcare provision entities such as the Veterans Administration (VA). Currently, all ESTs have been developed based on Eurocentric psychological theory and normed on dominant groups (Mandler, 2011; Watkins, 2012; Voss, 2008). In many sites of psychological practice (e.g., many VAs, publicly-funded community mental health agencies, forensic settings, hospitals, etc.), ESTs are the only approved modalities of treatment and graduate programs increasingly emphasize EST training in their curricula, practica, and internship sites (Tolin, McKay, Forman, Klonsky, & Thombs, 2015). The tension between ethically-mandated multicultural practice and the emphasis on ESTs places current practitioners

in a dilemma, in which they risk ignoring culture altogether by utilizing ESTs that are not designed to be culturally responsive, come into conflict with the policies of the systems of care in which they work, or attempt to modify interventions on an ad hoc basis. Research into culturally specific psychological theory and intervention is ongoing and is key to psychology's ability to respond to the whole human family. Simultaneously, the tension between culture and ESTs is responded to, in part, by efforts to systematically adapt ESTs so that they are more appropriate for ethnoculturally diverse clients and other under-served and under-represented groups (Barrera & González-Castro, 2006; Bernal, Jimenez-Chafey, & Rodriguez, 2009; Griner & Smith, 2006; Hwang, 2006b; Lau, 2006; Miranda et al., 2005; Nagayama Hall, Ibaraki, Huang, Marti, & Stice, 2016; Smith & Trimble, 2015). It is these adaptation efforts, for the purpose of guiding researchers and clinicians operating in our EST-mandated clinical environments that are the focus of this dissertation. This narrowing of focus does not presuppose that cultural adaptation interventions are superior to cultural specificity interventions (in fact, the opposite is vigorously argued by many psychologists), but rather seeks to offer guidance for clinicians and researchers currently working with underrepresented groups within the limitations of a clinical environment which identifies ESTs as the standard of care (Levant, 2005).

Adaptations range from surface to deep and can include everything from language translation, to use of culturally appropriate visual imagery and idioms, to incorporation of culturally held values, to freestanding adaptations that are developed specifically for a particular group of people (Falicov, 2009). While the field of cultural adaptation is young, research suggests that interventions that incorporate culture are more effective than those that do not. A 2006 meta-analysis of 76 studies found an average effect size of $d = .42$, suggesting a

moderately strong benefit from cultural adaptation of treatment (Griner & Smith, 2006). Further, interventions targeted to a specific cultural group were found to be four times more effective than groups with culturally diverse participants and interventions conducted in the participant's primary language (rather than English) were twice as effective (Griner & Smith, 2006). Pan, Huey, and Hernandez (2011) make a significant contribution with an effectiveness study comparing a randomized pilot evaluation of standard one-session treatment (OST-S) versus culturally adapted OST (OST-CA) with phobic Asian Americans (Pan et al., 2011). This study (*n = 30*) found that both OST and OST-CA treatments outperformed the self-help control condition. Further, they found that the culturally adapted condition was more effective than the standard treatment for two phobia related outcomes, catastrophic thinking and general fear. They further found acculturation level of the participant moderated outcomes. Most recently, Nagayama Hall et al. (2016) examined eleven meta- analyses of culturally adapted vs. unadapted psychological interventions. This analysis included prevention interventions as well as treatment interventions. This meta-analysis included 78 studies, spanning 13,998 participants (51% women/girls; 24% non-US interventions; 29% African American or African; 30% Asian American or Asian; 26% Latino; 4% First Nations or Native American; and 1% Arab ancestry). Nagayama Hall et al. (2016) found an overall effect size of *.67*, indicating that culturally adapted conditions achieved substantially better outcomes than non-adapted comparison controls.

Specific Aims and Objectives

The ambition of this dissertation was to refine a model, developed from the existing cultural adaptation theoretical literature, and to review the most current culturally adapted psychotherapeutic and psychosocial interventions through the lens of this model.

The specific objectives of this dissertation were:

1. To conduct a comprehensive literature review of the most current cultural adaptation research (2000-2015).
2. To develop a model based on theoretical and practical existing literature on cultural adaptation.
3. To critically analyze existing culturally-adapted psychotherapy and psychosocial interventions through the lens of this model in terms of:
    a. Research evidence and methodological issues
    b. Theoretical bases for adaptation
    c. Provisions for:
        i. Cultural context and content
        ii. Engagement efforts
        iii. Development and equivalence processes
        iv. Therapist cultural competence
    d. Process of adaptation creation
    e. Outcomes of the adapted intervention where data is available
4. To categorize existing culturally adapted psychotherapy interventions by:
    a. Cultural group
    b. Theoretical approach (e.g., cognitive behavioral, psychodynamic, ecological, etc.)
    c. Psychological disorder (e.g., DSM-5 diagnosis) or target issue (e.g., parenting)

for the purpose of informing professional practice and exposing gaps in current literature.

5. To provide suggestions and illuminate implications for future research and practice.

Chapter 2: Literature Review

Empirically Supported Treatment and Practice

The commitment to research, science, and evidence as the cornerstone of applied psychology has existed since the founding of the first psychological clinic in 1896 (APA, 2006). As early as 1947, the American Psychological Association mandated that doctoral psychologists be educated as scientists and practitioners (APA, 2006). In 1952, Hans Eysenck first published research, hotly contested even at the time, that indicated that psychotherapy failed to produce results that exceed that of changes in life over time (Fago, 2009; Kazdin, 2008). Research into psychotherapy treatment exploded. Since the 1950s, well-controlled outcome studies (randomized controlled trials [RCTs]) have established specific therapies and interventions for specific disorders, conditions, and target problems, establishing a body of ESTs. Currently, the existence of two randomized controlled trials conducted by independent research teams is the current standard for the classification of a well-established EST (Tolin et al., 2015). At the same time, there exists a body of interventions described as evidence based interventions (EBIs), which are derived from a broader base of empirical support than just randomized controlled trials, which are costly to conduct and difficult to obtain funding for. APA standards expect psychologists to have an *evidence-based practice*. "Evidence-based practice in psychology is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (Levant, 2005, p. 5). Psychologists are expected to stay informed about the best practices indicated by current research for the best patient outcomes and care (Falzon, Davidson & Bruns, 2010). In short, ESTs are just one form of evidence that comprises the "best available research" evidence (Figure 1). Making these distinctions more difficult is that fact that these terms are used interchangeably throughout literature and practice

and have continued to be refined over time with increased emphasis, in recent years, on specific, manualized treatments such as Trauma Focused Cognitive Behavioral Therapy (TF-CBT) or Cognitive Processing Therapy (CPT), whereas earlier literature may discuss something Cognitive Behavioral Therapy broadly (without a manual) as an EST. Confusing matters even further, VA, the largest trainer of psychologists, refers to these specific, manualized treatments as evidence based psychotherapies (EBPs; Department of Veterans Affairs, June 22, 2015). Fidelity to the distinctions between these terms is important and clarity is attempted throughout this dissertation, however, when quoting from primary source material, some term confusion may be evident.

Figure 1. Evidence based practice in psychology.

Despite support for psychological practice grounded in research, agencies, professions, professional organizations, and other stakeholders, both domestic and international, assess and define what constitutes an evidentiary base on a variety of different criteria (Kazdin, 2008).

The field of psychology is not alone in its increased emphasis on ESTs. Psychology is just one member of the multi-disciplinary, medical framework that includes medicine and nursing, the stakeholders of which govern health care decisions at the consumer and provider level (APA, 2006). There is widespread effort from federal and state agencies, state and local funding requirements, hospital administrations, and insurance companies to inform and provide

mental health interventions for which there is empirical support (Fago, 2009; Kazdin, 2008). These efforts have created controversy and division between clinicians and researchers within psychology as clinicians argue that conditions between experimental conditions and real-life conditions differ dramatically in terms of heterogeneity of clinical presentation, selection of participants, and context of client and therapist, and, as a result, the findings of the research fail to generalize to real life (Hwang, 2006b; Kazdin, 2008; Lau, 2006).

Not only are experimental and real-life conditions vastly different, but non-White participants are under-represented in psychological research studies, contributing to the marginalization of diverse communities in psychological study (Muñoz & Mendelson, 2005; Sue, 2009; Watkins, 2012). Watkins (2012) conducted a meta-analysis of 104 studies on psychodynamic psychotherapy, including over 9,000 participants from 1960-2010 and discovered that in 75% of the studies, race and ethnicity information was not even gathered. Of the 25% of studies that did ask for race information, 75% of those participants were White, and of the 25% who identified as non-white (primarily African American and Hispanic) 80% of those came from three data sets (collected more than 15 years ago) from studies focusing on cocaine and opiate users. A total of 50 years of research into psychodynamic psychotherapy yielded virtually no information on the efficacy of psychodynamic psychotherapy with non-white participants. Watkins argues that:

> [Psychodynamic psychotherapy is not] a for Whites only treatment but our research up to this point does little to belie that interpretation. Unfortunately, unless we actively work to change the grounds for that interpretation, the relevance and richness of psychodynamic treatment for an increasingly diverse clientele may well go widely under recognized and vastly underappreciated. (p. 298)

As late as 1996, APA Division 12 (Clinical Psychology), tasked with identifying and defining ESTs, reported that not a single EST met criteria required to demonstrate efficacy with

clients of color (Muñoz & Mendelson, 2005). Significant progress has been made in the intervening 20 years, in large part due to the cultural adaptation studies included within this review. The APA Division 12 website provides an alphabetized list of psychological treatments with a description of the treatment and its research support; the list is also searchable by psychological disorder. However, while studies highlighting ethnoculturally diverse samples and/or cultural adaptations are listed within the description of individual treatments, there remains no way to search for treatments by target population. Psychology's purported aim is to study human behavior and to use that study to inform clinical practice, however, study samples are overwhelming White, educated, Euro/American, and English-speaking and their applicability with ethnic minority populations remains unproven (Bernal et al., 1995; Guthrie, 1998; Muñoz & Mendelson, 2005; Taylor, 1999).

While there is little research to demonstrate the applicability of ESTs developed and normed on White sample populations, there is also little research suggesting that ESTs *are not* effective for diverse populations. Proponents of *fidelity* argue that ESTs should follow a proscribed set of procedures, based on the hypothesis that the mechanisms of change, theory, and procedural models are largely universal for all clients; this perspective draws heavily from a conceptualization of psychological treatment in line with the medical model and aims to increase psychology's similarities to medicine through efficiency and standardization, while allowing for clinical judgment (Spring, 2007). Even among those who are critical of the implementation of ESTs with diverse populations, there exists a perspective that cultural adaptation of ESTs is excessively costly, time-consuming, creates too much difficulty in terms of training clinicians, and is simply not feasible given the vast ethnic and cultural variation in the United States and around the world (Hwang, 2006b; Kazdin, 2008). Proponents of this argument appear to

suggest that expedience is sufficient rationale to disregard the variability of the human population and privilege the worldview of the few to the detriment of the many and that, because a task is difficult, it should not be undertaken. Interestingly, one strains to hear similar arguments for other high-cost clinical innovations such as the abundance of research conducted in the area of neuroanatomy.

While there is increasing endorsement of the view that culture is an important mediating factor in psychotherapy interventions, clinicians and researchers offer different solutions on how and whether to address culture within ESTs. Miranda et al. undertook a comprehensive review of the available literature on the use of ESTs with various ethnocultural populations in 2005. Miranda et al. (2005) looked closely at treatment outcome data for children, adolescents, and adults, offering support for the efficacy of culturally adapted treatment as well as the efficacy of (in some cases) non-adapted ESTs with clients of color. For example, Miranda et al. (2005) reviewed two studies affirming the efficacy of a culturally adapted Cognitive Behavioral Therapy (CBT) intervention for Latino youth experiencing depression. These culturally adapted EST studies provide valuable information about treating Latino youth with depression because previously no published studies examined the relative effects of CBT for reducing depression among any different ethnic groups. Their results suggested that many ESTs are effective for populations of color, particularly with African American and Latino populations. However, literature that establishes ESTs for use with Asian populations is sparse and is virtually nonexistent for Native American populations (Miranda et al., 2005). Miranda et al. (2005) stated the following in conclusion:

> Our review of the literature has led us to believe that evidence-based care is likely appropriate for most ethnic minority individuals. In the absence of efficacy studies, the combined used of protocols or guidelines that consider culture and context with evidence-based care is likely to facilitate engagement in treatment and probably to enhance

> outcomes. In conclusion, we encourage clinicians to provide state-of-the-art, empirically supported care to our ethnic minority populations. We also believe that tailoring this care to be sensitive to the culture of the individual is extremely important. *It is our hope that future research will help us to systematically identify ways to consistently tailor care to be most effective for diverse clients* [emphasis added]. (p. 135)

More recently, Chu and Leino (2017) undertook a systematic review of 45 cultural adaptations published over a 20-year time span with the specific goal of contributing the debate over fidelity and cultural adaptation. In their review they examined what they described as EBIs, however, ESTs formed the basis of evidence used. Their review found that all adapted EBIs in their study made changes in what Chu and Leino term "peripheral components" or changes in how clients were engaged in treatment (e.g., through modifications in location, timing, orientation strategies, retention strategies, and communication style). However, only 11.11% of culturally adapted EBIs within the 2017 review yielded core therapeutic component modifications. Instead, "60.0% *required core additions* that address sociocultural, cultural skill, and psychoeducation needs" [emphasis added] (p. 45). This recent addition to the discussion of cultural adaptation reinforces the notion, widely advocated by cultural psychologists and psychologists interested in indigenous healing modalities, that the current frameworks are inherently limited in their ability to meet the needs of ethnoculturally diverse communities and must be augmented in ways that are context-specific (Gone, 2004; Harrell, 2015; Kim, 2000; Kwate, 2005; Marsella, 2015; Nobles, 2013; Piper-Mandy & Rowe, 2010; Walker, Whitener, Trumpin, & Migliarini, 2015).

Cultural Adaptation

In the intervening ten years since Miranda et al. published their review, much work has been done to define cultural adaptation and to establish systems and methodologies of adaptation. Harrell (2015) describes three different treatments of culture within the field of

psychology: cultural categorization, cultural comparison, and cultural infusion. Cultural categorization seeks to include under-represented groups in research samples but makes no other efforts to acknowledge culture. Cultural comparison has historically ignored issues of intersectionality, focusing instead on narrow aspects of culture such as demographics, and assumes a normative standard against which diverse groups are judged (Harrell, 2015). As Harrell points out, cultural comparison research can yield valuable information and has been a prolific area of the field. In the last thirty years, hundreds of comparison studies have been undertaken, outlining and describing differences between groups in terms of social and affective experiences (Markus & Kityama, 2010). A very common example of cultural comparison is the binary construct of individualist/collectivistic cultures or independent/interdependent views of the self. However, these binaries fail to account for the complexity and dynamism of culture as it is experienced (Harrell, 2015; Miller, 2002). Miller (2002) argues:

> The inattention to meanings in interpreting views of self, relationships, and groups contributes to the tendency, in the individualism–collectivism literature, for straw man hypotheses to be formulated regarding anticipated cross-cultural differences. Such hypotheses are then easily refuted by empirical findings, which in turn are interpreted as demonstrating that culture appears less important than originally claimed. (p. 102)

A more thorough discussion of the pitfalls of cultural categorization (also called cross cultural psychology) is explored later in this chapter.

Cultural infusion, as defined by Harrell (2015) begins with utilizing "theoretical frameworks…that incorporate culture into the foundational conceptualization of human behavior and experience. Cultural processes are infused into multiple aspects of the research or intervention process" (Harrell, 2015, p. 34). According to Harrell, there are two types of cultural infusion approaches: cultural adaptation and cultural specificity. Cultural adaptation refers to using a model/theory/intervention that was designed and validated with one population

and then adapting it to a culturally different population. Cultural specificity refers to focusing an intervention on one intersectional niche (e.g., 2nd generation Japanese American women in Los Angeles; Latino migrant workers in central California) and building an intervention out of the specific ways of being and belief systems operant in those communities. For the purposes of this inquiry, it is cultural adaptation interventions (as defined by Harrell) that will be explored in detail as all empirically supported treatments in the United States have been normed on predominantly white and highly educated samples. Again, this narrowing of focus does not presuppose that cultural adaptation interventions are superior to cultural specificity interventions, but rather seeks to offer guidance for clinicians and researchers operating in an environment which identifies empirically supported treatment as the standard of care (Levant, 2005). In order to explore how these distinctions inform psychotherapy and psychosocial interventions, it is important to look more closely at the history of scientific thought and its relationship to the exploration of culture in the field of psychology.

History of Scientific Thought and Research Methodologies

A full exploration of the history of Western thought and its relationship to psychological inquiry is outside of the scope of this review (see Ponterroto, 2005, for a more comprehensive analysis). In brief, however, psychological science is located within the trajectory of philosophical thought that has its origins in the 17th and 18th century Enlightenment. "Enlightenment brought with it the notions of the centrality of the individual, the world as objectively knowable, and the use of language (including numerical language) as the conveyor of truth" (Ponterroto, 2005, p. 128). Positivism is the philosophy of science that emerges logically out of the Enlightenment. Emerging in the 19th century, positivism focuses on efforts to verify hypotheses, most often stated quantitatively and converted into mathematical formulas that

express functional relationships. The primary goal of positivism is to explain a given phenomenon, eventually leading to prediction and control of said phenomena (Creswell, 2009; Ponterroto, 2005). While the postpositivist school of thought arose out of dissatisfaction with the positivism view, many of the basic tenets of positivism remained, notably the goal of prediction and control of phenomena. The constructivist-interpretivist is an alternative view, which holds that reality is constructed subjectively in the mind of the individual, rather than existing as an external entity. Ponterroto (2005) explains that "the goals of constructivism–interpretivism are both idiographic and emic. Qualitative research….can be traced back to [constructivist thought] (p. 129)." Critical theory has earlier roots, but emerged as a powerful force in intellectual thought in the 1960s. Central to critical theory is an emphasis on power relationships as a mediator of human experience. The goal of critical theory is liberation from oppression and a more egalitarian social order (Creswell, 2009; Ponterroto, 2005). Critical theory and the constructivist/interpretivist approach have many overlapping views, specifically the stance that reality is constructed within a socio-historical context. The shift from a positivist to a constructivist-interpretivist/critical perspective is significant for discussions of culture within psychology. Kral (2008) highlights the move, in the 1970s, from positivism to interpretivism, "based on the belief that 'the intelligibility of any action requires reference to its larger context, a cultural world'" (p. 260). The interpretivist goal is not consensus, but rather "an understanding of the multivocal community in which individuals reside, examining social and intersubjective, rather than merely individual practices" (Kral, 2008, p. 260).

While anthropology and other interpretive social sciences have a long history of centering the lived experiences of individuals through research methodologies like ethnographies, mainstream psychology hews to an Enlightenment-era worldview that prioritizes logical

positivism and empiricism, as evidenced by psychology's prizing of quantitative, experimental research design (Kral, 2008).

> The discipline of psychology has built for itself a scientific methodological fortress with quantitative, objective knowledge as its goal. Its walls are thick and while its doors tend to open easily for newer scientific methods, e.g., bio-electronic, they are still drawn almost closed for methods often still viewed as less scientific (e.g., hermeneutic or qualitative). (Kral, 2008, p. 258)

Recognizing the powerful bias towards the etic, the universal, the quantifiable within psychology based on its positivistic origins, sheds light on research like that of Rennie et al. (2002). Rennie et al. performed a content analysis search using the entire 20th century's available literature (1900-1999). The researchers entered five search terms (qualitative research, grounded theory, discourse analysis, phenomenological psychology, and empirical psychology) into the PsychINFO database to track methodological changes and trends in published research. The researchers discovered that even in the 1990s (the peak decade of the survey), the submitted terms results in hits accounting for less than one half of 1% of the total. Seminal ethnic psychology researcher, Stanley Sue, summarizes thusly:

> Criteria used to judge the suitability of research for publication and for funding are selectively enforced so that internal validity is elevated over external validity. Because ethnic minority research is not as well developed as mainstream research and is more difficult to conduct, internal validity criteria suppress research progress. This in turn keeps ethnic minority research from becoming better developed. Thus the very tools used in psychological science—research methodologies and emphases—steer us away from culture. (Sue, 2009)

Why is this significant? Psychology is built on foundational theory and science that has systematically ignored the perspectives on human functioning that derive from outside of the Euro-North-American worldview. All subsequent work will, therefore, reify that worldview without specific efforts to broaden the frame. The bias towards positivism further narrows psychology's scope, such that easily reducible variables are preferred (in order to produce

statistically significant outcomes, which in turn confer funding, institutional support, and professional status) over constructs like culture that do not easily reduce to controllable variables, This is the epistemological as well as methodological fortress that Kral (2008) references, and it can be argued that its exclusion of culture and culturally diverse peoples is a feature, and not a flaw, of the design.

Cross-Cultural Psychology and Cultural Psychology

Consistent with the positivist/quantitative and constructivist/critical/qualitative divide, exploration of culture has historically been encapsulated in one of two perspectives. Group comparison research designs, what Cole (1996) calls the "culture-as-context" view (p. 334) (also called cross-cultural psychology), aim to uncover truly universal models and processes that can explain and be applied to all peoples (Cole, 1996; Kral, 2008; Miller, 2002). In contrast, the "culture-as-constructed" (Cole, 1996, p. 334) view investigates local meaning and "is a search for subjective/intersubjective, agentic, and contextualized meanings as an additional form of understanding people" (Kral, 2008, p. 265). While cross-cultural psychology dominated most of the 20th century's psychological research into culture, cultural psychology enjoyed a renewed interest in the late 20th and early 21st centuries, consistent with critical and constructivist re-assessment of knowledge (Miller, 2002; Sue, 2009).

The distinct goals of cross-cultural psychology (the universal) and cultural psychology (the specific) are critically important and contribute to very different theoretical perspectives and applications. Miller (2002) explains,

> Early cross cultural work on individualism and collectivism did not challenge the universality of basic psychological theory or call into question the assumption—held also in mainstream psychology—that psychological processes do not depend on culture for their basic form. (p. 99)

Cultural psychology, by contrast, is a heterogeneous "marketplace" of ideas (Valsiner,

2009, p. 5) and disciplines, including psychology, anthropology, and philosophy (Bruner, 2008; Kral, 2008; Valsiner, 2009). Bruner (2008) writes that throughout cultural psychology's history,

> It has remained remarkably steady in its dedication to a single cardinal issue: how mind comes under the sway of culture— mind as somehow ''inside'' and subjective, culture as ''outside'' and superorganic….How, if you will, does the ''outside'' get ''inside''? That has been the guiding query. (p. 29)

Bruner (2008) argues that culture is both transindividual and superorganic, *and* subjectivized and local. That is to say that people in all cultures have their own conception of what is "real" in their local life, but also understand norms or "rules" (both implicit and explicit) governing behavior with respect to those realities. Miller (2002) summarized three significant insights developed out of cultural psychology:

> (a) The contextually mediated nature of cultural influences on psychological functioning, (b) the importance of social practices in underlying cultural variation in behavioral outcomes, and (c) the complexity of sociocultural processes. (p. 99)

A full discussion of implications of these insights is beyond the scope of this review but, it is worth noting that research derived from this tradition of thought has provided a powerful counter-argument to widely-held psychological views (codified and enforced by intelligence testing, school systems, and public agencies, etc.) on a wide range of subjects including cognitive functioning in unschooled populations, patterns of language socialization, literacy practices of public education systems, and more (Miller, 2002).

Defining Culture

Definitions of culture abound (Brunner, 2008; Harrell, 2015; Shweder, 1999). A few favorites are presented here: the shared meanings that make social life possible (Christopher, 2001); shared ordinariness (Brunner, 2008); an "untidy and expansive set of material and symbolic concepts, such as world, environment, contexts, cultural systems, social systems, social structures, institutions, practices, policies, meanings, norms, and values, that give form and

direction to behavior" (Markus & Kitayama, 2010, p. 422); and the social, political, historical, and economic contexts of peoples' lives and that impact their behavior (APA, 2003). The influential cultural anthropologist, Clifford Geertz (1973) wrote,

> Man is an animal suspended in webs of significance he himself has spun, I take culture to be those webs, and the analysis of it to be therefore not an experimental science in search of law but an interpretive one in search of meaning. It is explication I am after, construing social expressions on their surface enigmatical. (Geertz, 1973, p. 5)

Christopher (2001) relates Geertz's 'webs of significance' to the concept of "signification" articulated by hermeneutic philosopher, Martin Heidegger. Christopher explains:

> According to Heidegger, the most fundamental aspects of our agency, what he called being-in-the-world, presuppose care, concern, and signification. In other words, our behaviors, thoughts, and feelings are underwritten by deep assumptions concerning what is real, important, and valuable. Culture, then, can be thought of not only as webs of significance but also as webs of care….care refers to what we value, what we attend to in life, what we give our time and energy to, the aspects of reality that we focus upon. (Christopher, 2001, p. 117)

Harrell (2015) offers this definition of culture in an attempt to capture the complexity that is so often oversimplified:

> the multiple historical, sociopolitically-situated, and organizing systems of meaning, knowledge, and daily living that involve patterns of being, believing, bonding, belonging, behaving, and becoming which provide foundational frames for developing worldview, interpreting reality, and acting in the world for a group of people who share common ancestry, social location, group identity, or defining experiential context; but for whom, as individuals or intersectional subgroups, particular elements of a cultural system may be embraced, internalized, and expressed differently. Cultural systems emerge and transform over time through cumulative and adaptation-oriented person-environment transactions, and are maintained and transmitted through collective memory, narrative, and socialization processes. (Harrell, 2015, p. 18)

As a brief example of the profound impact of culture on the conceptualization of human behavior, theory of mind is the innate human ability to understand the thoughts, perspectives, beliefs and intentions of others (Cozolino, 2010; Lillard, 1998). It is believed that a theory of mind begins to develop in very young children, starting at age 18 months and developing

throughout childhood (Santrock, 2011). Contrary to a single, homogenous theory of mind, research shows that people have the capacity to hold multiple meaning-making narratives by which they attempt to understand themselves (Mandler, 2011). Lillard argues that the theory of mind that psychology has taken to be universal is, in fact, the specific theory of mind that emerges out of European American (EA) culture. In an EA theory of mind, the mind is understood to be rational, it is the origin of feelings and thoughts, the mind is able to overcome emotions, it is housed in the brain, it is private (other people cannot read your mind) but knowable (you can understand and explain your own mind), and it is understood to be separate from the body. Lillard cites folk psychologies around the world with theories of mind applicable to those communities. For example, Lillard describes the Illongot people of the Philippines. The Illongot have a concept of *rinawa.*

> Rinawa's characteristics are in some ways very different [from the EA "mind"]: It can leave the body during sleep, it animates the body while alive, and it gradually leaves over the life course, making it thin in older persons. The Illongot truly have a different concept of mind in terms of its physical identity, functions, and characteristics, although in some ways it overlaps with the EA concept. (p. 12)

While the word culture strains the ability to create a tidy, concise definition, this brief example highlights how thoroughly culture provides the foundational understanding of reality, from what we value, to daily living patterns, to theory of mind.

Cultural Adaptation Theories, Forms, and Models

The theory and research of culturally appropriate psychological interventions emerges out of a relatively recent period in Western scientific thought in which a human experience is recognized as complex and culturally-constituted. It is now important to turn to how cultural adaptation (used broadly) has been conceptualized, developed, and implemented. Emergent from psychology, there are four primary models of cultural adaptation that and one meta-model

whose major contributions, differences, and common themes will provide direction for the inquiry of this dissertation, those are: Bernal's Ecological Validity Framework (Bernal et al., 1995); the Psychotherapy Adaptation and Modification Framework (PAMF; Hwang, 2006b); A Selected and Directed Approach for Youth (Lau, 2006); the Heuristic Framework for the Cultural Adaptation of Interventions (Barrera & Castro, 2006); and the meta-model of Cultural Competence, as articulated by Derald Sue et al. (1982). Important contributions from the field of public health are also described. The cultural competence foundational meta-model will be presented first, as the ideas contained within the cultural competence literature are not represented as a discrete model, but rather than evolution of thought that is ongoing today. The four primary models will be presented in chronological order followed by a brief description of public health adaptation models.

Cultural Competence

In 1962, C.G. Wrenn wrote:

> The counselor, like the rest of mankind, protects himself against the disturbing reality of change by the maintenance of an encapsulation within a subculture of his own based upon the pretense that the present is enduring. In attempting to work from his "present" to the client's "present" and "future" it is necessary for the counselor to examine his personal patterns of pretended reality. These may include the tendency to be surprised or even unbelieving regarding changes in truth, the cushioning of the counselor in academic cocoons having little relevance to the total culture, and the assumption that it is safe to draw upon one's own education and experiences in counseling. (p. 444)

Since that time, multicultural psychology and cultural competence have become mainstream buzzwords, achieving popularity in graduate school admissions materials, internships applications, and job descriptions. However, recognition of the need for cultural competence is decades old, with calls to action throughout the 1960s and 1970s. The American Association of Black Psychologists (ABPsi) was established in 1968, calling for cultural competence against the cultural hegemony of the APA (Rowe, 2018, personal communication).

An early and influential multicultural counseling textbook was written in 1981 (Sue, 1981) and in 1982 a comprehensive list of cultural competency benchmarks for practitioners was clearly outlined in a position paper for APA Division 17 (Counseling Psychology) (Romero and Chan, 2005; Sue et al., l992; Sue et al., l982). However, while these benchmarks were praised, they were not codified into professional guidelines and standards for psychology as a whole until 2003, over 20 years later (APA, 2003). Sue writes powerfully about the resistance to cultural competence from within the field of psychology:

> As a whole, the profession has not always been a willing participant in the recognition, endorsement or infusion of multiculturalism into our standards of practice, code of ethics, and training programs. At best, the mental health professions can be characterized as unenlightened and reluctant to consider racial/ /cultural issues in counseling and psychotherapy; and, at worst, they have been downright hostile, antagonistic, and guilty of cultural oppression. . . . We recognize that these are strong allegations that arouse intense emotions in many of our colleagues. Yet, this book is about multicultural competence; and, multicultural competence demands that we take responsibility for and acknowledge potentially unpleasant aspects of our societal, professional, and individual histories. (Sue et al., 1998, pp. xi–xii)

While cultural competence is now considered the ethical standard (APA, 2003, 2016), with the 2016 APA Multicultural Guidelines update providing a significantly more robust set of directives, problems persist in terms of both training and implementation. Scholars argue that personal exploration is a critical component of cultural competence (Charles, 2007; Comas-Díaz, 2005). However, there is great variety in the level and degree of personal examination of background, bias, power, experience, and attitudes among clinicians and training programs (Sue, Torino, Capodilupo, Rivera, & Lin, 2009). In fact, research suggests that White faculty experience such anxiety when addressing racial issues in the classroom that their pedagogical effectiveness is compromised, and that students of color experience subtle discouragement from discussing racial issues with faculty or students (Sue et al., 2009). Research on White psychology graduate students suggest that while students reported greater multicultural

competence over the course of their training, their implicit racial biases remained unchanged (Boysen & Vogel, 2008). Even when training programs encourage cultural awareness of self and other, some trainees report that supervisors in the field are hesitant to "expand the therapeutic context….in ways that challenge the therapeutic status quo" (Gallardo et al., 2009, p. 429). Counselors who attempt to adopt multiculturally competent practices may find themselves challenging the well-entrenched standards of practice, professional code, and ethics (Romero & Chan, 2005). When practicing clinicians are faced with a clinical dilemma, the lack of wholesale integration of cultural issues within clinical formulation lead some clinicians to prioritize clinical competence *sans culture* for fear of violating their professional ethics (Gallardo et al., 2009). And, even well-intentioned efforts to increase cultural knowledge, can lead to stereotyping (Lake, Lopez, & Garro, 2006; Sue, 2009).

In keeping with the self-disclosing, emic, qualitative style typical of scholars writing about culture, several prominent psychologists have written movingly and personally about their own cultural backgrounds, the impact of their background on their worldview, their experience entering the field of psychology and their growth and development of their cultural identity and cultural competence (Charles, 2007; Comas-Díaz, 2005; Harrell, 2015). These narratives offer much insight into how the academy and training programs within psychology can both foster and inhibit cultural competence.

In the paper that lays the foundation for what would become the 2003 APA Multicultural Guidelines, D.W. Sue et al. (1992) outlined the three dimensions: (a) beliefs and attitudes, (b) knowledge and, (c) skills. The authors explain:

> The first deals with counselors' attitudes and beliefs about racial and ethnic minorities, the need to check biases and stereotypes, development of a positive orientation toward multiculturalism, and the way counselors' values and biases may hinder effective cross-cultural counseling. The second recognizes that the culturally skilled counselor has good

> knowledge and understanding of his or her own worldview, has specific knowledge of the cultural groups he or she works with, and understands sociopolitical influences. The last deals with specific skills (intervention techniques and strategies) needed in working with minority groups (it includes both individual and institutional competencies). (Sue et al., 1992)

See Sue et al. (1992) for a full exploration of the tripartite model. Sue and Zane (1987, 2009) add to the discussion of cultural competence as an exploration of therapist credibility and giving. They state that the therapist must achieve credibility within the first few sessions, particularly with a non-White client who is unlikely to proffer high ascribed credibility to the therapist or the treatment. The researchers argue that achieved credibility is influenced by therapist/client match, not in terms of ethnicity or race, but in terms of (a) conceptualization of presenting problem, (b) means for problem resolution, and (c) goals for treatment. Sue and Zane do not argue that the therapist and client always need to agree, but rather they suggest that the therapist must be alert to discrepancies and inconsistencies, recognizing that, when inconsistencies occur, it leads to decreased credibility for the therapist which must be rectified either through reconsideration of the treatment strategy or demonstration of the validity of the therapist's point of view. Rather than cultural competency being a test of cultural knowledge, Sue and Zane argue "the role of cultural knowledge is to alert therapists to possible problems in credibility" (Sue & Zane, 2009, p. 9).

Ecological Validity Framework (Bernal et al., 1995)

Bernal et al.'s (1995) ecological validity framework builds off of the work of Urie Bronfenbrenner (1977) on ecological validity in treatment research and is designed to "increase the congruence between the client's experience (of his or her cultural or ethnic world into a particular treatment program) and the properties of that treatment assumed by the clinician or the investigator" (Bernal et al., 1995, p. 70). Bernal outlines possible pitfalls of what he names

culturally sensitive intervention, specifically stereotyping and/or overemphasis on culture to the detriment and distraction of the treatment. Bernal's original framework was designed based on research with Hispanic populations and outlines eight dimensions of culturally sensitive interventions:

1. Language
2. Persons (ethnic match between client and therapist)
3. Metaphors (sayings, idioms, "dichos")
4. Content (cultural knowledge, values, traditions, aspects unique to the group)
5. Concepts (e.g., interdependence vs. independence)
6. Goals (to support the adaptive values of the culture)
7. Methods (development of unique treatments/adaptation of pre-existing treatments)
8. Context (e.g., acculturation, phase of migration, social support)

This model was used to adapt CBT and interpersonal therapy (IPT) for use with Latino, adolescent populations experiencing depression and two randomized, controlled studies were undertaken to examine the efficacy of the interventions and both interventions were found to produce positive outcomes (Bernal & Domenech Rodriguez, 2009). This model was also used to adapt a parent-child interaction program with Puerto Rican children and families (Bernal & Sáez -Santiago, 2006; Sáez-Santiago, Bernal, Reyes-Rodríguez, & Bonilla-Silva, 2012).

The ecological validity model was later expanded the eight dimensions into ten target areas and proposed a three-stage process of adaptation that includes community participation. During the initial phase of the adaptation, the intervention leader or researcher collaborates with a community opinion leader to "find a balance between community needs and scientific integrity" (Bernal et al., 2009, p. 365). In the second phase, evaluation measures for assessing

the intervention are selected and adapted in a parallel process to the adaptation of the intervention itself. In the final stage, the insights and data gathered in phases one and two are packaged into the new intervention. Throughout all three phases, there is an ongoing process of evaluation, revision, and reinvention (Bernal et al., 2009).

Psychotherapy Adaptation and Modification Framework (PAMF; Hwang, 2006b)

Hwang (2006b) significantly reframes the cultural adaptation discussion from Bernal et al. (1995) and Bernal et al. (2009) whose major contributions are the inclusion of community members and the articulation of specific domains in which culture should be addressed. Hwang focuses on engagement and retention of minority clients in treatment as key factors contributing to poor outcomes. Bernal et al. specifically cite ethnic match as a desirable cultural adaptation, whereas Hwang cites Sue (1998, as cited in Hwang, 2006b), who suggests that, rather than ethnic match between therapist and client, it is cultural competence on the part of therapist that makes a crucial difference in engagement and treatment retention. Hwang's Psychotherapy Adaptation and Modification Framework (PAMF) was developed based on his research with Asian American clients, however, Hwang suggests that the model is applicable to other groups. The specific inclusion of cultural competence on the part of the therapist, the focus on culturally-derived conceptualization of illness and wellness, as well as the primary importance placed on engagement and retention of clients are the major contributions of PAMF. PAMF is a synthesis of two frameworks: the cultural influences on mental health model, in which Hwang outlines six treatment domains influenced by culture:

> (a) the prevalence of mental illness, (b) etiology of disease, (c) phenomenology of distress, (d) diagnostic and assessment issues, (e) coping styles and help-seeking pathways, and (f) treatment and intervention issues. (Hwang, 2006b, p. 705)

His model consists of 18 therapeutic principles for working with Chinese American clients. The

resulting model (PAMF) consists of:

> six therapeutic domains and 25 therapeutic principles. The domains include the following: (a) dynamic issues and cultural complexities, (b) orienting clients to psychotherapy and increasing mental health awareness, (c) understanding cultural beliefs about mental illness, its causes, and what constitutes appropriate treatment, (d) improving the client–therapist relationship, (e) understanding cultural differences in the expression and communication of distress, and (f) addressing cultural issues specific to the population. (Hwang, 2006b, p. 706)

Hwang calls for a top-down theory driven approach to intervention adaptation that includes a bottom-up aspect, for example, holding focus groups with community members to solicit input. "The three-tiered framework of the PAMF (i.e., thinking about broader domains, developing specific therapeutic adaptation principles, and critically thinking about the rationale for modifications) provides a sequential framework for approaching therapy adaptation" (Hwang, 2006b, p. 706). Hwang also suggests preemptively addressing issues that contribute to treatment failure such as stigma, early drop-out, lack of understanding of the therapy process, and conflicting expectations of therapist/client roles based on cultural norms (both the client's and the therapist's).

A Selected and Directed Approach for Youth (Lau, 2006)

Lau (2006) presents a conservative view of adaptation, calling for a selected and directed approach to cultural adaptation for youth/family interventions, focusing on constellations of presenting problems/target communities for which there is likelihood of generalizability failure of ESTs. Lau argues that

> A selective approach based on evidence of poor fit between particular ESTs and particular communities is meant to focus treatment adaptation efforts where they are most needed, while safeguarding against less defensible, improvised drifts away from EST fidelity in the name of cultural competence. (Lau, 2006, p. 297)

Lau argues for two primary circumstances for which a culturally adapted treatment is appropriate and warranted. Firstly, when there are community-specific processes of

developmental psychopathology (cultural ontology of symptoms), cultural adaptation is warranted. For example, the high rate of suicide attempts among Latina adolescents; cultural discrimination factors and "historical loss" (Lau, 2006, p. 298) related to Native Americans and substance use disorders; and the unique presentation of panic symptoms and posttraumatic stress in Southeast Asian refugees (Lau, 2006). Secondly, Lau, like Hwang (2006b), views engagement as a means of measuring the social validity of an intervention. She argues that where there is low social validity, for example when members of the community view a therapeutic intervention as useless or problematic, cultural adaptation is also warranted. Lau calls for research into cultural adaptation to proceed along two lines of inquiry contextualizing content and enhancing engagement. Lau provides detailed examples from two parent management training interventions, adapted for underrepresented communities as exemplars of adaptation targeted towards culturally appropriate content and engagement of participants as a way to improve outcomes.

Heuristic Framework for the Cultural Adaptation of Interventions (Barrera & González-Castro, 2006)

Barrera & González-Castro (2006) respond to Lau's (2006) analysis of the state of cultural adaptation research by providing a framework for therapeutic intervention that borrows from the widely accepted procedures of linguistic translation of psychological testing measures to determine equivalence. In determining equivalence of psychological measures, researchers test for equivalence of (a) language/content, (b) reliability, (c) validity, (d) factor structure, and, sometimes, (e) magnitude of scores.

> For research that compares two or more subcultural groups, we are proposing a tripartite framework with subcomponents to evaluate equivalence of (a) *engagement*, (b) *action theory*, the ability of treatments to change mediating variables, and (c) *conceptual theory*, the relations between mediators and outcomes. Observed differences at each step of this framework could identify aspects of EST content and implementing procedures that merit

> adaptation. [emphasis added] (Barrera & González-Castro, 2006, p. 312)

Barrera & González-Castro (2006) outline four steps to generating an adaptation. These four steps are largely consistent with those described by Hwang (2006b) and Bernal et al. (1995), suggesting consensus is emerging about how to develop a cultural adaptation. Barrera González-Castro (2006) describe the process as: (a) information gathering, including qualitative and quantitative research and incorporating community feedback; they particularly suggest an organized and systematic partnership with a wide range of community stakeholders (e.g., agencies, providers, clients); (b) preliminary adaptation design; (c) preliminary adaptation tests; and (d) adaptation refinement through case studies or pilot testing, to be evaluated within a research design capable of assessing whether the intervention had the desired effects on the three key domains of engagement, action theory, and conceptual theory. While not included in their stage model, Barrera and González-Castro (2006) also highlight cultural competence of the therapist as a key factor mediating effectiveness of interventions.

Contributions from Public Health

Public health, as a discipline, has devoted significant scientific resources to establishing adaption protocols and frameworks. Recent literature identified 12 adaptation frameworks within public health, including ADAPT-ITT (an eight-part model consisting of Assessment, Decision-Making, Adaptation, Production, Topical Experts, Integration, Training Facilitators, and Testing); Map of Adaptation Process (MAP); Intervention Mapping (IM) all of which feature prominently among the adaptations under review within this dissertation (Escoffery, 2016). Escoffery (2016) offers a framework analysis of public health adaptation. They describe a consensus stage process of adaptation that mirrors the adaptation process consensus within psychology, including a combination of top-down and bottom-up approaches consisting of assessment of community need, collaboration with community stakeholders, expert consultation,

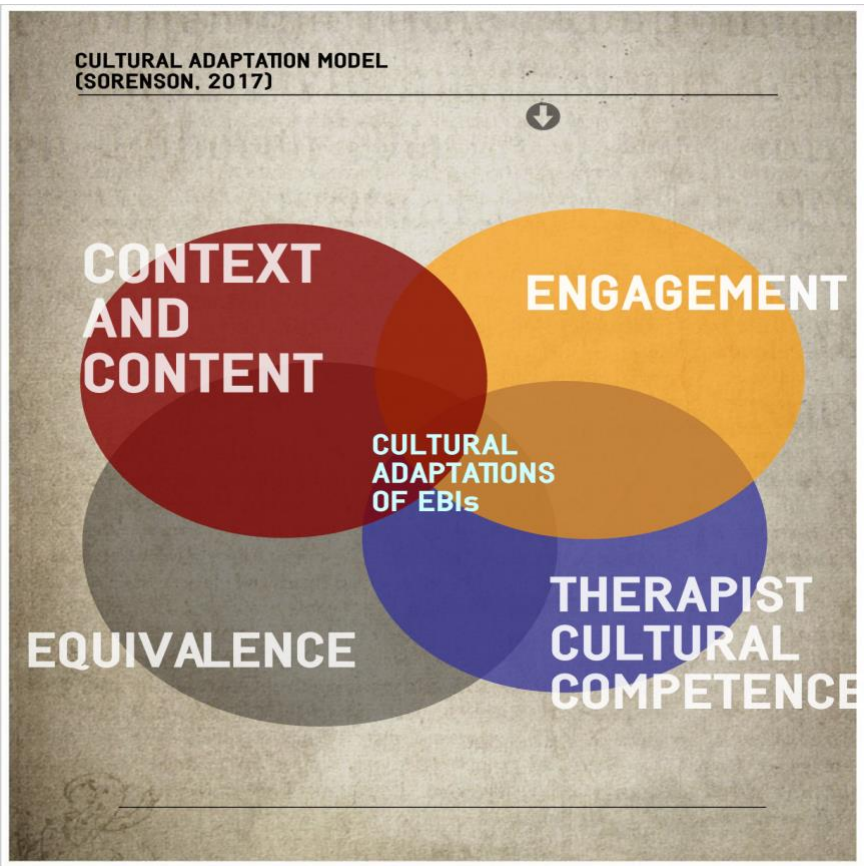
adaptation, testing, and refinement/evaluation post-implementation. Specifically worth noting is the work of the Centers for Disease Control (CDC), as it is a significant shaper of national health policy. In 1994, the CDC changed the manner of intervention planning and implementation for HIV prevention. Specifically, the researchers:

> were asked to share with representatives of affected communities and other technical experts, the responsibility for developing a comprehensive HIV prevention plan….the basic intent has been threefold: to *increase meaningful community involvement in prevention planning*, to improve the scientific basis of program decisions, and to target resources to those communities at highest risk. (CDC, 2003, p. 3)

These guidelines outline a flexible, participatory community planning adaptation process that currently operates for HIV prevention interventions in all 50 states, six cities, and eight territories (CDC, 2003). It is worth noting, therefore, that, unlike within the field of psychology where the merits of cultural adaptation remain under debate, cultural adaptation and an attendant community-inclusive process has been and remains the standard of care in federally funded HIV prevention treatment for over twenty years.

Cultural Adaptation 4-Part Model

Taken as a collective, the four psychology adaptation theories, public health adaptation frameworks, and the multicultural competence foundational literature explored in this chapter represent a consensus in thought and research about the mechanisms, change agents, mediators, and key components of cultural adaptation. These authors' research offers many foundational ideas to advance understanding of when and how to adapt an EST or EBI (used here as the larger descriptive category for which more than one form of scientific evidence may provide evidentiary base) for a given population. From this review, four major themes of cultural adaptation can be identified: cultural context and content, engagement efforts, development and equivalence processes, and therapist cultural competence.



F*igure 2.* Cultural Adaptation Model (Sorenson, 2018).

Cultural context and content. This includes adaptations that relate, specifically, to values, beliefs, cultural understandings of wellness/illness, cultural ontology of symptoms, unique community factors, issues related to intersectionality or within-group differences, and linguistic differences. Adaptations in this category can include both "shallow" changes (e.g., visual images portraying an ethnic match) as well as deep changes (e.g., incorporation of indigenous wisdom traditions).

Engagement efforts. This includes addressing barriers to treatment and contributors to treatment failure such as structural barriers like transportation, but also communication style differences between client and therapist, role expectations, orienting clients to the therapy process, addressing stigma and discomfort in therapy, and increasing the acceptability of

psychological intervention in communities in which there is mistrust, stigma, and/or unfamiliarity.

Development and equivalence processes. Adaptation design consists of an integration between clinical/research-derived knowledge with a bottom-up approach that includes community stakeholders. Conceptualization should include *why* adaptation is required (i.e., seeks to address unique community factors) and identifies the change agents within the original EST that are designated for preservation. In accordance with qualitative research principles, the data collected from community members informs the creation of the intervention, which is then piloted, re-examined, and refined.

Therapist cultural competence. Cultural competence focuses on the therapist's beliefs and attitudes, knowledge, and skills. Cultural knowledge and familiarity is important, as is credibility of the therapist by the client, personal introspection on the part of the therapist related to personal cultural identity development, positions of power and privilege relative to her clients, historical bias and inequity within the field of psychology, and an attitude that "difference is not deviance, but is to be valued, honored, and affirmed" (Harrell and Gallardo, 2008, p. 116). This also includes *dynamic sizing* or efforts to incorporate the dynamism and complexity of culture and how it manifests and shapes lives differentially. This can also include agency/system cultural competence.

Summary and Rationale

The four domains of cultural adaptation: cultural context and content, engagement efforts, development and equivalence processes, and therapist cultural competence represent a working model through which culturally adapted empirically supported interventions can be analyzed and critiqued.

Psychology has a poor track record of incorporating the dynamic complexity of culture into conceptualizations of human behavior. Additionally, psychology has a long history of privileging the experiences of a (proportionally) few members of the human family over all others. Psychology purports to study the human experience, to engage meaningfully with data and scientific principles as the foundation of the field, however, the strong positivistic tradition of psychology has resulted in a methodological bias towards quantitative research. The complex and dynamic qualities of culture do not easily lend themselves to quantification, and so cultural psychologists who utilize more qualitative data are further marginalized, as are psychologists whose commitment to multicultural competence often puts them at odds with entrenched and values-laden professional role expectations and identities. However, changing demographics, data that reflects poor outcomes for clients of color, and an increasingly large and vocal subset of psychologists who are the leaders and beneficiaries of a constructivist/interpretive and critical theory evolution have increased pressure on mainstream psychology to adapt its methodologies, its conceptualizations, and its treatments to better serve the *whole* human family. In our data-driven world, empirically supported treatments are the standard of care. Given the emphasis on evidence based practice, discussions have emerged about how to best incorporate a more comprehensive understanding of the role of culture into treatments that were not designed to be culturally responsive. This dissertation explores those efforts and provides an overview and critique of the theory, process, and outcomes of cultural adaptation of empirically supported treatments and evidence based interventions.

Chapter 3: Review and Analysis Plan

This dissertation involved a critical review of existing literature on culturally adapted psychotherapy and psychosocial interventions in the context of evidence-based practice, cultural adaptation and cultural psychology theory, cultural competence, and the efficacy of empirically supported interventions with culturally diverse populations. The primary aims of this dissertation were (a) to perform a comprehensive literature review and critical analysis of current (2000-2015) culturally adapted psychotherapy and psychosocial intervention approaches; and (b) to offer an overview of existing culturally adapted psychological interventions by disorder or target problem, ethnic group, and theoretical approach (e.g., cognitive behavioral, psychodynamic, ecological, etc.).

Additionally, this dissertation aimed to offer an integrative model for the cultural adaptation of empirically supported psychological interventions that can be used to both inform professional practice and further scientific inquiry. The culturally adapted interventions reviewed in this dissertation were analyzed within the framework of this model, which served as a test and/or revision opportunity for the model.

Topic Areas

The general topic areas that were included in this comprehensive, critical literature review are the history of multicultural psychology, multicultural competence in psychology, empirically supported intervention theory and history, psychological interventions outside of the United States, and specific culturally adapted interventions of empirically supported psychotherapy and preventive psychosocial interventions. Although psychotherapy intervention is of primary interest, psychosocial prevention programs were also included in the topic areas. Much cultural adaptation has been done in the area of psychosocial prevention programs (e.g.,

parenting programs) and excluding these studies would eliminate valuable data about the process and outcomes of cultural adaptation. Additionally, their inclusion may illuminate current research priorities within the field of cultural adaptation.

Exclusion Criteria

For the purpose of narrowing the scope of this review to recent psychological interventions, this review did not include analysis of psychological assessment instruments or interventions developed prior to 2000. Mere inclusion of a diverse sample was not a sufficient criterion to warrant inclusion, rather the researcher(s) must have self-identified as having made a specific effort towards cultural adaptation such that the depth and quality of the adaptation could be critiqued.

Dates of Publication and Databases

The dates of publication within which theoretical and conceptual literature were sought were from approximately 1900 to the present since this critical review includes a historical dimension and thus makes use of primary sources relevant to the development of the role of culture within psychology. The literature reviewed and analyzed was located through the computer search of databases including, but not limited to (a) EBSCO Web, which includes indices such as Academic Search Elite (contains full text for more than 2,100 journals spanning 1985 to the present); (b) PsychArticle and PsychInfo, the American Psychological Association's resource for abstracts, scholarly journal articles, book chapters, books, and dissertations spanning the 1900s to the present; and (c) Academic Search Complete, a multidisciplinary database containing peer-reviewed articles from across the social sciences and humanities including psychology, anthropology, sociology, and law. In terms of the empirical studies included in the

review of culturally adapted interventions, only studies published from the year 2000 to the present were included.

Types of Documents and Keywords

Two types of literature sources were searched. Firstly, empirical studies of culturally adapted psychotherapy interventions and psychosocial prevention programs were identified. Secondly, critical analyses and theoretical papers were also researched. The following initial key words were used in the literature review process: empirically supported treatments, evidence based practice, culturally adapted intervention, culturally sensitive, cultural competence, multicultural competence, ethnic psychology, multicultural psychology, multicultural psychology history, diversity, culture. Demographic and ethnic-identifier keywords were also included such as African, African American, Indigenous, Native American, American Indian, Caribbean, Middle East/Eastern, Latino/a/x, South/Central America, Asian, Asian American, China, etc. Additional key words were added as the review progressed.

The critical analysis included a thorough review of current empirical studies outlining efficacy and effectiveness results from culturally adapted versions of empirically supported psychotherapy and preventive interventions. The following topics were discussed then integrated: the history of multicultural psychology, multicultural competence in psychology, empirically supported treatment theory and history, and specific culturally adapted interventions of empirically supported psychotherapy interventions. This critical analysis aimed to develop a model for conceptualizing the process and necessary components of cultural adaptation. Cultural adaptations of empirically supported interventions were analyzed through the lens of the presented model and the data was presented in terms of cultural group, theoretical perspective, and disorder or target problem. This analysis aimed to offer direction to researchers on needs for

future research, as well as to clinicians seeking culturally adapted interventions, as well as to inform the process of undertaking a cultural adaption.

Data Coding and Analysis

Using qualitative research methodologies for systemic reviews has been recognized as a valuable and sound method of synthesizing a body of primary research (Barnett-Page & Thomas, 2009; Chu & Leino, 2017). Thematic synthesis (Dixon-Woods, Fitzpatrick, & Roberts, 2000; Thomas & Harden, 2008) was used in this dissertation to review the proposed model and identify overarching cultural adaptation concepts across and within studied groups. Thematic synthesis is a qualitative methodology that consists of three components: line-by-line text coding, the development of descriptive themes, and the generation of interpretive analytical themes (Thomas & Harden, 2008). Thematic synthesis combines and adapts aspects of other qualitative methodologies, analytical themes are comparable to 'third order interpretations' in meta-ethnography and, as with grounded theory, thematic synthesis is an inductive process that uses 'constant comparison' to refine themes (Barnett-Page & Thomas, 2009). The process of this review is highly similar to that of Chu and Leino (2017) and consisted of multiple stages. However, this analysis was not truly an inductive process, as a pre-existing theoretical framework was applied to the primary data.

Firstly, primary research articles were categorized by cultural group. Secondly, within a given cultural group, primary research articles were free coded which involved coding specific line-by-line text from articles describing specific adaptations, into the adaptation domains described in the model of this dissertation. Attention was paid to whether the domains of the model were sufficiently flexible to capture all specifically described modifications within the primary research; across 101 studies, no modifications were required to the underlying

theoretical model. Within a cultural group and within a given adaptation domain, lines of text were then broken down and labeled in terms of meaning units and these were compared across studies. Third, conversion to higher-order descriptive themes followed. This involved a constant comparative process where themes were continuously compared against data from each newly coded study. Each coded study was also explored for incongruous data that disconfirmed the developing descriptive themes, or indicated additional levels of coding. This process was repeated for each cultural group category and then descriptive themes were analyzed across cultural groups, yielding analytical or construct themes. Efforts were made to use terminology taken directly from primary research to maintain consistency and continuity of ideas, however, analysis was undertaken at the latent (or thematic) level, not just the semantic (e.g., the meaning of the adaptation, not merely the exact description). The frequency of occurrence of each analytical theme was also indicated.

Chapter 4: Results

Over the course of a 12-month period, the above referenced databases were searched and relevant articles were sorted according to their intended community. Results are reported for four population groups and integrated at the group level: Indigenous Peoples/Native Americans; People of African Ancestry; Latino/a/x; and People of Asian and Pacific Islander Descent. Additional studies that do not fit into the above categories are also briefly discussed, for example cultural adaptations with refugees and multi-country studies. Articles were read and the described adaptations were coded according to the four domains of the cultural adaptation model presented in this dissertation: Cultural Content and Context; Engagement strategies; Development and Equivalence processes; Cultural Competence. Outcomes were also reported.

Selection of Articles

A total of 187 published articles, chapters, and dissertations yielded from four database searches over a 12-month period. Of those, 86 articles did not meet inclusion criteria. Excluded articles included interventions better classified as culturally specific (i.e., interventions developed for a given community without reliance on a pre-existing EST or EBI framework; non-adapted) interventions (30); the remaining excluded studies included theoretical papers, guidelines for multicultural psychotherapy, literature reviews, among others. The remaining 101 articles were included in this review.

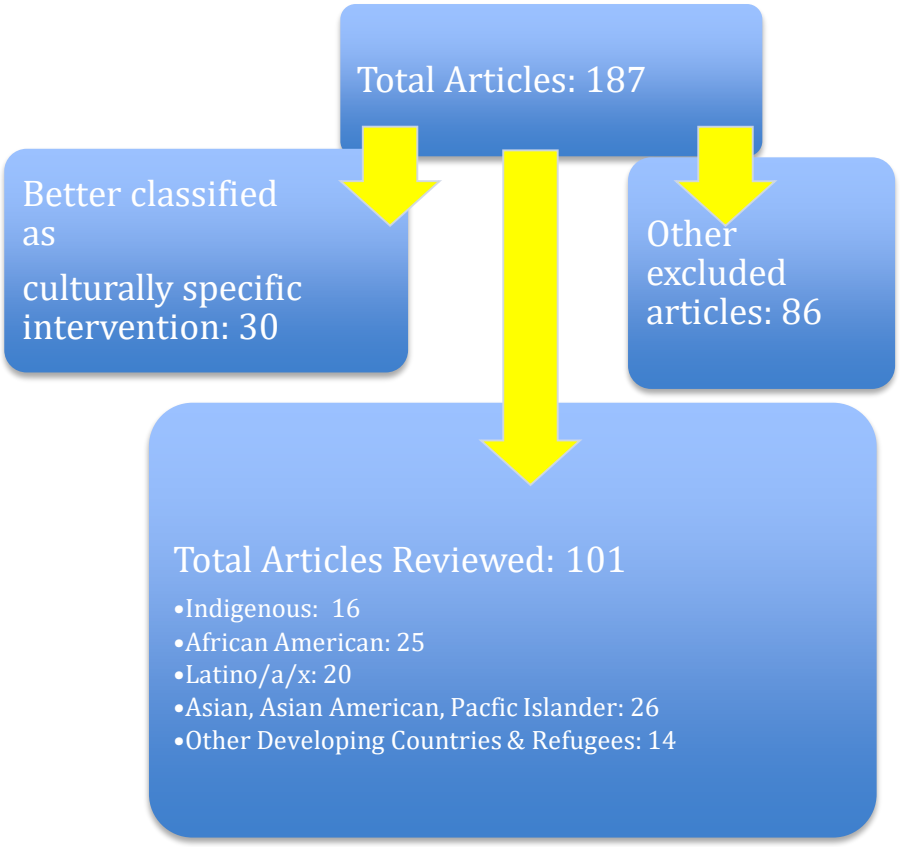


Figure 3. Flowchart of article selection.

Organization of Presentation of Results

The following four results sections follow the same format. The sample of group-relevant studies is introduced and categorized by characteristics of target population (e.g., age, gender, regionality, etc.), target concern of the intervention (e.g., psychological disorder, behavioral concern), and underlying theory of the intervention (e.g., CBT, MI). The descriptive themes yielded by the analysis of adaptations are then presented by model domain: context, engagement, equivalence, and therapist cultural competence.

> *Context and Content:* This includes adaptations that relate, specifically, to values, beliefs, cultural understandings of wellness/illness, cultural ontology of symptoms, unique community factors, issues related to intersectionality or within-group differences, and linguistic differences. Adaptations in this category can include both "shallow" changes (e.g., visual images portraying an ethnic match) as well as deep changes (e.g., incorporation of indigenous wisdom traditions).

> *Engagement:* This includes addressing barriers to treatment and contributors to treatment failure such as structural barriers like transportation, but also communication style differences between client and therapist, role expectations, orienting clients to the therapy process, addressing stigma and discomfort in therapy, and increasing the acceptability of psychological intervention in communities of color.
>
> *Development and Equivalence Processes:* Adaptation design consists of integration between clinical/research-derived knowledge and a bottom-up approach that includes community stakeholders. Conceptualization should include *why* adaptation is required (i.e., seeks to address unique community factors) and identifies the change agents within the original EST that are designated for preservation. In accordance with qualitative research principles, the data collected from community members informs the creation of the intervention, which is then piloted, re-examined, and refined.
>
> *Cultural competence:* Cultural competence focuses on the therapist's beliefs and attitudes, knowledge, and skills. Cultural knowledge and familiarity is important, as is credibility of the therapist by the client, personal introspection on the part of the therapist related to personal cultural identity development, positions of power and privilege relative to her clients, historical bias and inequity within the field of psychology, and an attitude that "difference is not deviance, but is to be valued, honored, and affirmed" (Harrell and Gallardo, 2008, p. 116). This also includes *dynamic sizing* or efforts to incorporate the dynamism and complexity of culture and how it manifests and shapes lives differentially. This can also include agency/system cultural competence.

Following, intervention results are addressed, a sample of exemplar adaptations are described in more detail, and a brief discussion is provided for the analysis for each cultural group. Lastly, an analysis of the integration of group level results is provided.

Indigenous/Native Populations

Database searches for cultural adaptations of psychotherapy and psychosocial interventions for indigenous and Native American/American Indian populations yielded 20 articles. The same intervention in two published articles and were only counted once in the final tally. One article was a brief commentary on an adaptation within this review (Bennet & Babbage, 2014). One study was a meta-analysis of eleven cultural adaptations for Native American youth (Jackson, 2010); of those, six studies fell within the publication date qualification for inclusion in this dissertation and are reviewed here independently. The last

excluded study contained general recommendations for adapting treatment to the Native American/Alaskan Native communities (Gray & Rose, 2012). The total number of studies reviewed in this inquiry was 16.

Communities addressed. Of the adaptations reviewed, 11 were geared towards Native American/American Indians; four represented non-US indigenous groups including Northwest Ontario Canada First Nations, Aboriginal Canadians, Aboriginal Australians/Torres Strait Islanders, and Maori people. Of the 11 interventions geared towards Native Americans/American Indians (NA/AI), 10 were aimed at youth and one at families. Of the 16 total, 13 interventions are geared towards indigenous children.

Table 1

Characteristics of Indigenous Target Populations

Target Population	Number of Culturally Adapted Interventions
Native American/American Indian	11
Youth	10
Families	1
Southwestern United States	2
Montana	1
Northeastern United States	1
Wisconsin	1
Urban-dwelling	2
International	4
First Nations (Canada)	2
Youth	2
Aboriginal Australian	2
Aboriginal Australian/Torres Straits Islanders	1
Maori	1

Target concerns or problems. Of the 16 studies within this review, 56% (nine) address health promotion and disease prevention interventions, with substance abuse accounting for the largest number within that category (three; 33%). Few psychological disorders listed in the

Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) are addressed as most of the reviewed interventions are primary prevention psychosocial interventions. Among the DSM5 disorders that are addressed, trauma (post traumatic stress disorder or PTSD) accounts for the largest body of adaptations (five); depression and anxiety each are addressed through one intervention.

Table 2

Target Concerns of Interventions for Indigenous Groups

Target Disorder	Number of Culturally Adapted Interventions
Health Promotion/Primary Prevention	9
- General Mental Health	1
- HIV/Substance Prevention	1
- Poly-Substance Prevention	3
- Alcohol Prevention	1
- Suicide prevention	1
- Academic Performance/Behavior Improvement	2
Anxiety	1
Trauma/PTSD	5
Depression	1

Theoretical basis of interventions. Behavioral and cognitive behavioral theory, when combined, underlie 68% of the studied interventions. Specific manualized ESTs including Trauma Focused Cognitive Behavioral Theray (TF-CBT), Cognitive Behavioral Therapy Intervention for Trauma in Schools (CBITS), and Parent Child Interaction Therapy (PCIT) are also included within this review.

Table 3

Theoretical or Programmatic Focus of Interventions in Indigenous Populations

Theoretical Basis	Number of Culturally Adapted Interventions
Cognitive Behavioral Therapy	8

(continued)

Theoretical Basis	Number of Culturally Adapted Interventions
-CBITS	2
-Trauma Focused-CBT	1
Behaviorism	2
Parent-Child Interaction Therapy (behaviorism/play therapy)	1
Mindfulness	1
Motivational Interviewing/Solution Focus	1
Other	3
-FAST	1
-Family Check	1
-Learning Theory	1

Analysis of adaptations. Context was the most frequently addressed domain, included by 15 out of 16 research teams. One study did not address context adaptation. While Nowrouzi, Manassis, Jones, Bobinski, and Mushquash (2014) describe culturally adapting CBT for a telehealth intervention for Western Ontario First Nations individuals, all context adaptations are left to individual practitioners and not sufficiently described.

Table 4

Specific Context and Content Adaptations in Indigenous Community Studies

Context and Content Adaptations	Number of Culturally Adapted Interventions
Not Addressed	1
Values: Identity, Community and Tradition	11
Stories, Metaphors	6
Spiritual Beliefs	5
Language	4
Visuals	3
Within Group Differences	3
Problematic Western Elements	2
Literacy	2

Values: Identity, community and tradition. Of the total, eleven adaptation design teams address incorporation of indigenous values and fostering a positive indigenous identity (Bennett, 2009; Bigfoot & Funderburk, 2011; BigFoot & Schmidt, 2010; Boyd-Ball, 2003; Dingwall,

Puszka, Sweet, & Nagel, 2015; Kratochwill, McDonald, Levin, Young, & Demaray, 2004; Moran & Bussey, 2007; Morsette et al., 2009; Rolf, Nansel, Baldwin, Johnson, & Benally, 2002; Schinke, Tepavac, & Cole, 2000; Weaver & Jackson, 2010). Incorporation of traditional practices, such as smudging, drumming, dancing, chanting, or beadwork, was included in two adaptations (Kratochwill et al., 2004; Weaver & Jackson, 2010). Incorporation of community members such as elders was included in three adaptations (BigFoot & Schmidt, 2010; Kratochwill et al., 2004; Morsette et al., 2009).

Metaphor and stories. Use of culturally relevant metaphor and stories (including traditional legends and proverbs), was addressed by six intervention teams (Bennett, 2009; Boyd-Ball, 2003; Goodkind, Lanoue, Milford, & Haley, 2010; Le & Gobert, 2015; Miller et al., 2011; Schinke et al., 2000). For example, Morsette et al. (2009) addressed removing Eurocentric stories (e.g., Christopher Columbus) or metaphors from the standard version of the intervention as part of the adaptation process of a trauma intervention for NA/AI youth in Montana. One intervention specifically described its adaptations as only surface changes, such as adapting metaphors (Goodkind et al., 2010). As an example, Miller et al. (2011) introduced a medicine pouch craft project in their school-based anxiety intervention for Aboriginal children; participants would place productive thoughts or objects in the medicine pouch, as a coping tool for anxiety management.

Spiritual beliefs. Smudging, prayer, and other spiritual practices such as incorporation of spiritual leaders and community elders were incorporated into the interventions by six research teams (Bennet, 2009; BigFoot & Schmidt, 2010; Goodkind et al., 2010; Le & Gobert, 2015; Miller et al., 2011; Morsette et al., 2009). In Montana, a school-based intervention for youth

provided referrals to traditional healers; traditional leaders also attended the beginning and end of the adapted CBT program to offer prayer in the local language (Morsette et al., 2009).

Language. Language adaptations were included in four interventions; adaptations included simplifying jargon and using local idioms (Bennett-Levy et al., 2014; BigFoot & Funderburk, 2011; Le & Gobert, 2015), and using the local language for select elements (e.g., prayer; Morsette et al., 2009).

Visuals. Of the total, four intervention teams addressed adapting visual images for cultural congruence (Bennet-Levy et al., 2014; BigFoot & Schmidt, 2010; Dingwall et al., 2015; Kratochwill et al., 2004). BigFoot and Schmidt (2010) use cultural imagery (e.g., tensing the string of a bow) when teaching progressive muscle relaxation in a TF-CBT adaptation.

Within-group differences. Native American psychology literature describes tremendous intra-group variation among American Indians and across indigenous communities, both between groups and in terms of individuals' level of affiliation. Three studies referenced this diversity (Bennett, 2009; BigFoot & Schmidt, 2010; Weaver & Jackson, 2010). One adaptation was specific as to tribal affiliation (Weaver & Jackson, 2010). Seeking to respond flexibly and tailor the cultural adaptation, Bennet (2009), included an assessment of cultural connectedness through a genogram exercise in a cultural adaptation designed to address depression symptoms among Maori people. BigFoot and Schmidt (2010) provide a useful tool, the American Indian/Alaska Native affiliation model "designed to assist therapists in understanding the level of affiliation that a particular American Indian or Native Alaska individual has with their indigenous culture" (BigFoot & Schmidt, p. 853).

Literacy. For an intervention with Aboriginal Australians, researchers adjusted traditional language-based thought records with visual/drawing-based records, reflecting the high

value on visual (rather than written) literacy within that community (Dingwall et al., 2015). Bennet (2009) similarly utilized visual diagrams, rather than written thought records, for an adapted CBT for depression intervention with Maori adults.

Removal of problematic western elements. Not all aspects of traditional models were considered appropriate, for example two adaptation designers addressed elements that may be fundamentally incongruent for use with indigenous communities (Bennett-Levy et al., 2014; Goodkind et al., 2010). For example, Goodkind et al. (2010) adapted a CBT (CBITS) intervention for Native American youth in the Southwest who were exposed to trauma. In the original intervention, some exposure elements address grief and death; cultural prohibitions against discussing the dead necessitated the removal of these exposure elements.

Engagement. Within the domain of Engagement, 14 out of 16 studies addressed adaptations to improve engagement in services. Only two interventions did not address engagement strategies (Boyd-Ball, 2003; Moran & Bussey, 2007).

Table 5

Specific Engagement Adaptations in Indigenous Community Studies

Engagement Adaptation	Number of cultural adaptations
Not Addressed	2
Community Settings	10
Extended Family and Community Inclusion	4
Indigenous Researchers	4
Technology	3
Communication Style	3
Community Interventionists	3
Stigma Reduction	1

Community setting. Utilizing community based treatment settings was used in 10 interventions. The most commonly utilized engagement strategy was basing the intervention

within a school. School-based interventions occurred in eight studies (Goodkind et al., 2010; Le & Gobert, 2015; Kratochwill et al., 2004; Miller et al., 2011; Morsette et al., 2009; Rolf et al., 2002; Schinke et al., 2000; Weaver & Jackson, 2010). Within the school-based interventions, engagement was further facilitated by offering class credit for participation (Le & Gobert, 2015), and providing transportation for a "summer camp" style intervention (Weaver & Jackson, 2010). Bennett-Levy et al. (2014) also made use of non-conventional spaces (e.g., outside, walking) for a CBT adaptation with Aboriginal Australians.

Extended family and community inclusion. Interventions included extended family members (Bennett, 2009; BigFoot & Schmidt, 2010), and/or important community members such as elders (BigFoot & Schmidt, 2010; Kratochwill et al., 2004; Morsette et al., 2009). As BigFoot and Schmidt (2010) describe,

> The concept of ''relationship'' is broadened to include the natural helpers and healers critical to the child's recovery. For AI/AN children, this may include extended family, traditional helpers and healers, and the child's relationship with elements within the natural and spiritual world. (p. 852)

Indigenous researchers. Four interventions described having Native or indigenous researchers as part of the research team (Bigfoot & Funderbank, 2011; BigFoot & Schmidt, 2010; Le & Gobert, 2015; Weaver & Jackson, 2010). An intervention was co-created in a structure that attempted collaborative equality between outside researchers and a sovereign Native College (Kratochwill et al., 2004). Differing strategies of adaptation design will be addressed more fully in the section on Equivalence.

Technology. Technological means of ensuring engagement was utilized by three research teams. Bennett-Levy et al. (2014) adapted a low-intensity format uses a combination of face to face and technology (mobile phone, internet) to accommodate transportation and other barriers. Dingwall et al. (2015) offered a unique phone-based intervention delivered via app with the goal

of increasing general mental health knowledge and wellbeing with Torres Straits Islanders and Aboriginal Australians. Nowrouzi et al. (2014) created a telehealth intervention for offering adapted CBT for Anxiety for a rural First Nations, Ontario, Canada community.

Communication style. Le and Gobert (2015) articulated efforts to adjust the communication style and facilitator role (e.g., increased self-disclosure on the part of the facilitator) in the intervention delivery. Kratochwill et al. (2004), also addressed modifications in communication style and role, for example avoidance of tip sheets and rather than asserting an expert role on the part of the facilitator, the family-inclusive school-based intervention was designed facilitate advice between parents. Bigfoot and Funderbank (2011), in adapting Parent Child Interaction Therapy for use with Native American/Alaskan Native families, described explicit adjustments to therapist/parent communications, including re-naming PCIT techniques, describing in culturally congruent terms the role and function of the therapist, adjusting the expectation for rate of parent response to child to be congruent with a non-dominant culture cadence, and using the traditional praise syntax rather than syntax associated with the dominant culture.

Community interventionists. Trained local community members were used in three studies (Le & Gobert, 2015; Morsette et al., 2009; Rolf et al., 2002) to deliver the intervention directly within the community.

Minimizing stigma. Efforts to minimize stigma was acknowledged by one study, Kratochwill et al. (2004); they chose not to screen for inclusion in a school-based academic performance and behavioral enhancement program.

Development and equivalence processes. Development and Equivalence Processes were addressed by 15 of the 16 interventions. Only one study did not address development and equivalence processes (Weaver & Jackson, 2010).

Table 6

Specific Development and Equivalence Adaptations in Indigenous Community Studies.

Equivalence Process	Number of cultural adaptations
Not Addressed	1
Integration of Top Down and Bottom Up Approaches	14
Adaptation Theory Referenced	7
Fidelity	4
Bottom Up – Community Driven	1

Adaptation theory. Of the total, seven interventions specifically referenced adaptation theory as, in part, guiding the development of their intervention (Bennett, 2009; Bennett-Levy et al., 2014; Goodkind et al., 2010; Le & Gobert, 2015; Miller et al., 2011; Morsette et al., 2009). Of those community based participatory-action research (CBPAR) guided two processes (Bennett-Levy, 2014; Morsette et al., 2009); and Bernal's EVM guided one (Miller et al., 2011).

Integration of top down and bottom up approaches. Integrating researcher and community-generated knowledge was addressed by 14 studies described (Bennett, 2009; Bigfoot & Funderbank, 2011; BigFoot & Schmidt, 2010; Boyd-Ball, 2003; Dingwall et al., 2005; Kratochwill et al., 2004; Le & Gobert, 2015; Miller et al., 2011; Moran & Bussey, 2007; Morsette et al., 2009; Nowrouzi et al., 2014; Rolf et al., 2002; Weaver & Jackson, 2010; Goodkind et al., 2010). Methods for generating community knowledge and input include: focus groups (Moran & Bussey, 2007; Rolf et al., 2002), consultation with mental health professionals who work with indigenous communities (Bennett, 2009; Boyd-Ball, 2003; Dingwall et al., 2005; Morsette et al., 2009; Nowrouzi et al., 2014), using indigenous researchers (Bigfoot &

Funderbank, 2011; BigFoot & Schmidt, 2010; Le & Gobert, 2015; Weaver & Jackson, 2010), working with tribal organizations (Kratochwill et al., 2004; Nowrouzi et al., 2014), consultation with community members such as elders and teachers (BigFoot & Schmidt, 2010; Boyd-Ball, 2003; Dingwall et al., 2005; Goodkind et al., 2010; Miller et al., 2011; Morsette et al., 2009), and creation of a community advisory board or cultural committee (Bennett, 2009; Le & Gobert, 2009; Weaver & Jackson, 2010).

Fidelity. Efforts to ensure fidelity were addressed in three studies (Bennett-Levy et al., 2014; Bigfoot & Funderbank, 2011; Kratochwill et al., 2004; Schinke et al., 2000). Fidelity was maintained through training (Bennett-Levy, 2014); consultation with the original intervention developer (Bigfoot & Funderbank, 2011); preservation of structure (e.g., order of modules, components of each session; Schinke et al., 2000); and identification of core elements for preservation (Kratochwill et al., 2004).

Bottom up – community driven. Rolf et al. (2002) describe a bottom up approach in which a school board initiated the intervention by inviting the researchers and articulating the needs of the community; the intervention was developed through informant interviews and there was ongoing community monitoring throughout.

Therapist cultural competence. Therapist cultural competence was not addressed by four studies (Goodkind, 2010; Moran et al., 2007; Morsette, 2009; Schinke et al., 2000).

Table 7

Specific Cultural Competence Adaptations in Indigenous Communities.

Cultural Competence Adaptation	Number of cultural adaptations
Not Addressed	4
Ethnic Matching	3

(continued)

Cultural Competence Adaptation	Number of cultural adaptations
Dynamic Sizing	2
Addressing Community Trauma and Skepticism	3
Cultural Knowledge Acquisition	1

Ethnic matching. Ethnic matching as part of intervention delivery was an adaptation described by three studies (Le & Gobert, 2015; Rolf et al., 2002; Weaver & Jackson, 2012). Le and Gobert (2015) described using ethnic matching, a community "champion," and facilitators from within the community (Le & Gobert, 2015, p. 15). Rolf et al. (2002) also employed indigenous staff and trained locals in intervention techniques. Native researchers were also involved in intervention delivery (Weaver & Jackson, 2012).

Dynamic sizing. The importance of recognizing within-group differences among Indigenous people was addressed by two research teams (Bennett, 2009; BigFoot & Schmidt, 2010). Bennett (2009) described efforts to individualize cultural integration collaboratively with clients depending on their level of enculturation, for example a practice of opening therapy sessions with prayer was rejected by some clients and respected by the therapist. BigFoot and Schmidt (2010) present a program called Honoring Children Mending The Circle, an adaptation of trauma-focused CBT. In this adaptation, a number of therapeutic tools are available to the therapist, including the American Indian/Alaska Native affiliation model “designed to assist therapists in understanding the level of affiliation that a particular American Indian or Native Alaska individual has with their indigenous culture” (BigFoot & Schmidt, 2010, p. 853). From there, BigFoot and Schmidt also provide an American Indian/Alaska Native Healing Practices worksheet to use in treatment planning.

Cultural knowledge acquisition. BigFoot and Schmidt (2010) provide ongoing support and supervision of the Honoring Children Mending the Circle program, available through local organizations with deep cultural knowledge to ensure sufficient cultural knowledge and access to experts for outside facilitators.

Addressing community trauma and skepticism. Rolf et al. (2002) specifically addressed community skepticism and how that was addressed through a philosophy of "giving, not taking away " (e.g., as in data collection; Rolf et al., 2002, p. 298). Additionally, this study uses indigenous staff and trained locals in intervention techniques. For Boyd-Ball (2003), cultural restoration is the stated goal and the article provides rich description of the heavy investment in indigenous wisdom systems. Bigfoot and Funderbank (2011) emphasize the importance of addressing the history of racism and oppression by the dominant culture, including oppressive practices by therapists and the natural skepticism of Native parents in working with dominant-culture psychological services.

Reported outcomes and results. The results of the studies reviewed can be organized in terms of the availability of results data, symptom reduction or behavior change, stakeholder satisfaction (measured through self-report, standardized assessment measures, anecdotal data, and levels of participation over time). Data that suggests contraindications is also related below.

Table 8

Results for Interventions with Indigenous Communities.

Type of Result reported	Number of cultural adaptations
Not reported/not available yet	3
Symptom Reduction/Behavior Change	6
Participant/Stakeholder Satisfaction	6
Contraindications	2

One of the criticisms of cultural adaptations is that they lack sufficient power for the kind of statistical analysis that confers the status of empirical support. However, it is worth noting that the sample size of the interventions reviewed varied considerably from single-subject case studies (N = 1), to a large-scale, multi-agency rollout (N = 3,335). Overall, studies indicated positive results, although they varied in their outcome measurement strategies. Some studies additionally did not address their results due to insufficient statistical power: BigFoot and Schmidt (2010; N = 1); Bigfoot and Funderbank (2011); Weaver and Jackson (2010; N = 16).

Symptom reduction/behavior change. Positive results in terms of symptom reduction or behavioral change were reported by six studies. A cultural adaptation of CBT for depression for Maori clients (Bennett, 2009) reported that symptoms reduced generally for most participants; 10 of the 15 participants experienced reductions in depression of 80% or more. The remaining five participants for whom treatment was less successful, experienced reductions in depression that ranged from 0% to 60% and gains remained at 6 month follow up. In a small pilot study, Morsette et al. (2009) reported that PTSD and depressive symptoms decreased for three of the four students who completed treatment. A substance abuse recovery program for Native American teens reported that incorporation of traditional stories and legends correlated with increased prosocial behavior and number of days abstinent from substances (Boyd-Ball, 2003). A multiple-site, school-based adaptation of CBT for PTSD and trauma for Native American youth reported that

> All 24 participants completed the intervention and 71% of participants attended 8 or more of the 10 sessions. Youth in this study showed significant decreases in PTSD symptoms, anxiety symptoms, and avoidant coping strategies at 3-month follow-up. We also identified a marginally significant decrease in participants' depression symptoms. For PTSD symptoms and avoidant coping strategies, the positive effects observed in the quantitative data as linear change over time began to reverse direction after the 3-month follow-up time period. (Goodkind et al., 2010, p. 868)

An alcohol prevention program for urban Native youth found significant effects for treatment in areas of alcohol beliefs, social support, locus of control, and depressive symptoms (Moran & Bussey, 2007). Rolf et al. (2002) also report a delay in the onset of sexual behavior and a reduction in high-risk sexual behavior in their school-based HIV/AIDS and substance abuse prevention program for American Indian youth.

Stakeholder satisfaction. Using client or community stakeholder satisfaction (e.g., teachers, parents, therapists) as the primary indicator of intervention success was an indicator of success noted by six studies. After a mindfulness-based suicide prevention school-based (elective class) intervention for American Indians described that 70% of participants said they gained valuable information; 89% reported social gains from class. The program was further described as "transformative" by teachers, participants, and facilitators and the class was instituted as a formal elective after the completion of the research study (Le & Gobert, 2009, p. 19). Kratochwill et al. (2004) piloted a randomized intervention consisting of an adapted and non-adapted condition of a multi-family group program to improve academic and behavioral functioning for Native American youth. Their results favored the adapted condition on scales of (teacher rated) aggressive behavior and (parent-rated) scale of withdrawal. At the one-year post follow up, the adapted condition maintained results and academic competence. Further, the researchers reported an 80% graduation rate from adapted condition and positive parent satisfaction per parent satisfaction surveys. Schinke et al. (2000) studied a substance abuse prevention program and compared two slightly different culturally adapted interventions to a control arm. They found that the culturally adapted interventions were superior to the control, across the three year-follow up. One of the culturally adapted versions included an additional component, which consisted of flyers and other marketing materials in the community; there was

no evidence of additional benefit for the arm of the study that included the community marketing materials. Boyd-Ball (2003) cited an 86% retention rate for participants as well as participants' report of post-intervention high level of support of family members (94.2%) and nonfamily adults (90.6%) and positive peer support (66%) as indicators of program effectiveness. Two interventions assessed results only from the perspective of therapists who work with indigenous communities. For Dingwall et al.'s (2005) app-based intervention, therapists viewed the app as effective. Nowrouzi et al. (2014) also only studied the therapist's perspective on a telehealth intervention for addressing anxiety in a rural Canadian First Nations context.

Contraindications. There were two suggestions of contraindications in the studies under review. Goodkind et al. (2010) reported both the large number of parents who declined to give consent for their children to be screened and the 30% of youth who were screened and approved for the intervention but who declined to participate in a group intervention for trauma raises questions about the potentially stigmatizing nature of the screening and intervention processes. They further explained that, following the conclusion of their primary study, the researchers worked closely with the tribal community to create a second intervention related to indigenous traditional healing. Additionally, an intervention with Montana NA/AI youth reported significant attrition (Morsette et al., 2009).

Exemplar adaptations. Of the 16 studies reviewed, five studies were coded for explicit description of all four domains of adaptation. Three exceptionally strong adaptations, in terms of depth and description, are presented here.

Table 9

Exemplar Adaptations for Indigenous Communities

Citation	Context	Engagement	Equivalence	Cultural Competence
Rolf et al. (2002). HIV/AIDS and alcohol and other drug abuse prevention in American Indian communities: Behavioral and community effects.	Goal of intervention: utilization of cultural resources	Trained locals in prevention techniques to deliver intervention; School based.	Adaptation design through multiple stages: focus groups with students and community members; piloted program, refined.	Addressed community skepticism, "Giving, not taking away " (e.g., as in data collection); use of indigenous staff; trained locals in intervention techniques.
Boyd-Ball (2003) A Culturally Responsive, Family-Enhanced Intervention Model.	Incorporates historical trauma; cultural restoration is stated goal of intervention; stated goals; addition of 2 AI legends; welcome home ceremony	Intervention located within an inpatient program contracted by federally recognized tribe; training was offered to community aftercare workers from each youth's area of origin.	Researcher driven; utilized Native psychology experts to create framework for intervention. Adaptation to MI technique. Adaptation of recruitment methods, tribal and treatment center agreements, referral contacts, and implementation of intervention and follow-up with adolescents and their families.	Cultural restoration stated goal, heavily vested in indigenous wisdom systems
BigFoot and Funderburk (2011). Honoring Children, Making Relatives: The Cultural Translation of Parent-Child Interaction Therapy for American Indian and Alaska Native Families.	Re-naming techniques by utilizing AI/NA terms and concepts; used culturally specific model as theoretical basis of adaptation.	Adjustment in communication style; use of traditional syntax; adjustment in expectations of parental responsiveness (culturally normative cadence); avoid clinical terms, using AI concepts to explain treatment and therapist's role (e.g., lead drummer, beading).	Ensured fidelity by including PCIT developers/trainers in adaptation process.	Focus on getting buy-in and encouraging the parent's "natural voice." Directly addressed skepticism and history of racism/dominance.

Discussion. The world's indigenous populations cover a vast geographic terrain. This review suggests that culturally adapted interventions remain limited in their scope of service to global indigenous groups as 11 of the 16 reviewed interventions were geared towards Native

American/American Indians; only four represented non-US indigenous groups including Northwest Ontario Canada First Nations, Aboriginal Canadians, Aboriginal Australians/Torres Strait Islanders, and Maori people. A range of disorders was targeted through this set of cultural adaptations. The majority of interventions were primary prevention interventions aimed at youth. Notably absent from this list are serious mental illness and psychotic spectrum disorders.

In terms of adaptations, within this sample of literature, content adaptations were the most frequently addressed. A significant area for improvement is in equivalence and adaptation process; seven studies did not describe any efforts to incorporate indigenous community stakeholders into the intervention design process at all. Additionally, four studies neglected to explicitly discuss issues of therapist cultural competence; of the remaining studies; three others only discussed cultural competence insofar as their intervention utilized ethnic matching between client and therapist. Given the demographics of the field of psychology (overwhelmingly White), reliance on ethnic matching may limit the reach and impact of the intervention.

Literature by indigenous psychologists, particularly Native American and Native American community-serving psychologists point to several key considerations in working with indigenous clients, including recognition of the vast diversity in beliefs, acculturation, enculturation, among indigenous peoples and the imperative to locate social and behavioral problems in the context of physical and cultural genocide and intergenerational transmission of historical trauma (Brave Heart, Chase, Elkins, & Altschul, 2011; Witko, 2010). Indigenous psychologists and scholars moreover point to restoration of lost cultural connections and integration into local, Native communities as the key to psychological healing (Gone, 2004).

This review found some exemplar programs, particularly those that included indigenous communities in the needs assessment, design, research team, intervention delivery, and

implementation. However, passages such as the one below describing adapting content from a module on the common CBT concept of cognitive distortion highlight the danger of clinical colonization.

> For example, in some cases children believed that all Caucasians held racist attitudes. Children were asked to reconsider this belief and asked to think of examples, or individuals, who were not racist. They were then asked to generalize these concepts and the principle of cognitive restructuring (‘‘changing thoughts’’) to their traumatic experiences, thus modifying negative beliefs associated with the events. Another example used in the CBITS procedure pertained to cognitive distortions in attributions made in response to hearing a loud noise; many children attributed this noise to a spirit. Strictly according to the procedures in the CBITS manual this might well be dealt with as an irrational belief. However, in some American Indian populations there is a strong belief in the metaphysical, and attributing the noise to a spirit is not a distorted thought in this context. Thus, the teaching example was either eliminated or used to encourage children to seek assistance from appropriate spiritual leaders in their community. (Morsette, 2009, p. 171)

This example provides two different illustrations—one belief that was treated as a distortion and one that was not. However, in both cases, the intervention is potentially oppressive in terms of the metacommunication to the client, in the first instance that believing that Caucasian people are racist is a cognitive distortion despite the overwhelming historical evidence to the contrary, and in the second place, failing to validate cultural beliefs and referring the children to community spiritual guidance could reinforce the need to code switch from an indigenous to a dominant-culture belief system in therapy, creating an invalidating atmosphere that is counter-therapeutic and possibly iatrogenic.

Given the history of colonialism’s impress on indigenous communities, psychology would do well to heed the concerns of indigenous clinicians, some of whom consider state mandates to implement specific ESTs “clinical colonization” that defies the sovereignty of Native tribes to determine their own health care needs (Walker et al., 2015, p. 2). The prevalence of prevention programs for Native/Indigenous Youth is both admirable as well as

concerning. Given the ongoing assault to Native and Indigenous family systems and cultural integrity by the dominant culture, interventions with youth should require high levels of parental and community informed consent (for a detailed analysis of the impact of the boarding school movement and Indian Child Welfare Practice in the United States, see Evans-Campbell (2010). It is also worth noting that there are family-based interventions that come directly out of indigenous psychology, rather than cultural adaptation. Those interventions include Positive Indian Parenting, a collaboration of mental health workers, traditional healers, and the National Indian Child Welfare Association (Witko, 2010); Parent Training For American Indian Families (BigFoot, 1989); and a storytelling-based intervention titled Honoring The Child (Witko, 2010).

People of African Ancestry

Academic databases were searched four times over the course of a 12-month period for peer reviewed articles, books, and dissertations published between 2000-2017. Various keyword combinations were used such as "African American + Evidence Based," "Cultural Adaptation + African American," "Evidence Based + Cultural Adaptation," "Culture + African American + Evidence, "additional keywords used in the above combinations included specifiers for regions of significant African ancestry populations, such as "Caribbean," "Brazil," "Africa," and "African Diaspora." These searches yielded a total of 76 studies. Of the 76 studies, 31 were not cultural adaptations. Of the 31 excluded studies, 20 were culturally specific interventions for African Americans and three were culturally specific interventions for people of African ancestry outside of the United States (South Africa, Caribbean, Jamaica). While culturally specific interventions are not within the purview of this study, many of these evidence based culturally specific interventions make significant contributions to the clinical treatment options for people of African ancestry. Additional studies (eight) were also excluded: two studies that were

research reviews and general guidelines (South Africa, general global), one non-adapted clinical trial of a Western EST (Brazil), three papers discussing a transdiagnostic, common elements approach to global mental health, one general discussion paper about global mental health for children, and one paper offering guidelines for using CBT in non-Western global contexts. A total of 45 studies were included for review, in two cases multiple articles (seven and two) described the same cultural adaptation and so were only counted once in the final tally, yielding a total of 36 studies that met criteria for inclusion in this study as cultural adaptations of empirically supported interventions.

Communities addressed. A total of nine countries are included in this review, Britain, the United States, and seven African Nations: South Africa, Zambia, the Democratic Republic of Congo, Tanzania, Nigeria, Egypt, Uganda. Of the studies in this review, four combine sample populations to include people of African ancestry and an additional target population, or study the same intervention across different countries. Due to the predominance of people of African ancestry within their sample as well as their articulation of adaptations specific to that community, those studies are also included in this chapter. For example, one article studied Black and Afro-Caribbean populations in Britain (Rathod, Kingdon, Phiri, & Gobbi, 2010; Rathod et al., 2013). There were two interventions that were cultural adaptations specific to African Americans and one other group, e.g., African American and Latino urban adolescents (Saulsberry et al., 2013); Black and White adolescent girls with binge eating disorder (Mazzeo et al., 2013). A study described their adaptation as targeting "minority" adolescents in Washington DC; their sample was 84% African American; this study was also included (Lewin et al., 2015, p. 139). A pair of studies (only counted once in final tally) examine an adapted intervention for

depressed adults that was piloted in Uganda (twice) as well as India and Pakistan (Patel, Chowdhary, Rahman, & Verdeli, 2011; Verdeli et al., 2003).

These 36 interventions focus on the following population characteristics and communities:

Table 10

Characteristics of African Descended Target Population

Target Population	Number of Culturally Adapted Interventions
Africa	**11**
- South Africa	3
+ Women	3
+ Pregnant	1
+ Urban	1
- Zambia	1
+ Girls	1
-Democratic Republic of Congo	1
+ Boys age 7-13	1
+ former child soldiers	1
-Kenya	2
+ Adults	1
+ Families	1
+ Rural	1
- Tanzania	2
+ Children	1
+ Orphans	1
+ Older Adults	1
+ Rural	1
- Tanzania, Nigeria	1
- Egypt	1
- Uganda*	2
- Uganda, Pakistan, India*	1
+ Mothers	1
African Americans	**23**
+Low Income	8
+Urban	7
+Rural	3
+Faith-identified	4
+Men and Women (adults)	4
+Adolescents	6

(continued)

Target Population	Number of Culturally Adapted Interventions
+Adolescent Boys	*1*
+Adolescent Girls	*2*
-Incarcerated	*1*
+Youth	1
+Boys	*1*
+Families	3
+Married Couples (heterosexual)	1
+Men	2
+Men who have sex with men (MSM)	*2*
+Couples (Same Sex, MSM)	*1*
+Women	7
+History of Intimate Partner Violence (IPV)	*2*
+Pregnant	*1*
+Residing in Public Housing	*1*
+Parenting Caregivers (Mothers, Grandmothers)	*1*
+College Students	*2*
Multi Population Studies	5
Afro-Caribbean/Black British/South East Asian (Pakistani)	1
Black/White (Teen Girls)	1
African American/Latino Adolescent Boys	1
Uganda, Pakistan, India*	1
+ Mothers	1
Tanzania, Nigeria*	1

Note. *counted once

Of the 36 studies specific to people of African ancestry, 23 (66%) are geared towards African Americans, 11 (30%) towards specific African nations and five (13%) towards multi-country or multi-population studies with a predominance of people of African ancestry included in the samples. Of the total, 13 (36%) of the interventions are designed for youth, 13% (36%) for women, and seven (19%) for families and/or couples. Studies within the United States offered more secondary description of the characteristics of the population. Of the 23 studies within the United States: 33% (eight) were targeted for low income individuals; 29% (seven) for urban-dwellers; 12.5% (three) for people living in rural areas; and 16% were geared towards

faith-communities or people who identify as a person of faith. In terms of gender, 16% (4) of the interventions reviewed are designed for both adult men and women; > 1% for men (two); and 33% (eight) for women. Among the interventions on the continent of Africa, national origin characteristics were the most widely reported. In terms of African nations, three interventions were studies in South Africa, two in Kenya, two in Tanzania (an additional one across Tanzania and Nigeria), two in Uganda (an additional one across Uganda, India, and Pakistan), and one each in Zambia, the Democratic Republic of Congo, and Egypt.

Target disorders and problems. The 36 reviewed studies addressed the following psychological disorders and psychosocial issues:

Table 11

Target Concerns of Interventions for People of African Ancestry

Target Concerns	Number of Culturally Adapted Interventions
Depression	6
- Prenatal Depression	1
Parenting	2
PTSD/Trauma	5
Behavioral Problems (Youth)	1
Marriage Education	1
Substance Use	2
Binge Eating Disorder (Loss of Control Eating)	1
Health Promotion/Disease Prevention	18
-*HIV*	*10*
-*Weight Management*	*3*
-*Cancer Detection*	*2*
- *Diabetes Management*	*1*
- *Smoking Cessation*	*1*
- *Health-Related Stress and Coping*	*1*
Speech Delay	1
Dementia	1

A range of issues was targeted through this set of cultural adaptations. The majority of interventions (18; 50%) were health promotion/disease prevention interventions; of those, 77%

were interventions targeting HIV prevention (10). In terms of mental health diagnoses, six studies (16%) addressed depression, including prenatal depression, and five (14%) addressed PTSD and trauma. Substance use was addressed by two studies (> 1%). A study based out of the United Kingdom provides the valuable addition of adaptation relevant to serious mental illness and psychotic spectrum disorders. Family-related interventions (marriage, parenting, child behavior) accounted for 11% of the total (four).

Theoretical basis of intervention. Of the 36 interventions in this section, twelve (33%) utilized Social Cognitive Theory (SCT) as the underlying theoretical basis for their intervention; of those three (12) incorporated some aspect of feminist theory into SCT to form the basis of their intervention. CBT formed the basis of seven interventions (19%), three of which also utilized IPT; Trauma Focused CBT (TF-CBT) provided the foundation for two cultural adaptations and Cognitive Processing Therapy (CPT) provided the foundation for one. Motivational Theory (MI) was used in three cultural adaptations (> 1%), Family Therapy models for two, and various other models also accounted for > 1% of the total including Mindfulness Based Stress Reduction (MBSR), behaviorism, and Dialectical Behavioral Therapy (DBT), among others

Table 12

Theoretical Basis of Interventions for People of African Ancestry

Theoretical Basis	Number of Culturally Adapted Interventions
Social Cognitive Theory (SCT)	12
+ Social Cognitive Theory and Behaviorism	*1*
Theoretical Basis	Number of Culturally Adapted Interventions
+ SCT + feminism	*3*
- Women's CoOp	*1*

(continued)

Theoretical Basis	Number of Culturally Adapted Interventions
- *SCT + Theory of Gender and Power*	*1*
- *SCT + Feminist and Empowerment Theory*	*1*
+ Diabetes Self Management Education (DSME)	*2*
Cognitive Behavioral Therapy (CBT)	7
+ CBT + Interpersonal Therapy (IPT)	*2*
+ CBT + Interpersonal Therapy (IPT) + Community Resiliency Model	*1*
Trauma Focused CBT (TF-CBT)	2
Cognitive Processing Therapy (CPT)	1
Relational Communication Theory (RCT)	1
Cognitive Stimulation Theory	1
Interpersonal Therapy (IPT)	1
Behaviorism	1
Dialectical Behavioral Therapy (DBT)	1
Mindfulness Based Stress Reduction (MBSR)	1
Parent Training	2
- *Parenting the Strong-Willed Child (PSWC)*	
-*Family Foundations/Strong Foundations*	*1*
Family Therapy	2
-*Multidimensional Family Therapy (MDFT)*	*1*
-*Family Therapy/Child Support Group model*	*1*
Motivational Theory	3
-*Transtheoretical Stages of Change/Motivational Interviewing*	*2*
-*Protective Motivation Theory*	*1*
Social Skills Training (Strong Start)	1
Marriage Education (Prevention and Relationship Enhancement Program (PREP)	1

Analysis of adaptations. Context and content were not sufficiently for this review by two studies. Specifically those researchers either stated that their adaptations were minimal (e.g., related to session sequence only; Dutton, Bermudez, Matas, Majid, & Myers, 2013), or that

while differences between groups were acknowledged, the content of the intervention was not tailored to a particular group (Mazzeo et al., 2013).

Table 13

Specific Context and Content Adaptations for Populations of African Descent

Context and Content Adaptation	Number of cultural adaptations
Language and Visuals	17
Incorporation of Faith/Spirituality, Music, and Traditional Practices	14
"Family" Feel: Food, Stories, Kinship, and Humor	12
Afrocentric/Collectivistic Values	11
Context adaptations	10
Oppression, Discrimination, and Stereotypes	8
Cultural Ontology of Symptoms and Treatment Rationale	7
Literacy	3
Problematic Western Concepts	3

Language and visuals. Adaptations to language and visuals was employed by 17 intervention teams. Simplification of language, avoiding jargon and psychiatric labels, and rephrasing psychological terms into common parlance was described by 11 studies (Chowdhary et al., 2014; Coard, 2004; Coard, Foy-Watson, Zimmer, & Wallace, 2007; Graves et al., 2016; Holt et al., 2014; Jalal, Samir, & Hinton, 2017; Murray et al., 2013; Patel et al., 2011; Saleh-Onoya et al., 2008; Saulsberry et al., 2013; Sawyer-Kurian & Wechsberg, 2012; Verdeli et al., 2003). Saleh-Onoya et al. (2008) adapted an HIV prevention intervention originally designed for African American women. Not only did they adapt names, slang terms, and idioms for cultural relevance, but "an isiXhosa motto of 'Bahlokom' abafazi kwamililizwe!' meaning 'Women will rise up so that our nation gets healed!' was added" (Saleh-Onoya et al., 2008, p. 189). This motto was used in each session to inspire dialogue about reducing vulnerability to HIV. For

Murray et al. (2013), adapting TF-CBT for sexually abused girls in Zambia, one of the linguistic challenges of the region is that one word can represent many different feelings. Since TF-CBT emphasizes labeling of emotions, counselors addressed this challenge by creating handouts with lists of emotion words for parents and children to discuss. Jalal et al. (2016) used non-stigmatizing local terms for PTSD in Egypt to normalize treatment and increase credibility. Graves et al. (2016) adapted (for K-5 African American boys with externalizing behavior problems) an original intervention that relied on literary sources for problem-solving discussions. Content adaptations included literature modifications were made to utilize storybooks that have central characters that were African American, while still maintaining the overall theme of each lesson. Similarly, Saulsberry et al. (2013) designed an internet-based depression prevention intervention for Latino and African American adolescents. They addressed pictures and website theme (hip hop) to appeal to the teens, and featured stories and vignettes that were re-written from the original intervention to feature African American or Latino cultural and family contexts including names, idioms and other cultural elements.

Adaptations to visual imagery, ensuring that visual materials featured African Americans (in the US) or Africans was a strategy employed six adaptation teams: Andrews, Felton, Wewers, Waller, and Tingen (2007; e.g., photos of African Americans); Holt et al. (2014; e.g., logos, pictures); Joseph et al. (2016; e.g., images of diverse African American women's body types and hair styles); Sawyer-Kurian and Wechsberg (2012; e.g., images of college-aged African American women of various shapes, shades, and styles). Papas et al. (2010) described adapting visual images to better represent the HIV-infected Western Kenya community being served through an alcohol reduction intervention. For Wu, El-Bassel, Donald McVinney, Fontaine, and Hess (2010), the need for representation was acutely echoed by the participants “We’re an

endangered species…Show two Black men as a couple [on a flyer], that indicates 'We do exist'" (p. 130). The need for translation was addressed by three adaptation designers (Mkenda et al., 2016; Papas et al., 2010; Poulson et al., 2010).

Incorporation of faith/spirituality, music, and traditional practices. Of the total, fourteen interventions within this review used faith/spirituality, local music, and local traditions such as familiar games, songs, and crafts in their adaptations (Andrews et al., 2007; Coard, 2004; Coard et al., 2007; Erwin et al., 2014; Hurt et al., 2012; Jalal et al., 2017; Lightfoot et al., 2014; McMullen, O'Callaghan, Shannon, Black, & Eakin, 2013; Murray et al., 2013; Patel et al., 2011; Poulson et al., 2010; Saleh-Onoya et al., 2008; Schütte & Ulrike, 2016; Ward & Brown, 2015). For example, Murray et al. (2013) framed the TF-CBT concept of "Cognitive Coping" with the question "what would God want you to think" to help the client generate a more "helpful" thought for TF-CBT in Zambia (Murray et al., 2013, p. 7). Another TF-CBT adaptation, for former child soldiers in the Democratic Republic of Congo (DRC) used familiar games and songs to teach relaxation techniques (McMullen et al., 2013). Jalal et al. (2017) use local religious strategies, such *dhikr* (religious chanting), *salah* (ritualistic prayer), and *dua* (supplication), as cultural bridges to mindfulness techniques, in that they also promote attentional shift from rumination topics and teach attentional control.

Adaptations specifically for African Americans identified with a faith community were created by four research teams; three designed to be implemented within church settings although one faith-community-embedded intervention included no mention of use of spirituality or prayer, rather the setting was used for enhancing engagement (Holt et al., 2014). Other church-based adaptations were more liberal in their use of prayer and local faith customs, for example Lightfoot et al. (2014) designed an HIV prevention program for adolescent boys, ages

12-15 (with a component for parents), within a church setting. Explicit use of opening and closing rituals incorporating tenets of faith and spirituality, scriptural references, spiritual tools including song and prayer were devised to link a non-faith-based intervention to the faith environment and increase the participant's feeling that the intervention (e.g., condom demonstration) was complementary and not contradictory to the teachings of the church, particularly related to sex (e.g., abstinence before marriage). The WORD (Wholeness, Oneness, Righteousness, Deliverance) is a health-promotion weight management intervention also designed and implemented within churches, for rural African Americans in the lower Mississippi Delta region (Yeary et al., 2015). Each session includes opening prayer, a Bible study that connects faith beliefs with health, and a closing prayer that petitions God for help to achieve specific intervention goals. Participants are paired as prayer partners throughout the intervention and between sessions and are asked to self-monitor time engaged in their faith. Social cognitive theory principles, such as self-efficacy expectations and beliefs, are tied to faith, for example by emphasizing how strength to achieve goals can be drawn from God.

In marriage education interventions, Erwin (2014) and Hurt et al. (2012) used incorporation of prayer, instruction in how to use prayer for one's spouse as a way to manage marital conflict and enhance marital connection. Designing a community health worker (CHW) facilitated smoking cessation program designed for African American women residing in public housing, the CHWs were encouraged to share spiritual themes and prayers, favorite biblical scriptures, poems, and inspirational meditations (Andrews et al., 2007).

Saleh-Onoya et al. (2008) ended every session with traditional Xhosa songs and creating traditional bead jewelry. Liddle (2006) used music in a psychotherapy intervention for

adolescent boys, playing and discussing music and lyrics chosen by the teens in session as a way to enter the world of the teen.

"Family" feel: Food, stories, kinship, and humor. Including culturally relevant stories and metaphors, use of storytelling, humor, and an experiential format was an adaptation utilized by twelve interventions. Role-plays, storytelling, narratives, or testimony-giving were used by six studies (Andrews et al., 2007; Coard, 2004; Coard et al., 2007; Latham et al., 2010; Lewin et al., 2015; Robinson, Galbraith, Lund, Hamilton, & Shankle, 2012; Sawyer-Kurian & Wechsberg, 2012).

Adapting metaphors and using culturally relevant stories was used by five intervention design teams (Chowdhary et al., 2014; Jalal et al., 2017; McMullen et al., 2013; Murray et al., 2013; Patel et al., 2011). For example, in two interventions adapting TF-CBT, adaptors employed locally relevant metaphors to explain progressive muscle relaxation in Zambia and the Democratic Republic of Congo (McMullen et al., 2013; Murray et al., 2013).

Creating an experiential and relaxed atmosphere was addressed by four research teams. For example, Latham et al. (2010) adapted an HIV prevention intervention for incarcerated adolescent girls. They incorporated a pampering activity to start each session to address the recurrent theme of loss of femininity while incarcerated, and build rapport and trust within the group. Designing a teen co-parenting program, experiential was prioritized over didactic content, including using a game-show format (Lewin et al., 2015). A smoking cessation program for African American women residing in public housing (Andrews et al., 2007), strived to create a "Sister to Sister" sensibility and included food at meetings, opportunities for storytelling, and pot luck dinners at the last group session. Ward & Brown (2015) also incorporated food, starting each "class" with a light meal set to soft background music, during

which participants share a meal, check in, and bond. Following the meal time, the next hour focuses on use of CBT conducted in a support group format, which allows participants the opportunity to share psychosocial issues they are struggling with and get emotional support from group. Also included is a celebratory booster session in which participants review key concepts, share their challenges and progress, receive support and encouragement, and are provided with a referral for continued care.

Afrocentric/collectivistic values. Afrocentric and/or collectivistic values were addressed across 11 cultural adaptations within this review. Three adaptations within this review adapted their original intervention to include or enhance a sense of community, consistent with local collectivistic values (Futterman et al., 2010; Poulson et al., 2010; Saleh-Onoya et al., 2008). Interventions (eight) specifically addressed adaptations made to incorporate Afrocentric values systems. However, one adaptation (Mazzeo et al., 2013), merely describes the existence of a group-therapy format as relating to collectivistic and Afrocentric values without further elaboration or evident adaptation in this domain.

Within this review, Ward and Brown (2015) are the most explicit in their articulation of Afrocentric values, presenting the Nguzo Saba principles as the depression intervention foundation, to foster a sense of direction, personal growth, and life purpose from an Afrocentric perspective. Family/parenting interventions (Coard, 2004; Coard et al., 2007) include the use of African proverbs, sayings and affirmations, poems, quotes, symbols, and pledges and an emphasis on African American values about collective responsibility, cooperation, and interdependence. Liddle (2006), similarly describe an underlying Afrocentric perspective in their substance and “street life” involved intervention for African American adolescent boys. Davey et al. (2012, 2013) facilitate Afrocentric coping skills, specifically described as relying on

faith, promoting fictive kin support, highlighting positives, and encouraging flexibility in family roles for an intervention to optimize coping in African American families following a parental cancer diagnosis. Lastly Breland-Noble et al. (2012) address the underlying collectivistic principle of "rebuilding the village" in an intervention for teens and parents in families with teens struggling with depression (Breland-Noble, 2012, p. 46).

Context adaptations. Addressing issues that were specific to the local context was an adaptation made by 10 intervention designers. Context-specific interventions addressed a wide range of topics, including: cultural symptoms of distress (Jalal et al., 2017; Verdeli et al., 2003); resource constraints (Murray et al., 2013; Saleh-Onoya et al., 2008; Verdeli et al., 2003); medical misinformation (Papas et al., 2010; Wechsberg, Luseno, Lam, Parry, & Morojele, 2006); local health information (e.g., incorporation of local statistics on HIV, unplanned pregnancies, and STIs in a parenting intervention in Western Kenya; Poulson et al., 2010); the role of apartheid in disempowering isiXhosa women (Saleh-Onoya et al., 2008); and instruction in effective self-advocacy within public service and assistance systems (Verdeli et al., 2003). In an intervention addressing an HIV prevention intervention for pregnant African-American women in substance abuse treatment (Wechsberg et al., 2011), the life circumstances context of the population was addressed and formed the primary basis of the context adaptations (e.g., homelessness, domestic violence, victimization while pregnant).

Oppression, discrimination, and stereotypes. Context adaptations made to address experiences of racism, oppression, double jeopardy (e.g., multiple minority status), discrimination, and the impact of stereotypes were addressed by nine interventions.

Parenting interventions for African American families (Coard, 2004; Coard et al., 2007) included racial socialization, culturally affirming strategies to address and respond to racism, and instruction in racial identity development.

In an intervention for African American, adolescent, substance-using boys, Liddle (2006) posits that the social forces of racial oppression, discrimination, and poverty deter these youth from normal and healthy development. The intervention delivers skills training in "role switching" and teaches bicultural competence to succeed in environments other than "the streets" (Liddle, 2006, p. 221). Other interventions shared the view that racism and discrimination serve as barriers to behavior change and optimal well-being (Springfield et al., 2015). Erwin (2014) and Hurt et al. (2012) adapted a marriage education program for African American, heterosexual, adult (21+), married and engaged couples including creation of a module addressing the impact of racism, acknowledging racism as marital stressor and identifying techniques for communicating within couple about it; the researchers identify the endemic nature and impact of race and racism as an underlying element throughout the intervention.

Stereotype threat, the "risk of confirming, as a self-characteristic, a negative stereotype about one's group," (Steele & Aronson, 1995, p. 797) was addressed by several interventions. Sawyer-Kurian & Wechsberg (2012) developed an adapted HIV prevention program for college-aged women at historically black colleges and universities (HCBUs) which included addressing the impact of identity and societal stereotypes of black women and men's sexuality on sexual health, knowledge, and decision-making. Similarly, Wu et al. (2010) adapted an HIV prevention intervention for men who have sex with men (MSM) couples in which at least one member has used methamphetamines, addressing sexualizing and stereotyping of African American men. An adaptation of *Coping With Depression* for African American men and

women, titled *Oh Happy Day* (Ward & Brown, 2015) included an anger management component to address the negative label of "angry Black men/women" (Ward & Brown, 2015, p. 14). In a marital education intervention for heterosexual, African American couples, researchers broke with marital education intervention tradition by separating by gender at end of each session; this innovation was born out of focus groups with men who related the need to address both stressors of role responsibilities and the need for support and positive marital role models as black men (Erwin, 2014).

A pair of interventions addressed double jeopardy, the experience of being multiply marginalized by intersecting identities, specifically for African American men who have sex with men. Robinson et al. (2012) addressed stigma and homonegativity within the Black and dominant communities in an intervention designed for seroconverted (HIV+) African American men who have sex with men (MSM). Wu et al. (2010) adapted an HIV prevention intervention for MSM couples in which at least one member has used methamphetamines; their program also addressed hypervigilance about being seen as non-heterosexual across different communities spaces, stress caused by different levels of acceptance of identity and sexual history within the couple based on salient cultural factors, and held an "anti-heterocentrist macrosystem understanding," culminating with the intervention having facilitators asking for and using the identity label that the participants prefer (Wu et al., 2010, p. 128).

Saleh-Onoya et al. (2008), in adapting an HIV prevention intervention for South African women, addressed the disempowering role of the apartheid system and framed the intervention as fostering "ethnic and gender pride, encourag[ing] women to reflect on the positive aspects of their gender and cultural heritage, and buil[ding] their self-esteem" (p. 189)

Cultural ontology of symptoms and treatment rationale. The need to explain treatment in culturally relevant ways that take cultural ontology and understanding of symptoms into account was addressed by six research teams. For interventions designed for use in Africa, designers addressed the need to provide a compelling rationale to clients and communities for using Western-style psychological treatment in an unfamiliar context. Jalal et al. (2016) draw from Hinton's earlier work (Hinton, Pham, Tran, Safren, Otto, & Pollack, 2004; Hinton, Hofmann, Pollack, & Otto, 2009; Hinton, Hofmann, Rivera, Otto, & Pollack, 2011) in cultural idioms of distress for PTSD interventions, advocating describing the entire treatment and its specific elements. They offer the useful concept of *cultural grounding*, in the service of bridging explanatory models of distress. For Murray et al. (2013), in adapting TF-CBT for Zambian girls, counselors developed a script to explain some advantages of open discussion about feelings, given contrary cultural norms about emotional expression. Similarly, the concept of praise was continually assessed with participants to determine caregiver perception of utility, in a context in which praise between caregivers and children is uncommon. Adapting Cognitive Stimulation Therapy for elders with dementia in rural Tanzania and Nigeria, developers provided education to caregivers about the cognitive health value of elders' continued participation in household activities and responsibilities, since the local custom (younger people relieving elders of household responsibilities out of respect) conflicted with the intervention goal, to increase elders' activity level and participation in both routine and complex tasks (Mkenda et al., 2016). Additionally, in Nigeria, Mkenda et al. (2016) also included a blood pressure screening and referral by a nurse; in Nigeria, psychological treatment independent of medical intervention is not common and the addition of a nurse in the program enhanced acceptability.

Rathod et al. (2010) and Rathod et al. (2013) use CBT to create a shared formulation about the etiology of psychotic symptoms, normalizing the origin explanations of religion and culture (e.g., delusions of possession by a ghost or spirit in African-Caribbean patients can be based on a cultural belief that the ancestors' spirits are protective of native tribes.) Ward & Brown's (2015) Oh Happy Day depression intervention addresses participants' perception that depression was normal, and creates a new module, not found in the original intervention, that focuses on the diagnostic process for depression and treatment options to frame depression as a medical condition. Lastly, Pena-Purcell, Jiang, Ory, and Hollingsworth (2015) created the Wisdom, Power, Control diabetes education program for rural African American communities, and describe it as addressing traditional beliefs about diabetes and food but those were not described sufficiently to satisfy the inquiry of this domain.

Problematic western concepts. For adaptations within Africa, three intervention design teams eliminated or delayed Western concepts that were problematic in the local context (Murray et al., 2013; Patel et al., 2011; Schulz, Huber, & Resick, 2006). For example, in a parenting intervention, the common Western construct time out was not considered feasible in Zambia due to space constraints and responsibilities held by children within the home (e.g., caring for siblings). In Uganda, a CBT/IPT intervention eliminated the concept of interpersonal deficits as that domain was found to be unacceptable or difficult to communicate (Patel et al., 2011).

Literacy. For three adaptation teams designing Africa-based interventions, addressing low levels of literacy was an important adaptation. They described utilizing visual, rather than text, messages on handouts, directions, homework, posters, etc. (Mkenda et al., 2016; Patel et al., 2011; Poulson et al., 2010).

Engagement. Engagement efforts were not addressed by six research teams (Graves et al., 2016; Latham et al., 2010; Pena-Purcell et al., 2015; Sawyer-Kurian & Wechsberg, 2012; Schütte & Ulrike, 2016; Wechsberg et al., 2006).

Table 14

Specific Engagement Adaptations for Communities of African Descent

Engagement Adaptation	Number of cultural adaptations
Not Addressed	6
Addressing Structural Barriers	17
Community Interventionists	12
Extended Family and Community Involvement	9
Stigma Reduction	8
Orienting to the Process	6
Technology	6
Communication Style	6
Addressing Skepticism, Cultural Mistrust, Shaming within the Therapy	3

Addressing structural barriers. The most common engagement strategy addressed in the current review related to minimizing structural barriers to engagement. Of the total, 17 interventions described engagement-enhancing adaptations to location such as community-based co-location, time of day, travel and transportation, coordinating with (provided) meal times, and providing child care, and reminder phone calls or emails, and in many cases all of the above. Dutton et al. (2013) created a mindfulness-based stress reduction intervention for low-income, African American women with PTSD and a history of intimate partner violence. The intervention was co-located within a homeless shelter that accepted children as well as in a community hospital. Many women came directly from work or school, were single mothers, and had no alternative child care, to maximize engagement, the interventionists provided dinner for participants (and their children for sessions held in the shelters), on-site child care for shelter

participants or reimbursement for transportation and assistance with child-care costs for cohorts attending at the hospital. Weekly calls and e-mails with reminders were sent out regularly to reinforce attendance (Andrews et al., 2007; Coard, 2004; Davey et al., 2013; Erwin, 2014; Springfield et al., 2015). Other community settings included a medical office, school, or the participant's home (Chowdhary et al., 2014; McMullen et al., 2013; Patel et al., 2011). Co-locating the intervention within a primary care setting so that the intervention was delivered as an embedded part of other health care visits was described by two research teams (e.g., 1st year well-baby checkups; Lewin et al., 2015; Saulsberry et al., 2013).

Reminders were a common engagement adaptation. For a motivational-interviewing classroom based intervention designed to facilitate treatment entry for African American families in which there was an adolescent with depression, phone sessions were used to inquire about and develop strategies related to structural barriers to treatment (e.g., transportation, money) (Breland-Noble, 2012). Interventionists followed up personally with a thank you card to the family and made reminder phone calls. Highfield et al. (2015) also used a phone intervention to solicit African American women's views on the barriers that prevent their keeping routine mammogram appointments. The adaptation validated and centered the women's own assessment of barriers in addressing problem-solving solutions.

Some of the adaptations used included arranging transportation or adjusting the location to reduce transportation burden (Mkenda et al., 2016; Papas et al., 2010), shortening the length or total number of sessions (Murray et al., 2013; Papas et al., 2010; Saleh-Onoya et al., 2008), providing text reminders, timing the provision of services to avoid the rainy season (Mkenda et al., 2016), flexibility about time/punctuality (Murray et al., 2013), and accommodating village

events and/or household responsibilities (Mkenda et al., 2016; Murray et al., 2013; Verdeli et al., 2003), and interruptions by the larger community (Verdeli et al., 2003).

Community interventionists. Using community-based interventionists was an engagement adaptation utilized in 11 studies for Africa-based interventions and one study within the US. Community based interventionists included lay leaders for TF-CBT in Zambia (Murray et al., 2013); lay leaders in Uganda, Pakistan, and India who were trained and supervised by mental health professionals for the provision of CBT/IPT for depression (Patel et al., 2011); peer mentors (mothers) for a HIV transmission prevention program with pregnant South African women (Futterman et al., 2010); black South African isiXhosa speaking community members with prior experience working in HIV prevention (Saleh-Onoya et al., 2008); caregiver student apprentices in a Tanzanian orphanage (Schütte & Ulrike, 2016); health workers embedded in the community in general maternal health care roles in Pakistan, China, India, Chile, Bangladesh (Chowdhary et al., 2014); community health workers in Nigeria and Tanzania (Mkenda et al., 2016); local community members in rural Western Kenya recruited to deliver a parenting intervention (Poulson et al., 2010); local fieldworkers who spoke Afrikaans, English, Zulu, and Sesotho for a 2-session HIV prevention intervention with sex workers in South Africa (Wechsberg et al., 2006); and non-clinician, college level employees of a local non-governmental organization (NGO) for an IPT-based depression interventions for rural, Ugandan adults (Verdeli et al., 2003). Additionally, in a TF-CBT adaptation for Congolese boys who were former child soldiers (McMullen et al., 2013), the intervention was collaboratively facilitated conducted by the first and second authors in conjunction with two local Congolese counselors and an interpreter. Lastly, a weight loss intervention (Springfield et al., 2015) addressed hair maintenance as a barrier for physical activity and incorporated consultation with

an African American hairdresser for styles conducive to a physically active lifestyle, as part of the weight management intervention.

Extended family and community involvement. Inclusion of extended family, non-blood kin, and important community members as means to facilitate engagement was an adaptation employed by nine teams (Andrews et al., 2007; Coard, 2004; Erwin, 2014; Liddle, 2006; Lightfoot et al., 2014; McMullen et al., 2013; Murray et al., 2013; Patel et al., 2011; Rathod et al., 2010; Rathod et al., 2013). Family and parenting interventions (Coard, 2004; Liddle, 2006) include extended family, teachers, and other important community members. Likewise, Andrews et al. (2007) welcomed inclusion of kinship relationships (e.g., mothers, daughters, sisters) for a community-based smoking cessation intervention. Pastors are also included in interventions for HIV prevention (Lightfoot et al., 2014) and marriage education (Erwin et al., 2014). Working with Black British/Afro Caribbean/Pakistani patients with psychotic spectrum disorders in the United Kingdom, Rathod et al. (2013) suggest enlisting the support of a family member or figure of authority (with the consent of the patient), in particular where the patient or family are hesitant to use interpreters due to fears of breach of confidentiality. They go on to explain,

> As members of these communities often trust their elders and priests more than services, education and information regarding available methods of treatment and collaborative working with these respected members of communities may help in engaging patients early. (Rathod et al., 2010, p. 528)

Stigma reduction. A total of eight interventions across the US, Britain, and Africa included adaptations designed to address stigma (Andrews et al., 2007; Dutton et al., 2013; Jalal et al., 2017; Papas et al., 2010; Rathod et al., 2013; Robinson et al., 2012; Ward & Brown, 2015; Yeary et al., 2015). Some of those adaptations included gender segregation (Papas et al., 2010); not identifying the clinic when making reminder calls (Papas et al., 2010; using culturally

normative terms for distress (Jalal et al., 2017); and addressing the stigma-associations with hospitals and traditional mental health settings. Within this domain, four of the nine interventions within this domain adjusted the location of the intervention setting to reduce the stigma associated with mental health (Dutton et al., 2013; Rathod et al., 2013; Yeary et al., 2015). For example, Rathod et al. suggested locating interventions outside of traditional mental health settings, such as in the participant's home or near places of worship (Rathod et al., 2013). Yeary et al. (2015) delivered their intervention within a church setting. Robinson et al. (2012) describe assessing and attempting to remove barriers to care within the two agencies that were designated to deliver an intervention for HIV+ African American MSM (e.g., removing "gay-identifiable symbols," (p. 215) in storefront, facilitating staff trainings at agencies identified with white MSM but not viewed as a community of care for African Americans, or at agencies identified with the African American community, but not MSM). A pair research teams adjusted vocabulary to reduce stigma, such as calling group therapy sessions "classes" (Ward & Brown, 2015), or referring to community health workers (e.g., nurses) as "coaches" (Andrews et al., 2007).

Orienting to the process. Within this review, six adaptation design teams include an orientation to treatment (Dutton et al., 2013; Lightfoot et al., 2014; McMullen et al., 2013; Murray et al., 2013; Poulson et al., 2010; Rathod et al., 2013). For example, in Zambia, counseling is associated with HIV testing, so Murray et al. (2013) include education about the difference between local counseling (i.e., for HIV) and their TF-CBT adaptation for sexually abused girls. McMullen et al. (2013) opened traditional parent sessions to caregivers and staff at a boys' home for former child soldiers in the DRC. These sessions explained the intervention, the impact of trauma on young children, and also included training on child protection and

children's rights from local NGO staff. Dutton et al. (2013) added extra sessions for a MBSR intervention for low income women with a history of intimate partner violence (IPV) and substance abuse, these sessions were designed to orient the clients, shape expectation, and reassure them that treatment would not be focused on retelling their trauma stories. Lightfoot et al. (2014) also added pre-intervention sessions with youth for a HIV prevention within a faith setting; these sessions served to build comfort among the youth and gain buy-in by emphasizing how the intervention could help youth manage societal pressures about sex and mitigate concern about the intervention contradicting church teachings. Rathod et al. (2013), adapting CBT for psychosis in the United Kingdom with Black Britons and Afro-Caribbeans lengthened the initial assessment and works at the patient's pace with emphasis on listening and understanding the cultural perspective.

Technology. Use of technology as a means for increasing engagement was a strategy employed by six research teams working with U.S. African American communities. Highfield et al. (2015) used a phone-based intervention to increase mammography adherence in African American women. The internet was also used as a means of reaching participants. Interventions were web-based (Holt et al., 2014); or combined a web-based intervention with limited live intervention (Joseph et al., 2016). Texting was used by Mazzeo et al. (2013), in an intervention for loss of control eating in black and white teen girls, as well as by Lewin et al. (2015) for a teen co-parenting intervention. Lastly, an intervention for HIV prevention for women in substance abuse treatment was delivered via laptop for ease of portability between sites (Wechsberg et al., 2011).

Communication style. Specific efforts to adjust the communication style of the intervention were made by five interventions teams. In three US interventions, communication

style was adjusted toward a highly collaborative, non-authoritarian approach that emphasized the client's subjective experience (Andrews et al., 2007; Coard, 2004; Highfield et al., 2015). A pair of studies (Uganda, Zambia) specifically addressed the need to hew to cultural norms of conversation and work appropriately with cultural taboos (Murray et al., 2013; Verdeli et al., 2003). For example, Verdeli et al. (2003) describe the acceptability, in Uganda, of general inquiry about one's community and relatives, but caution that that specific questions that may be considered innocuous in Western medical settings, such as the number of children one has, should be avoided unless the information is freely offered by the client. Additionally, common psychological intervention norms related to confidentiality were seen as potentially problematic. Verdeli et al. (2003) describe receiving feedback from the trainees who facilitated the intervention,

> The group members were asked to not disclose the content of the group meetings to people outside the group. However, the trainees pointed out that this may be misconstrued as secrecy or conspiracy (as one trainee said, 'the village will think that we are starting a new political movement or that we are encouraging women to use birth control'). The trainers and the trainees decided that some general information about the purpose of the group should be given to the community. (p. 116)

Murray et al. (2013), in adapting TF-CBT for sexually abused Zambian girls addressed cultural prohibitions around discussing sex. Adaptations to the program included a more gradual introduction of sex education, seeking permission from the caregiver before addressing sexual issues with the child, and working with the caregivers to explain to the child that it was acceptable (and not disrespectful) to ask questions or speak about sex in this context.

Addressing skepticism, cultural mistrust, shaming within the therapy. Cultural mistrust of mental health and medical providers within the African American community was addressed by three teams. They sought to minimize the experience of shame and criticism within the therapeutic relationship by deemphasizing dynamics that could result in the therapist establishing

expectations that the client would or could not meet, including eliminating take-home practice (e.g., homework; Dutton et al., 2013; Lewin et al., 2015) and adjusting goal expectations to conform more closely to participants' life experience (e.g., adjusting long-term goals to a 12-month duration for an intervention with incarcerated teen girls; Latham et al., 2010).

Development and equivalence processes. Only Chowdhary et al. (2014) did not address their equivalence and development process. However, in the case of Chowdhary et al., many of the researchers associated with the study also participated in Patel et al. (2011), in which development process were thoroughly discussed including foundational qualitative interviews. It may be that, while not referenced specifically, Chowdhary et al. (2014) drew on this pre-existing body of qualitative research, stakeholder interviews, and review of adaptation theory.

Table 15

Specific Development and Equivalence Adaptations in Interventions for Communities of African Ancestry

Equivalence Process	Number of cultural adaptations
Not Addressed	1
Integration of Top Down and Bottom Up	24
Fidelity	18
Adaptation Theory Referenced	17
Top Down Approach	6
Bottom Up Approach	1

Integration of top down and bottom up approaches. Of the total, 24 adaptation design studies described integration of top down (clinician/researcher generated) knowledge and bottom up (community generated) knowledge (Andrews et al., 2007; Breland-Noble, 2012; Davey et al., 2013; Dutton et al., 2013; Erwin, 2014; Futterman et al., 2010; Highfield et al., 2015; Holt et al., 2014; Joseph et al., 2016; Latham et al., 2010; Lightfoot et al., 2014; Mazzeo et al., 2013; Mkenda et al., 2016; Murray et al., 2013; Papas et al., 2010; Patel et al., 2011; Poulson et al.,

2010; Rathod et al., 2013; Saleh-Onoya et al., 2008; Sawyer-Kurian & Wechsberg, 2012; Verdeli et al., 2003; Wechsberg et al., 2006; Wechsberg et al., 2011; Wu et al., 2010). Commonly used formats for generating community data was the use of focus groups and community advisory boards. As an example, Holt et al. (2014) created a nine-member community advisory board for their church-based cancer screening intervention. Community stakeholders for that intervention included cancer survivors, healthcare professionals, and faith leaders in an adaptation of a parenting intervention for rural Kenyan families (Poulson et al., 2010), and final approval of the adapted program was held by the community advisory board.

Other/adjunctive strategies included qualitative pilot studies to develop an understanding of the needs, values, and priorities of the community and potential participants, which was then used to develop the intervention (Breland-Noble, 2012; Coard, 2004; Coard et al., 2007; Rathod et al., 2013). For example, Rathod et al. (2013), in adaptation CBT for psychosis with ethnocultural minorities in the United Kingdom (UK), described a rigorous data collection process to inform their intervention design, consisting of both individual semi-structured interviews with patients with schizophrenia (n = 15); focus groups with lay members from selected ethnic communities (n = 52); as well as focus groups or semi-structured interviews with CBT therapists (n = 22); and mental health practitioners who work with patients from the ethnic communities (n = 25). Research teams described a stages model in which community feedback was used to refine the intervention (Breland-Noble, 2012; Highfield et al., 2015; Lewin et al., 2015; Sawyer-Kurian & Wechsberg, 2012). For example, in Highfield et al.'s (2015) medical appointment adherence phone-based intervention, phone calling scripts (based on qualitative data about barriers to appointment adherence) were pre-tested with local African American women,

working in role-play pairs. The pre-testers noted needed changes in the scripts to make them as relevant as possible to local women.

Community-based interventionists, local to the intervention context, were also important sources of local knowledge for adaptation in four studies (Murray et al., 2013; Papas et al., 2010; Poulson et al., 2010; Verdeli et al., 2003).

Fidelity. Efforts to ensure fidelity between the adapted and original version of the intervention were described in 18 studies. Supervision (whether live or through long-distance video conference) as a means to ensure fidelity was described in three studies (Chowdhary et al., 2014; Schütte & Ulrike, 2016; Verdeli et al., 2003). Training local facilitators as a means of protecting fidelity was addressed by six researchers (McMullen et al., 2013; Murray et al., 2013; Papas et al., 2010; Poulson et al., 2010; Saleh-Onoya et al., 2008; Verdeli et al., 2003). Other fidelity provisions included consulting with the original developers to ensure that the adaptation retained the core principles of the original intervention (Coard, 2004; Lewin et al., 2015; Mkenda et al., 2016; Robinson et al., 2012), using standardized instruments to assess coherence to the model (Papas et al., 2010; Wu et al., 2010), and maintaining session order/skills training order (Coard, 2004; Wechsberg et al., 2011). Nine researcher teams described identifying essential elements for preservation (Highfield et al., 2015; Liddle, 2006; Poulson et al., 2010; Robinson et al., 2012; Sawyer-Kurian & Wechsberg, 2012; Saleh-Onoya et al., 2008; Wechsberg et al., 2011; Wu et al., 2010; Yeary et al., 2015). Wu et al. (2010) were notable for their well-described deconstruction/reconstruction matrix to ensure session-by-session core component fidelity.

Adaptation theory referenced. Adaptation theory was referenced by 17 studies. Specifically identified were: community based participatory action research (Andrews et al., 2007; Murray et al., 2013; Rathod et al., 2013; Sawyer-Kurian & Wechsberg, 2012; Schütte &

Ulrike, 2016; Springfield et al., 2015; Yeary et al., 2015); Hwang's PAMF framework (Mkenda et al., 2016); Barrera and Castro's heuristic model (Lewin et al., 2015; Ward & Brown, 2015); the CDC/public health frameworks ADAPT-IIT (Latham et al., 2010; Saleh-Onoya et al., 2008); MAP (Poulson et al., 2010; Robinson et al., 2012); and Intervention Mapping (IM; Highfield et al., 2015). Highfield et al. (2015) is especially notable for an excellent description of Intervention Mapping. Two studies referenced adaptation theory guidelines and governing principles more generally (Rathod et al., 2013; Sawyer-Kurian & Wechsberg, 2012).

Top down approach - researcher/clinician driven. While most of the adaptations in this review were notable for their adherence to adaptation theory guidelines, including a bottom-up approach that includes meaningful integration of community participants in the intervention design, four adaptations included minimal or no inclusion of participants. Top down approaches were driven by clinician knowledge (Jalal et al., 2017) or researchers with post-adaptation input from a local NGO (McMullen et al., 2013). Liddle's (2006) motivational-theory based intervention for engaging African American adolescent males in depression treatment, included scant bottom-up integration (validating the adolescent's perspective in therapy) and was largely theoretically-derived. Pena-Pucell et al. (2015) were clear in their design of a diabetes management program that curriculum content was theory-based and predicated on the standards developed by the American Diabetes Association and the American Association of Diabetes Educators. A web-based depression intervention for African American and Latino adolescents describes the formation of community advisory board consisting of adolescents (the target population for the intervention), however the advisory board reviewed the website after its creation, rather than informing the creation and design (Saulsberry et al., 2013). Notably, Graves

et al. (2016) described lack of a bottom-up component as a major limitation of their school-based social-emotional intervention for African American boys,

> In particular, one teacher commented, "I liked the goals of the intervention; however, there needed to be more of a cultural focus on Black boys. The developers of these interventions have good intentions, however they ignore race." Another teacher commented, "The skills that you went over are extremely necessary so it's critical that they have a grasp of this information; however, a majority of our boys are so traumatized with the gun violence and drugs in the community they definitely need something stronger. (Graves et al., 2016, p.70)

Bottom up – community driven. An intervention in the field of public health (nursing), described that the creation of their smoking cessation intervention for African American women residing in public housing, was initiated by a community member (a school counselor), rather than a researcher (Andrews et al., 2007).

Therapist cultural competence. Therapist cultural competence was not addressed by ten adaptation design teams (Dutton et al., 2013; Graves et al., 2016; Joseph et al., 2016; Latham et al., 2010; Lightfoot et al., 2014; Mazzeo et al., 2013; Pena-Purcell et al., 2015; Saulsberry et al., 2013). One intervention described general alliance-building competencies, rather than addressing cultural competence, per se (Liddle, 2006). One intervention only addressed adaptations within the domain of cultural competence in terms of a general requirement to acquire local cultural knowledge (Jalal et al., 2017)

Table 16

Specific Cultural Competence Adaptations for Populations of African Ancestry

Cultural Competence Adaptation	Number of cultural adaptations
Not Addressed	10
Community Interventionist	18
Ethnic Matching	7
Resolving Past Negative Experiences	2
Non-Hierarchical Collaboration	2

(continued)

Cultural Competence Adaptation	Number of cultural adaptations
APA Guidelines	2
Community Investment	1
Self Disclosure and Gifts	1
Anti-Racism	1

Community interventionists. Using community-based interventionists was a cultural competence adaptation utilized in 18 studies (Chowdhary et al., 2014; Futterman et al., 2010; McMullen et al., 2013; Mkenda et al., 2016; Murray et al., 2013; Patel et al., 2011; Poulson et al., 2010; Saleh-Onoya et al., 2008; Schütte & Ulrike, 2016; Wechsberg et al., 2006; Verdeli et al., 2003). Research teams utilized peers, in the form of trained lay facilitators with deep intersectional overlap (e.g., race, gender, socioeconomic status, church community, neighborhood) with the intervention recipients (Andrews et al., 2012; Holt et al., 2014; Robinson et al., 2012; Sawyer-Kurian & Wechsberg, 2012; Wechsberg et al., 2011; Yeary et al., 2015). In a neighborhood-based tobacco cessation program, peer-led groups included trained lay community health workers (CHWs) who were indigenous to the local community and who were trained to use their own language and cultural style and share testimonials and personal experiences (Andrews et al., 2007).

Ethnic matching. Ethnic matching between client and therapist was utilized in seven studies (Coard et al., 2004; Davey et al., 2013; Erwin, 2014; Highfield et al., 2015; Papas et al., 2010; Springfield et al., 2015; Ward & Brown, 2015). In a marriage intervention for African American couples, the group intervention was facilitated by one male and one female African American therapist, and was often led by a married couple (Erwin, 2014). Papas et al. (2010) utilized matching of therapists on the basis on national origin in their adapted CBT intervention to reduce alcohol use among HIV positive men and women in Kenya.

Resolving past negative experiences. Two interventions addressed cultural biases within the field of psychology and the need to address and repair those injustices by the therapist. One aspect of cultural competence addressed by Breland-Noble (2012) is predicated on identification of "culturally encapsulated psychological barriers to depression treatment utilization" (Breland-Noble, 2012, p. 43). As a result, part of the intervention requires assessing and addressing past negative experiences with mental health professionals and developing skills for utilizing mental health systems successfully. Rathod et al. (2013), direct their focus on the cultural competence of therapist. They also highlight systems-level biases within mental health that have contributed to poor care for ethnoculturally diverse clients, including issues related to translators, need for culture-specific supervision, awareness of bias within systems (e.g., national institute of health or NIH), caution against applicability of cognitive models, and respect for traditional healing.

APA guidelines. APA multicultural guidelines were specifically cited by two intervention teams in terms of rationale or guidance for adaptations (Coard et al., 2004; Rathod et al., 2013).

Community investment. Coard (2004), in describing a parent training intervention, focused on attaining credibility through regular interactions in the community and staff involvement in community activities.

Gifts and self-disclosure. Mkenda et al. (2016) adapted a cognitive stimulation therapy intervention for elder adults with dementia in sub-Saharan Africa with clinical trials in Tanzania and Nigeria. In both settings, Western norms around gift giving and self-disclosure were adapted to hew to cultural norms, such as giving participants a small gift, such as a sweet to give to a grandchild, following attendance.

Anti-racism. Wu et al. (2010), adapting an HIV intervention for methamphetamine involved African American men who have sex with men, articulate an explicitly anti-racist stance.

> The anti-racist perspective expands upon notions of cultural competence and cultural humility [29] by explicitly paying attention to race-based power, privilege, and oppression. Such issues cannot be ignored as they underlie the social and structural factors that drive the health disparities, such as HIV, shouldered by African Americans. Finally, the anti-racist perspective also accommodates the varied phenotypes that may be represented among partners as well as the service providers and researchers working with the target population. Paralleling the anti-racist perspective, we pose and employ an anti-heterocentrist ideology; this perspective affirms and accepts different sexual identities and labels (especially those beyond gay and bisexual), which is particularly relevant given the attention paid to non-gay identities and labels for same-sex behaviors (e.g., "down-low") among African American MSM. Some participants stated they identify as gay and/or homosexual. Some embraced subverting the derogatory nature of the term "faggot," and others noted referring to themselves or others as a "snow queen" or "Carlton." This was further refined by the anti-heterocentrist macrosystem understanding, culminating with the intervention having facilitators asking for and using the identity label that the participants prefer.
> (Wu et al., 2010, p.129)

Non-hierarchical collaboration. Adjustment of the therapist's communication style towards a collaborative relationship is a cultural competence adaptation described by two interventions, both designed for African American families (Breland-Noble, 2012; Erwin, 2014).

Reported outcomes and results. Nine of the interventions studied here described their research design as a randomized controlled trial; an additional five research teams described their research design as a pre- post-test design with a control group. Methods of analyzing intervention success included statistical analysis of symptom reduction and/or behavior change, participant satisfaction self-report data, attrition rates, and replication of the intervention. Problems in implementation or failure to yield positive results were also reported.

For fourteen of the reviewed 36 studies, results data was not reported (Andrews et al., 2007; Chowdhary et al., 2014; Erwin, 2014; Jalal et al., 2017; Latham et al., 2010; Lightfoot et

al., 2014; Patel et al., 2011; Saulsberry et al., 2013; Sawyer-Kurian & Wechsberg, 2012; Springfield et al., 2015; Wechsberg et al., 2011; Wu et al., 2010; Yeary et al., 2015). Participants were lost to follow up for Robinson et al. (2012).

Table 17

Type of Result Reported in Interventions for Communities of African Ancestry

Type of Result reported	Number of cultural adaptations
Not reported/not available yet	14
Symptom Reduction/Behavior Change	18
Participant Satisfaction	11
Low Attrition	9
Problems/Poor Outcomes	3
Replication	1

Symptom reduction/behavior change. Eighteen studies reported symptoms reductions or behavioral change as a result of their intervention (Futterman et al., 2010; Graves et al., 2016; Highfield et al., 2015; Joseph et al., 2016; McMullen et al., 2013; Mkenda et al., 2016; Murray et al., 2013; Papas et al., 2010; Poulson et al., 2010; Rathod et al., 2013; Verdeli et al., 2003; Wechsberg et al., 2006).

For example, Rathod et al. (2013) adapted CBT for Black British, Afro-Caribbean, and Pakistani patients with psychosis in the UK (CaCBTp). Participants in the CaCBTp group achieved statistically significant results post-treatment compared to those in the treatment as usual group with some gains maintained at follow-up. There was a significant reduction of symptomatology, although gains were maintained unevenly across symptomatology assessment measures at follow-up. Ward and Brown (2015) adapted Coping With Depression into Oh Happy Day, a depression intervention for African American adults. Their studies (N = 55) showed statistically significant decline in depression symptoms from pre- to post-intervention, and a 0.38 effect size. For men, the adapted intervention showed a 1.01 effect size and for

women, a 0.41 effect size. Coard (2013), in assessing the effectiveness of a parenting intervention, found that adapted treatment families showed increases in positive parenting and reduction in harsh discipline over time, whereas control families showed increases in harsh discipline and reductions in positive parenting. She further reported that the effect sizes for Positive Parenting, Harsh Discipline, Conduct Problems, and Responsibility were all considered large.

Three studies measured behavior change indirectly or adjunctively, in terms of in participant knowledge acquisition as a result of their intervention (Futterman et al., 2010; Pena-Pucell et al., 2015; Schütte & Ulrike, 2016). For example, Pena-Purcell et al. (2015) created the Wisdom, Power, Control diabetes education program adapted for rural African American communities. Their study (N = 103) indicated that the intervention group reported a significantly higher level of diabetes knowledge, higher self-efficacy, more self-care behaviors, lower distress level, and higher health status.

Participant satisfaction. Participant satisfaction was reported by eight research teams (Coard et al., 2004; Davey et al., 2013; Lewin et al., 2015; Mkenda et al., 2016; Poulson et al., 2010; Rathod et al., 2013; Saleh-Onoya et al., 2008; Ward & Brown, 2015). Rathod et al. (2013) reported high scores on the patient experience questionnaire for CaCBTp. Coard et al. (2007) reported parent satisfaction for a family intervention; she described that 100% of parent participants said they would recommend the program to a friend, and reported one participant as stating "I learned a lot about how to raise a confident Black child" (Coard et al., 2007, p. 812).

Lewin et al. (2015) reported positive participant rating for a teen co-parenting intervention collocated within a primary care setting (N = 64). Participants rated classes on a five-point Likert scale with a range of ratings from 4.2 - 4.7 on questions about intervention

helpfulness, clarity, perception of listening on the part of the facilitators, appreciation of class material, and usefulness in the future. An intervention for African American families coping with a parental cancer diagnosis (Davey et al., 2013) reported that parents and school-age children who completed the culturally adapted family intervention reported being more satisfied compared with the psycho-education control group. Ward and Brown (2015) reported that participants in an adapted depression intervention described themselves as "very satisfied" with the intervention on self-report measures (Ward & Brown, 2015, p. 17).

Low attrition. Studies (eight) used data on attrition and program completion as validators of the intervention (Breland-Noble, 2012; Coard et al., 2007; Lewin et al., 2015; Liddle, 2006; Poulson et al., 2010; Rathod et al., 2013; Schulz et al., 2006; Verdeli et al., 2003). Liddle (2006) created a treatment-engagement enhancement intervention for substance using African American adolescent boys; they found that 95% of clients in intensive outpatient culturally adapted program stayed in treatment for 90 days, compared with 59% in non-adapted residential treatment. They also completed a therapy process study with African American teens that suggested that using the cultural themes and clinical method of the adapted intervention enhanced the adolescent's participation and engagement in family-based therapy. Lewin et al. (2015) found their teen co-parenting adapted program had a higher participation rate than the two non-adapted co-parenting teen programs already published. Rathod et al. (2013), as indicated above, also reported low attrition rates and high mean number of sessions attended for CaCBTp. Coard et al. (2007) reported that average attendance across 12 sessions was 85% for a parenting intervention.

Poor results/problems. Holt et al. (2014) described feasibility problems with their church-based intervention, specifically that the program would be unlikely to be maintained in the churches subsequent to the research study due to the demands of staff and resources.

Dutton et al. (2013) designed an MBSR PTSD program for low-income African American women with a history of IPV. They reported a higher than average dropout rate for CBT across 25 controlled PTSD studies. It may be worth noting that, based on the model presented in this dissertation, the adaptation by Dutton et al. only covered 2 of the 4 domains of adaptation. Similarly, Mazzeo et al. (2013) reported some improvements in behavior for binge and loss of control eating among adolescent girls, however, the intervention arm did not outperform the control group. It may be worth noting, again, that intervention only covered 2 of the 4 domains of adaptation.

Replication. Poulson et al. (2010) measured intervention success as evidenced by its replication in Botswana and Côte d'Ivoire.

Exemplar adaptations. Of the 36 studies reviewed, 21 studies were coded for explicit description of all four domains of adaptation. However, while Rathod et al. (2013) described all four domains of the model, their research on adapting CBT for British minority populations was notable for its elucidation of guidelines to adapted CBT, rather than describing a specific program or intervention. Additionally, while Holt et al. (2014), addressed all four domains, however, adaptations were minimally described beyond ethnic matching. Several adaptations stood out for their use of surface and depth adaptations, as well as the richness of their description of the adaptation process, three are presented here.

Table18

Exemplar Adaptations for Communities of African Descent

Citation	Context	Engagement	Equivalence	Therapist CC
Coard (2004). Towards Culturally Relevant Preventive Interventions: The Consideration of Racial Socialization in Parent Training with African American Families.	Adaptations include: inclusion of racial socialization, culturally affirming strategies, racism, instruction in racial identity development, and the African American–perspective use of we; African American language expression, common language; emphasis on values, collective responsibility, cooperation, and interdependence; use of African proverbs, sayings and affirmations, poems, quotes, symbols, and pledges; the use of prayer, role-playing, storytelling, and humor.	Collaborative approach with parents; communication style adaptations-- African American language expression, common language, use of "we"; extended family participation. Multiple efforts to facilitate engagement and reduce barriers, including providing dinner, reminder phone calls, and child care.	APA Cultural competency guidelines discussed. Ethnic matching; focus on credibility through regular interactions in the community.	Adaptation Theory guided intervention design including development of an initial qualitative pilot study. Fidelity ensured through ongoing consultation from original program developers.
Saleh-Onoya, et al. (2008). SISTA South Africa: the adaptation of an efficacious HIV prevention trial conducted with African-American women for isiXhosa-speaking South African women. SAHARA-J : Journal of Social Aspects of HIV/AIDS, 5(4), 186–191. http://doi.org/10.1080/17290376.2008.9724918	Collectivistic language adaptations; more time in the curriculum allowed for discussions and exploration; names, terms, and regional slang common in South Africa were incorporated into the curriculum. Poetry by isiXhosa women was introduced to stimulate discussion about gender and cultural pride, the strengths of isiXhosa women role models, as well as the challenges of being an isiXhosa woman. Much of the discussion of the challenges reflected on the role of apartheid in disempowering isiXhosa women. Participants also discussed personal and community values that could facilitate safer sex practices. Focus on ethnic and gender pride, encouraging women to reflect on the positive aspects of their gender and cultural heritage, and built their self-esteem. Workshops ended with traditional Xhosa songs, as well as creating traditional bead jewelry (bracelets, necklaces and rings).	Reduction of number of overall sessions.	Stage model, integrating top down and bottom up knowledge through focus groups and meetings with key stakeholders (e.g., community members, nurses, physicians, clinics). Adaptation theory was used, specifically public health framework ADAPT-IIT. Fidelity ensured through identification of core elements for preservation. U.S. African-American health educators implemented a training program to train the South African facilitators, using a train-the-trainers strategy.	Non health/mental health facilitators were used; facilitators were black South African women who spoke and read isiXhosa fluently, had completed their secondary education and were selected based on their demonstrated communication skills and enthusiasm for the project, as well as prior experience working in the field of HIV prevention
Ward & Brown (2015). A culturally adapted depression intervention for African American adults experiencing depression: Oh Happy Day.	Afrocentric paradigm; use of prayer and spirituality, addresses discrepancies between professional and cultural views of depression; Incorporation of anger management module; addresses relationship between depression and health conditions.	Light meal is provided with soft background music is played, during which time participants share a meal together, check in, and bond with each other; use of group format; language changes from "sessions" to "classes."	Adaptation Theory referenced: Bernal's Stage Model; conducted series of studies examining African Americans' beliefs about mental illness, perceptions of stigma, experiences in counseling, and treatment preferences.	Ethnic matching; encouragement of appropriate self-disclosure on the part of the therapist relevant to topics of discussion about their experiences of being African Americans.

Discussion. The existence of 36 cultural adaptations of empirically supported interventions for people of African ancestry is encouraging. Of these, 23 (66%) are geared towards African Americans, 11 (30%) towards Africans, and five (13%) towards multi-country or multi-population studies with a predominance of people of African ancestry included in the samples. The existence of 11 cultural adaptations of evidence based interventions for the continent of Africa is encouraging. However, of the 54 countries on the continent of Africa, only seven are represented within this review. Clearly the global African diaspora still remains underserved in regard to availability of cultural adaptations of evidence based treatments. It may be worth noting that there were culturally specific interventions (23) that were excluded for the purposes of this review, which would have expanded the global reach of psychological study to include the Caribbean, a notable gap in the available adaptations for people of African descent. Culturally specific knowledge is critical to effective adaptation or delivery of an adapted intervention. Given the number of excluded studies (23) and the fact that that for most African countries under this review, only one cultural adaptation is yet available, culturally specific research should be consulted in conjunction with cultural adaptation research.

The contributions of public health, which account for 50% of the studied interventions, should offer a valuable blueprint, validated by 25 years of continuous use and high-level governmental support, for adaptation psychologists. Of the 50% of health promotion and disease prevention interventions, 77% were interventions targeting HIV prevention (10). Family-related interventions accounted for another 11%. DSM-5 disorders such as depression, PTSD, psychotic spectrum disorders, eating disorders, and substance use only accounted for a combined 32%. Significant sections of the DSM-V remain un-addressed by cultural adaptations including

anxiety disorders, developmental disorders, and psychotic spectrum disorders for people of African ancestry seeking psychological treatment.

In terms of this dissertation's four-part adaptation model, Context and Content was the most heavily invested arm of the model, with context and content adaptations made in 34 of 36 adaptations. Consistent with literature indicating under-utilization of mental health services by African Americans (LaVeist et al., 2000), Engagement was the second most invested arm of the model, with 30 of 36 interventions addressing engagement strategies. Somewhat surprisingly, given the long history of racially-based abuses, client preference for ethnic matching, and the demographics of the field of psychology that suggest that many, if not most, therapeutic dyads with African American clients will be cross-cultural, ten studies failed to address therapist cultural competence. It is worth noting that in the domain of cultural competence, use of a local interventionist supplanted most other discussion of cultural competence for adaptations in African countries. It may be that cultural competence is more implicitly taken for granted in interventions designed for a global setting and delivered by interventionists local to that environment. It may be that cultural competence becomes more salient when working cross-culturally, such as in the case of immigration, refugee status, or ethnocultural minorities within a pluralistic society. Further research should seek to address the question of how or if cultural competence is understood and conceptualized when working in a global context with local providers indigenous to the community. The most dominant interventions within Context and Content, Engagement, and Cultural Competence were: Language and Visuals; Addressing Structural Barriers; and Ethnic Matching (respectively). Adaptation theory best practices which consist of integration of top-down and bottom-up approaches to adaptation were utilized by 24

research teams, with adaptation theory referenced by 17, and fidelity efforts delineated by 18 intervention designers.

When analyzing themes across the four domains, there was a strong emphasis on community. Of the total, twelve adaptations were led by or incorporated community interventionists; involvement of extended family and/or important community members was an Engagement adaptation utilized by nine teams. Creation of a family feel was a Context adaptation addressed within 12 adaptations; and Afrocentric or collectivistic values were addressed by 11 research teams. It is worth briefly referencing Afrocentrism here, as it has emerged as a dominant culturally-specific frame of intervention and theory pertaining to African American psychological wellbeing (Bent-Goodley, 2005; Gilbert, Harvey, & Belgrave, 2009; Myers & Speight, 2010; Nobles, 2015; Nobles & Goddard, 1993). Afrocentrism contains three assumptions: a) human identity is a collective identity; b) spiritual aspects of life are as important as material aspects; and c) affective knowledge is as valid as other forms of knowledge (e.g., rational; Stewart, 2004). Afrocentric values can be seen across multiple Context and Content themes including *Incorporation of Faith/Spirituality, Music, and Traditional Practices, "Family" Feel: Food, Stories, Kinship, and Humor*, *Afrocentric/Collectivistic Values.*

The impact of racism, oppression, discrimination, and stereotypes occurred thematically across the four domains of the cultural adaptation model. A total of nine adaptations addressed these negative contributors to mental and physical health within the domain of Context and Content. Cultural mistrust of mental health and medical providers was referenced by three interventions; eight interventions addressed stigma associated with hospitals and mental health settings as Engagement adaptations. Within the Therapist Cultural Competence domain, two interventions addressed past negative experiences within mental health as an aspect of treatment,

one specified a deliberate anti-racist stance, and one addressed the need to build community-wide credibility through ongoing investment.

Latino/a/x

Academic databases were searched four times over the course of a 12-month period for peer reviewed articles, books, and dissertations published between 2000-2017. Various keyword combinations were used such as "Latino + Evidence Based," "Cultural Adaptation + Latino," "Evidence Based + Cultural Adaptation," "Culture + Latino + Evidence," yielding a total of 33 studies. While in the keyword search the words "Latino" and "Hispanic" were both used, for the purposes of this review, variants of Latino are used. Of the 33 studies identified, 12 studies were not cultural adaptations. Of the 12 excluded studies, three were qualitative studies with Latinos, five identified guidelines for cultural competence with Latinos, three were better classified as evidence-based culturally specific interventions for Latinos, and one was a general review of interventions with Latinos.

Of the 33 studies, 21 met criteria for inclusion in this study as cultural adaptations of empirically supported interventions, yielding a total of 20 cultural adaptations for this review (two interventions were described across two separate articles, however the intervention was only counted once in this review).

Communities addressed. These 20 interventions focus on the following population characteristics and communities:

Table 19

Characteristics of Latino/a/x Target Communities

Target Population	Number of Culturally Adapted Interventions
Latinos in the United States	18
- Primary Spanish Speaking	4
- 1st generation immigrants	2
- English speaking/ESL	3
- Parents/Caregivers	4
- Caribbean Latinas	1
- Men	1
- Mexican descent	4
+ Youth	1
+ Parents	2
+ Migrant Farmworkers	1
- Women	1
- Women	4
- Central American descent	1
- Latinos in Puerto Rico	1
- Youth	1
Mexico	2
- Youth	1

The global Latino/a/x is very large, encompassing Spanish-speaking countries across the Americas and the Caribbean. While the presence of 18 cultural adaptations developed for Latino communities in the United States in encouraging, particularly as Latinos are the fastest growing demographic group in the US (US Census, 2015), there is a severe paucity of adaptations available for Latinos in their home communities or Latinos living abroad in other Spanish-speaking countries.

Target disorders. The 20 reviewed studies addressed the following psychological disorders and psychosocial issues:

Table 20

Target Concerns of Interventions for Latino/a/x Communities

Target Population	Number of Culturally Adapted Interventions
Depression	9
- Postpartum depression	1
- Depression with comorbid anxiety	1
- Parents with depressed adolescent	1
Parent Management/Family Intervention	5
PTSD	1
HIV Prevention	1
Heavy Drinking	1
Bulimia Nervosa	1
Anxiety Disorders	2
- Social Anxiety Disorder	1

Adaptations for depression account for 50% (nine) of the available adaptations for Latinos; 27% (five) address family issues including parenting; > 1% address other psychological and psychosocial concerns including Anxiety, Bulimia, Alcohol Abuse, HIV Prevention, and PTSD.

Theoretical basis of intervention. CBT provided the underlying theoretical base for 67% (12) of all adapted interventions for Latinos; Social Cognitive Theory accounted for an additional 22% (4); the remaining interventions were grounded in Motivational Interviewing and Behaviorism.

Table 21

Theoretical Basis of Interventions for Latino/a/x Communities

Target Population	Number of Culturally Adapted Interventions
Cognitive Behavioral Therapy	12
- CBT + Interpersonal Theory	1
Social Learning Theory	4
Motivational Interviewing	2
Behaviorism	2

Analysis of adaptations. The 20 reviewed studies were analyzed for their adaptations according to this dissertation's four-part model.

Context. Context adaptations were included in all 20 reviewed studies. Thematic grouping of contextual adaptations were as follows:

Table 22

Specific Context and Content Adaptations in Latino/a/x Community Studies

Context and Content Adaptation	Number of cultural adaptations
Cultural Values – *Simpatia, Familismo, Respeto*	12
Translation, Idioms, and Dichos	12
Contextual Issues	10
Acculturation	5
Literacy Adaptations	4
Visuals	2
Spirituality	2

Cultural values – respeto, familismo, personalismo, and simpatia. In the 20 reviewed studies, 12 interventions included adaptations that address collectivistic values generally or, more commonly, specifically referenced Latino cultural values of *respeto* (respect), *familismo* (importance of family), *personalismo* (formal friendliness), and *simpatia* (not easily translatable; English correlates include sympathy, fellow feeling, pleasantness, relational harmony; Agazzi, 2010; Aguilera, Garza, & Munoz, 2010; Domench-Rodriguez, Baumann, & Schwartz, 2011; Dumas, Arriaga, & Moreland Begle, 2011; González-Prendes, Hindo, & Pardo, 2011; Hovey, Hurtado, & Seligman, 2014; Interian, Allen, Gara, & Escobar, 2008; Interian, Martinez, Rios, Krejci, & Guarnaccia, 2010; Le, Zmuda, Perry, & Muñoz, 2010; Lee et al., 2011; Reyes-Rodríguez, Bulik, Hamer, & Baucom, 2013; Sáez-Santiago et al., 2012).

Some examples include a motivational interviewing intervention to improve antidepressant adherence, in which antidepressant adherence was reframed as a way to *poner de*

su parte (do one's part), so that antidepressant adherence was aligned with collectivistic and family-oriented cultural values (Interian et al., 2010). Another example comes from Lee et al. (2011) whose heavy drinking intervention included a model about the impact of heavy drinking consequences on children and family, emphasizing positive role modeling for children. Reyes-Rodríguez et al. (2013) include extended family members into treatment for eating disorders, adapting standard ED treatment to reflect the role of family.

Translation, idioms, and dichos. Language plays an important role in cultural adaptation for Latinos and 12 of the reviewed 20 studies included adaptations to translate text, often with emphasis on linguistic regionalisms and local idioms (Agazzi, 2010; Bauman, 2014; Interian et al., 2008; Interian et al., 2010; Le, Zmuda, Perry & Munoz, 2010; Parra Cardona et al., 2012; Sáez-Santiago et al., 2012; Simoni et al., 2013; Weiss, Singh, & Hope, 2011) and/or incorporate dichos. Dichos are traditional sayings, proverbs, or wise words and are a popular and culturally congruent way to communicate important concepts. Dichos were specifically referenced by five studies (Aguilera et al., 2010; Interian et al., 2008; Ramos & Alegría, 2014; Sáez-Santiago et al., 2012).

Addressing context-specific issues. Context-specific issues addresses a range of issues specific to the local community being served. For the ten studies that incorporated contextual issues as part of a culturally adapted intervention, such topics included: fear of children calling Child Protective Services in a parenting intervention for Latino families (Domenech Rodríguez et al., 2011); the importance of monitoring children's whereabouts related to widespread community drug use for a parenting intervention with families in Mexico (Baumann, 2014); cultural idioms of distress (e.g., *nervios*; Hinton et al., 2011); social and family context of behaviors (e.g., antidepressant adherence; Interian et al., 2010; Sáez-Santiago et al., 2012;

Simoni et al., 2013); experiences of discrimination (Lee et al., 2011; Wood, Chiu, Hwang, Jacobs, & Ifekwunigwe, 2008); experience of being separated from family and low-status employment (Lee et al., 2011); local norms of sexual behavior in a safe sex promotion/HIV prevention public health intervention (Pick, Poortinga, & Givaud, 2003); empowerment, domestic violence, and trauma (Hovey et al., 2014).

Acculturation. Acculturation broadly refers to the processes of adaptation and changes that take place when a person comes into contact with culturally dissimilar others (people, groups, social influences; Schwartz, Unger, Zamboanga, & Szapocznik, 2010). Acculturation was addressed in five of the reviewed studies. Of the 19 reviewed studies in this section, four addressed parenting and/or youth with Latinos residing in the United States; all four of those adaptations included discussion of acculturation as part of their adaptations (Dumas et al., 2011; Le et al., 2010; Wood, Chiu, Hwang, Jacobs, & Ifekwunigwe, 2008; Parra Cardona et al., 2012). Hovey et al. (2014) also addressed acculturative differences between parents and children as part of a depression intervention for Latina migrant farmworkers in rural Colorado, as the majority of the women participating were mothers and intergenerational stressors contributed to their distress. One intervention, addressing adult depression, also included an ethnocultural assessment to ascertain acculturative experiences and identification as part of treatment planning (Interian et al., 2008).

Literacy adaptations. Low levels of literacy were addressed by four interventions teams through use of visual, rather than written material (Aguilera et al., 2010; Domenech-Rodríguez et al., 2011) and simplifying psychological "jargon" or concepts (Ramos & Alegría, 2014). Hinton et al. 2011 referenced unspecified changes to accommodate low literacy levels.

Adaptation to visual imagery. Adapting visual images was an adaptation utilized by two research teams, including adjusting the phenotypic representation of people to "match" the intervention population (Baumann, 2014) and modifying the visual imagery used in mindfulness exercises, such as presenting Christian-type imagery (e.g., Sagrado Corazón de Jésus) during compassion meditation (Hinton et al., 2011).

Spirituality. Spirituality was included as a cultural adaptation in two studies (Le et al., 2010; Ramos & Alegría, 2014). For example, in Ramos and Alegría's (2014) brief depression intervention in a low-resource setting, spiritual and religious activities were added to the repertoire of behavioral activation activities suggested to participants.

Engagement. Engagement strategies were not addressed by four out of 19 studies (Dumas et al., 2011; Hinton et al., 2011; Simoni et al., 2013; Weiss et al., 2011).

Table 23

Specific Engagement Adaptations for Latino/a/x Communities

Engagement Adaptation	# of cultural adaptations
Not Addressed	4
Flexibility and Structural Barriers	10
Extended Family Involvement	5
Community Settings	5
Communication Style	4
Community Interventionists	4
Stigma Reducing Language	3
Technology	3
Orientation	2

Flexibility and structural barriers. Addressing structural barriers including transportation, childcare, and the demands of employment, ten research teams included flexibility into their intervention and/or assistance with structural barriers, such as those referenced above. For example, in a Mexico City based parent-training program, parents are

welcome to make up any missed class by taking any other class offered (Baumann, 2014). Domenech Rodríguez et al. (2011) adapted a formal appointment-based assessment model to a drop-in model. Flexible start/end times were employed by Interian et al. (2008) and Agazzi (2010). Shortening the term of therapy was a strategy used by three intervention teams (Hovey et al., 2014; Lee et al., 2011; Ramos & Alegría, 2014). In a psychoeducational program for parents of depressed adolescents in Puerto Rico, the parent program ran concurrently with the teen's therapy and all programs took place on Saturday, reducing the transportation burden on the family (Sáez-Santiago et al., 2012). Additionally, four adaptations include efforts to remove structural barriers by providing things like transportation, meals, childcare, evening sessions, (Domenech Rodríguez et al., 2011; Hovey et al., 2014; Parra Cardona et al., 2012; Sáez-Santiago et al., 2012).

Extended family involvement. Recognizing the important role of non-nuclear family members in many Latino families, five cultural adaptations incorporate extended family members into treatment. Extended family members were incorporated into parent management training interventions in the US and Mexico (Agazzi, 2010; Baumann, 2014; Domenech-Rodríguez et al., 2011); into a school based intervention for Mexican American students with anxiety (Wood et al., 2008); and into eating disorder treatment (Reyes-Rodríguez et al., 2013).

Community setting. Utilizing a known and trusted community setting was a stigma-reduction and engagement strategy employed in five interventions. Non-clinical settings included school-based "parent liaison" rooms or community parent centers (Domenech-Rodríguez et al., 2011); primary care (Interian et al., 2008); pre-natal care (Le et al., 2010); and churches (Hovey et al., 2014; Parra Cardona et al., 2012).

Communication style. Communication modifications, reported in four studies, stress the importance of conveying a personal touch (some examples include personal reminders, phone calls, hand-written letters, etc.) and a warm and respectful stance towards the client (Aguilera et al., 2010; González-Prendes et al., 2011; Interian et al., 2008; Interian et al., 2010). Interian et al. (2010) describes "we viewed these efforts as compatible with the cultural expectation of *personalismo*, where relationships with providers were personalized and involved trust (*confianza*; Interian et al., 2010, p. 221). One example, from a psychotherapy case study highlights use of the formal Spanish *usted* (González-Prendes et al., 2011).

Community interventionists. Using non-clinical interventionists solely or in conjunction with a mental health professional was a strategy employed in four cultural adaptations for Latinos. Interventions included parent liaisons (Agazzi, 2010); *promotoras* (lay health workers) (Hovey et al., 2014); pharmacy staff (Pick, Poortinga, & Givaudan, 2003); and school faculty or staff (Wood et al., 2008).

Stigma reducing language. Three research teams describe efforts to reduce stigma through changes in language (Aguilera et al., 2010; Domench-Rodríguez et al., 2011; Reyes-Rodríguez et al., 2013). Aguilera et al. (2010) renamed CBT homework as *proyecto personal* (personal project) to reduce negative associations to homework given at school; similarly Domench-Rodríguez et al. (2011) described homework as "practice assignments" to not alienate parents with a negative view of educational systems for a parenting intervention.

Orientation. Two intervention design teams sought to orient clients to therapy. Wood et al. (2008) include an orientation session with parents designed to address feelings of stigma, shame, and apprehension about counseling for a school-based intervention for students with anxiety. Lee et al. (2011) scripted the introduction of the intervention to include an orientation

that emphasized the participants' rights to speak up even if they disagreed with the interventionist, using "cultural scripts" to recast the interventionist/client relationship into a more familiar dynamic (Lee et al., 2011, p. 320).

Technology. Technology was used by two intervention teams as a means to increase engagement and reduce barriers to care. Aguilera et al. (2010) utilized an mp3 as an "audio coach" and automatic text messaging system to send daily mood tracking texts as well as content related to treatment themes (Aguilera et al., 2010, p. 865). Ramos and Alegría (2014) offer a telephone based brief depression and health literacy intervention.

Development and equivalence processes. Only one reviewed study did not clearly delineate their adaptation process (Interian et al., 2008).

Table 24

Specific Development and Equivalence Processes Adaptations for Latino/a/x Communities

Equivalence Process	Number of cultural adaptations
Not Addressed	1
Adaptation Theory Referenced	12
Fidelity	10
Top Down Approach – Researcher/Clinician Driven	8
Integration of Top Down and Bottom Up Approaches	9

Adaptation theory referenced. Of the total, 12 studies referenced adaptation theory in the design of their intervention (Agazzi, 2010; Baumann, 2014; Domenech-Rodríguez et al., 2011; Dumas et al., 2011; Interian et al., 2010; Le et al., 2010; Lee et al., 2011; Ramos & Alegría, 2014; Sáez-Santiago et al., 2012). Many adaptations identified the adaptation theory that guided their process, including community based participatory action research (Parra

Cardona et al., 2012), Hwang's PAMF (Wood et al., 2008), Bernal's EVM (Baumann, 2014; Sáez-Santiago et al., 2012), and CDC/MAP public health models (Simoni et al., 2013).

Fidelity. Ten studies addressed efforts to preserve fidelity between the adapted version and the original version of the intervention (Agazzi, 2010; Baumann, 2014; Domenech Rodríguez et al., 2011; Dumas et al., 2011; González-Prendes et al., 2011; Interian et al., 2010; Parra Cardona et al., 2012; Ramos & Alegría, 2014; Reyes-Rodríguez et al., 2013; Simoni et al., 2013).

Fidelity efforts included provision of equally intensive intervention (e.g., number of sessions and session duration) (Agazzi, 2010); and curriculum (e.g., topics covered, organization of content) (Agazzi, 2010; Parra Cardona et al., 2012). Four adaptations ensured fidelity through supervision, training, and certification with original intervention developers or skilled facilitators (Baumann, 2014; Domenech-Rodríguez et al., 2011; Interian, 2010; Simoni et al., 2013). Five adaptation processes ensured fidelity through the identification and preservation of core components or specific mechanisms of change within the original intervention (Domenech Rodríguez et al., 2011; Dumas et al., 2011; González-Prendes et al., 2011; Interian et al., 2010; Ramos & Alegría, 2014).

Top down approach – researcher/clinician driven. Within this review, eight adaptations were driven by research, clinical, or theoretically derived knowledge, rather than incorporating community based knowledge (Aguilera et al., 2010; González-Prendes et al., 2011; Hinton et al., 2011; Hovey et al., 2014; Lee et al., 2011; Ramos & Alegría, 2014; Weiss et al., 2011; Wood et al., 2008). Of those, four adaptations were guided by clinically derived knowledge (Aguilera et al., 2010; González-Prendes et al., 2011; Hinton et al., 2011; Wood et al., 2008). One research

team described an adaptation process that was largely top down, although community feedback was sought after the adaptation was created (Ramos & Alegría, 2014).

Integration of top down and bottom up approaches. Of the studies reviewed here, nine adaptations integrated top down and bottom up approaches, such as generating community driven knowledge through a stage process, focus groups, qualitative interviews, and/or collaboration with community leaders (Agazzi, 2010; Baumann, 2014; Domenech-Rodríguez et al., 2011; Dumas et al., 2011; Interian et al., 2010; Le et al., 2010; Pick et al., 2003; Reyes-Rodríguez et al., 2013; Sáez-Santiago et al., 2012).

Therapist cultural competence. Two adaptations did not address cultural competence (Dumas et al., 2011; Pick et al., 2003). Two adaptations only addressed cultural competence in terms of generalized suggestions to be sensitive to cultural differences (Reyes-Rodríguez et al., 2013; Weiss et al., 2011). An additional two adaptations only addressed cultural competence insofar as they assigned a facilitator who spoke the primary language of the participants (i.e., linguistic match; Hinton et al., 2011; Interian et al., 2008).

Table 25

Specific Cultural Competence Adaptations for Latino/a/x Communities

Cultural Competence Adaptation	Number of cultural adaptations
Not Addressed or Only Linguistic Match	6
Ethnic Matching	5
Self Disclosure and Personalismo	5
Community Interventionist	3
Awareness of Differences	3
Ethnic Match of Researchers	2
Dynamic Sizing	1
Community Broker	1

Ethnic matching. Ethnic matching was employed by five adaptation teams (Baumann, 2014; Domenech-Rodríguez et al., 2011; Ramos & Alegría, 2014; Sáez-Santiago et al., 2012;

Simoni et al., 2013). However, Sáez-Santiago et al. (2012) specified that ethnic matching was a byproduct of the location of their intervention (Puerto Rico), rather than a discrete cultural adaptation in and of itself.

Self disclosure and personalismo. Of the total, five adaptation designers described using enhancing the feeling of *personalismo* (personal touch) and *confianza* (trust). Four adaptation teams urged clinicians to self-disclosure, particularly sharing relevant or shared background (e.g., where they are from, some hobbies), prior to asking the client to disclose personal information (González-Prendes et al., 2011; Ramos & Alegría, 2014; Wood et al., 2008). Interian et al. (2010) enhanced the sense of *personalismo* through hand-written reminders and treatment plan to personalize the relationship between provider and client.

Community interventionist. Three adaptations utilized a community-based partner as sole or co-interventionist. Agazzi (2010) stated,

> The addition of a Hispanic liaison who also was a parent was thought to be the most critical component in the implementation of HOT DOCS Español, as her experiences as a mother provided credibility to this service. This was evidenced by the increased enrollment of Hispanic caregivers, their attendance rates, and their willingness to implement HOT DOCS strategies. (Agazzi, 2010, p. 193)

Parra Cardona et al. (2012) also utilized paraprofessional community members for their parenting intervention for Latino immigrants in urban Detroit. Hovey et al., (2014) adapted a CBT for depression intervention for Latina migrant farmworkers in rural Colorado; their intervention was co-facilitated by a Spanish-speaking therapist and a *promontora* (community health worker).

Awareness of differences. Three studies highlighted therapist awareness and self-reflection of cultural differences between the interventionist and the community (Agazzi, 2010; Le et al., 2010; Wood et al., 2008). For example, in a parenting intervention (Agazz, 2010),

cultural differences in normative forms of discipline were framed non-judgmentally in the context of preparing children for success in United States school settings. Wood et al. (2008) included an extensive discussion of cultural competence and social justice.

Ethnic matching of researchers. Two adaptation design teams focused on ethnic match between researchers and the intended community (Agazzi, 2010; Parra Cardona et al., 2012).

Community broker. Domenech-Rodríguez et al. (2011) used community brokers to increase the acceptability of their intervention to the community.

Dynamic sizing. Only one adaptation addressed the need to evaluate within-group differences (Aguilera et al., 2010).

Reported outcomes and results. Four of the interventions studied here described their research design as a randomized controlled trial. Methods of analyzing intervention success included statistical analysis of symptom reduction and/or behavior change, participant satisfaction self-report data, and attrition rates. Problems in implementation or failure to yield positive results were also reported. Four interventions did not report results (González-Prendes et al., 2011; Le et al., 2010; Reyes-Rodríguez et al., 2013; Wood et al., 2008).

Table 26

Type of Results Reported for Adaptations for Latino/a/x/ Communities

Type of Result reported	Number of cultural adaptations
Not reported/not available yet	4
Symptom Reduction/Behavior Change	9
Participant Satisfaction	7
Low Attrition	5
Reach of intervention	1

Symptom reduction/behavior change. Of the studies reviewed, nine measured the results of their intervention through measures of symptom reduction and/or behavior change (Baumann,

2014; Dumas et al., 2011; Hinton et al., 2011; Hovey et al., 2014; Interian et al., 2008; Ramos & Alegría, 2014; Sáez-Santiago et al., 2012; Simoni et al., 2013; Weiss et al., 2011). Hovey et al. (2014) reported impressive findings for a CBT support group for Latina migrant farmworkers in Western Colorado, with eighty-three percent of participants achieved clinically significant pretreatment-posttreatment change and 100% achieved clinically significant pretreatment-follow-up change.

Participant satisfaction. Measuring results in terms of participant satisfaction was utilized by seven teams (Agazzi, 2010; Aguilera et al., 2010; Dumas et al., 2011; Interian et al., 2010; Lee et al., 2011; Parra Cardona et al., 2012; Sáez-Santiago et al., 2012). In two studies, positive satisfaction report was anecdotal (Aguilera et al., 2010; Interian et al., 2010). Agazzi (2010) adapted a behavioral parent-training program for which 97% of participants (both caregivers and clinicians) indicated that the adapted program was beneficial. A motivational interviewing intervention to address heavy drinking measured participant engagement, satisfaction, and perceived relationship between culture and drinking behavior (Lee et al., 2011). High satisfaction was reported by participants in a parenting intervention for Latino immigrants, specifically resulting from the opportunity to reflect on issues associated with immigration and biculturalism (Parra Cardona et al., 2012).

Low attrition. Low attrition and levels of attendance were reported by five adaptation studies (Agazzi, 2010; Domenech-Rodríguez et al., 2011; Dumas et al., 2011; Parra Cardona et al., 2012; Sáez-Santiago et al., 2012).

Reach of intervention. Pick et al. (2003) developed a public health intervention for HIV prevention in Mexico; results were measured in terms of the reach of the program, rather than the

impact on individuals. Over 100,000 culturally-adapted posters and pamphlets were distributed nationwide.

Exemplar adaptations. Of the 19 studies within this review, nine addressed all four domains of the presented model of cultural adaptation. Several adaptations stood out for their use of surface and depth adaptations, as well as the richness of their description of the adaptation process; two are presented here.

Table 27

Exemplar Adaptations for Latino/a/x Communities

Citation	Context	Engagement	Equivalence	Therapist CC
Domenech Rodríguez, Baumann, & Schwartz (2011). Cultural Adaptation of an Evidence Based Intervention: From Theory to Practice in a Latino/a Community Context. American Journal of Community Psychology. http://doi.org/10.1007/s10464-010-9371-4	Translated into Spanish, use of visual rather than written materials where possible to address literacy concerns, use of researcher and participant-generated Latino dichos, explicitly stated cultural values used to frame intervention goals, contextual issues were relevant to the treatment process in the form of examples, stated challenges to parents in parenting (e.g., fear of having children call CPS and having deportation be a possible consequence).	Delivered in a community context, family members were invited (brother, sister) as persons that co- parented even if they were not the biological parent or lived in the home; used drop-in rather than appointment format for assessment. Homework renamed as ‘‘practice assignments’’ to avoid alienating parents with negative view of the educational system. Groups scheduled on weekday evenings to accommodate work schedules and family responsibilities; dinner, childcare, and transportation provided when available.	The adaptation took place in stages: a pilot study to ensure feasibility, focus groups to establish appropriate format and goals, and a test of the intervention; utilized adaptation theory process model of Domenech-Rodriguez and Wieling (2004) and the ecological validity model (EVM) of Bernal et al.,. (1995). Fidelity efforts: treatment developer made intervention materials available and created trainings to support skills acquisition and implementation, advocating for adherence to the components identified as mechanisms of change (e.g., core parenting practices) for the child outcomes	Use of community brokers to increase acceptability during needs assessment review. Ethnic matching.

(continued)

Citation	Context	Engagement	Equivalence	Therapist CC
Parra Cardona, et al. (2012). Culturally Adapting an Evidence-Based Parenting Intervention for Latino Immigrants: The Need to Integrate Fidelity and Cultural Relevance. Family Process. http://doi.org/10.1111/j.1545-5300.2012.01386.x	Curricula, supportive materials, and research activities utilized in this study were adapted in order to ensure linguistic and cultural appropriateness, as well as cultural sensitivity in their delivery. Two culture-specific sessions were added addressing parental stress associated with being immigrants, economic difficulties, work exploitation, and the impossibility of traveling for extended periods of time to their home countries, and biculturality, and intergenerational conflict. The CAPAS- Enhanced intervention also includes brief reflections associated with the cultural relevance of each core PMTO component.	All sessions include full dinner for participants and their children, as well as childcare services; intervention delivered in the building of a local religious organization widely recognized and trusted by the Latino community.	Adaptation theory used, CBPAR approach, qualitative interviews. Fidelity: used original structure, i.e. manuals with detailed session agendas, objectives, exercises, role-plays, and group process suggestions.	Included paraprofessional interventionists who are community members and highly trusted by Latino parents. Ethnic matching: Latino research staff carried out recruitment, assessment, and intervention delivery. These professionals were also well matched on immigration, acculturation, and general stressors.

Discussion. The existence of 20 culturally adapted evidence based interventions for Latinos is encouraging. Several salient points are worth noting, however. Firstly, the overwhelming majority of interventions within this review target Latino populations in the United States (17); the remaining two interventions are based in Mexico. Within the US-based interventions under this review, there were relatively few population specifiers, especially when considering the significant diversity of the US Latino population (e.g., national origin, immigration experience, level of acculturation). This may reduce the generalizability of the interventions. Adaptation theory was referenced in 12 of the 20 reviewed studies. This is not surprising considering that many of the researchers associated with the studies in this review are the very adaptation theorists from which this dissertation's model is built (e.g., Bernal et al.,

1995; Domench-Rodrigeuz et al., 2011). Interestingly, however, eight of the adaptations relied on top-down researcher/clinician derived knowledge, rather than integrating community-based and theoretical knowledge, as is the overwhelming consensus of adaptation theorists. One possible explanation for this is that linguistic barriers between Latino clients and predominantly White clinicians serve as a *de facto* selection criterion, thus leading to less research in which White psychologists study communities of color within this ethnic category, compared to the other groups studied within this dissertation. It might be that Latino clinicians and researchers with substantial personal experience working with and living in Latino communities feel equipped to assess clinical needs informally or through top-down processes. Additionally, four of the interventions studied were case studies, which tend to rely on clinical judgment and theoretical knowledge. However, given the large and growing Latino community in the United States (to say nothing of the global Spanish-speaking world), it is unlikely that clinical knowledge alone will suffice to adequately capture the needs of such a broad and diverse group of people. One example is that within the domain of Context and Content (in which 100% of interventions made adaptations), incorporation of traditional values, and adaptation to metaphors, stories, and idioms were widely used (12 out of 19 studies). Additionally, this section was notable for ten interventions making context-specific adaptations. Those adaptations were made to address the particular needs of the local community and ranged across a variety of topics with little overlap. This, again, points to the diversity of the Latino community and the impossibility of establishing reductionist interventions in a "one size fits all" manner. Even when using interventions within the Latino community, adaptations must be made. For example, in adapting a parenting intervention from a US Latino context to a Mexico context, modules on biculturality and fear of deportation were removed (Baumann, 2014). While culture-specific interventions

are outside the scope of this review, it is worth noting that there exist culturally specific interventions born out of and designed for Latino communities, such as *mujerista psychotherapy* (Comas-Díaz, 2016).

It is worth noting that for several foundational adaptation theorists, whose work forms the basis of this dissertation's four-domain model, began their work within and for the Latino/a/x/ communities, including Bernal, Castro, Barrera, and Domenech-Rodriguez. In their work, by contrast to the review above, language adaptations and translation of materials and intervention from English to Spanish are critical advancements in terms of acceptability and access for Latino communities, particularly within the United States. These theorists were working as pioneers in the realm of cultural adaptation, a practice that has received more mainstream attention in recent years. Language and translation played a relatively small role in the above review, in contrast to the foundational theory, suggesting that the need for language and translation adaptations has become an accepted fact in common practice, rather than seen as a stand-alone adaptation

People of Asian and Pacific Islander Ancestry

Academic databases were searched five times over the course of a nine-month period for peer reviewed articles, books, and dissertations published between 2000-2017. Various keyword combinations were used such as "Asian + Evidence Based," "Cultural Adaptation + Asian," "Evidence Based + Pacific Island," "Culture + Asia + Evidence," yielding a total of 49 studies. Of these, 31 were considered within this review as cultural adaptations of evidence based treatments. In several cases, multiple articles were published relating to one intervention, these articles were consolidated so each intervention was only reviewed once. A total of 26 interventions were reviewed.

Of the excluded 18 studies, nine are better classified as theoretically-derived and/or research-derived general recommendations or guidelines for therapy with clients in Asia/Southeast Asia or of Asian ancestry, three studies are better classified as effectiveness/efficacy research on non-adapted evidenced based interventions with Asian clients, one excluded study examined a culturally-derived assessment measure for culturally specific PTSD symptoms in Cambodian refugees was excluded, an adaptation of outreach materials on Autism Spectrum Disorder for US-based Korean language communities was also excluded. Also excluded from the current review was an excellent review of the 20 year history of cultural adaptations of the Strengthening Families program, culturally adapted versions of which have shown positive effects in the United States for African American, multicultural, Asian and Pacific Islander, Hispanic, and American Indian families and a study of the applicability of Indo-Tibetan self-healing practices to Western therapy. Lastly, *Feminist Reflections on Growth and Transformation: Asian American Women in Therapy,* edited by Debra Kawahara and Olivia Espin (2007), and Reiko Homma True's review of the same (2008) were both excluded. However, the contributions of these works bear particular mention, despite the fact that they do not fall within the inclusion criteria of this review. Importantly, these works emphasize an intersectional and dynamic view of the lives of Asian women, and include discussions of issues faced by group previously neglected including Indians, South Asians, Filipinas, Native Hawaiians, Pacific Islanders, and lesbians, as well as specific clinical issues of Asian American women, such as suicide, domestic violence, marital conflicts, and eating disorders. As with some other studies in the current review, Kawahara and Espin's (2007) contributors address pre-Confucian thought, specifically with an eye toward "reviving the ancient mythological image of

the powerful woman warrior in China, where matriarchal social order preceded Confucian patriarchy" (True, 2008, p. 219).

Population characteristics. These 26 interventions focus on the following population characteristics:

Table 28

Characteristics of Asian/Pacific Islander Descended Populations

Population Characteristics	Number of Culturally Adapted Interventions
Living In The West	15
"Asian American"	9
+ Women	1
+ Divorced	1
+ Mothers	1
- Cambodian-, Chinese-, Korean-, Laotian-, and Vietnamese-American	1
- Chinese American	3
+ Women	1
+ Older Adults	1
+ 1st generation	1
- "East Asian"	1
- First Generation Immigrants	1
- Pacific Islander - American	1
- Samoan American	1
Chinese-Australian	2
Southeast Asian-British	1
Refugees	3
-Vietnamese	1
- Cambodian	2
+ Khmer Rouge survivors	2
+ Women	1
Within Asian Countries	11
China	3
- Adults	2
- Youth	1
+ School-based	1

(continued)

Population Characteristics	Number of Culturally Adapted Interventions
Singapore	1
- Youth	1
+ Residential Home Residents	1
Pakistan	7
- Urban	4
+ Women	1
+ College Students	1
- Non-urban	1
- Inpatient facility	1

As is evident from the table above, there is profound heterogeneity in the sample of population characteristics served by the reviewed interventions. Asia is the world's most populous continent, with an estimated 4.5 billion people spread across 48 countries with distinct cultural, linguistic, religious, philosophic, spiritual, and sociopolitical histories (Williams, 2017). Additionally, Western-style diagnostic categories did not exist in Asia until the period following World War II and are largely a Western export (Hodges & Oei, 2007). These factors contribute to the relatively under-developed literature base for cultural adaptations for clients of Asian descent, both living in Asian countries, as well as living within Western societies as ethnocultural minorities (e.g., Australia, the United States, Britain). Of the 26 studies reviewed 61% (16) studies focus on Asian populations living in the West; of those, 62% (ten) interventions are geared towards Asian Americans, 19% (three) focus on Refugee communities living in the West (i.e. Canada, the US), 12% (two) Chinese Australians, and 6% (one) targeted Southeast Asians living in Britain. Of the 26 studies reviewed, 42% (11) are geared towards Asian populations within Asian countries. Of those, interventions within this review include contributions for the following Asian countries: Pakistan (64%, seven studies); China (27%, three studies); Singapore (9%, one study).

Target disorders. A range of disorders and clinical problems were addressed by interventions in the current review. The most addressed disorder was depression, accounting for 30% (eight) interventions, including one intervention targeting post-partum depression. Preventive health interventions accounted for the second-largest category, 19% (five interventions) spanning medical adherence (two interventions, HIV medication-adherence, colorectal screening adherence), weight management, smoking cessation, and aiming to increase physical activity (one intervention each). The next category was trans-diagnostic, with interventions designed to address a variety of psychological problems; these interventions accounted for 15% (four) of the total. Trauma (including PTSD) interventions accounted for 11% (three). Psychotic-spectrum disorders including schizophrenia accounted for 7% (two). The remaining 19% (five) was accounted for by single interventions addressing: obsessive compulsive disorder (3%, one), parenting (3%, one), phobias (3%, one), social anxiety disorder (3%, one), and building emotional regulation skills (3%, one).

Table 29

Target Concerns of Interventions for Communities of Asian/Pacific Islander Descent

Target Disorder	Number of Culturally Adapted Interventions
Depression	8
+ *Post-Partum Depression*	1
Preventive Health	5
- Medical Adherence	2
+ *HIV medication*	1
+ *Colorectal screening*	1
- Smoking Cessation	1
- Weight Management	1
- Physical Activity Level	1
Trans-diagnostic	4
Trauma	3
Psychotic-Spectrum	2
Obsessive Compulsive Disorder (OCD)	1

(continued)

Target Disorder	Number of Culturally Adapted Interventions
Parenting	1
Social Anxiety Disorder	1
Emotion Regulation	1

Theoretical basis of intervention. In total, 70% (19) of all interventions reviewed were based in CBT; one intervention was based in CBT with additional elements of problem-solving therapy. Acceptance and Commitment Therapy (ACT) was used in one intervention; with two additional interventions using acceptance and mindfulness-based theories as the intervention basis, accounting for a total of 11% (three). Theoretical basis was not defined for two interventions (7%). The remaining 11% (three interventions) was accounted for by one intervention each of the following bases: Social Learning Theory (one, 3%); Motivational Interviewing (one, 3%); person–environment transactional model/risk and protective factor model (one, 3%).

Table 30

Theoretical Basis for Interventions for Communities of Asian/Pacific Islander Descent

Theoretical Basis	Number of Culturally Adapted Interventions
Cognitive Behavioral Therapy (CBT)	19
+ Problem Solving Therapy	1
+ Mindfulness	1
Acceptance and Commitment Therapy	1
Mindfulness + Acceptance Theories	1
Social Learning Theory	1
Motivational Interviewing	1
Not stated	2
Person-Environment Transactional Model	1

Analysis of adaptations. Of the 25 studies reviewed, three studies were coded for explicit description of all four domains of adaptation.

Context. Two interventions did not address culture and context adaptations (Chu, Huynh, & Areàn, 2012; Kim, Quinn, Chandrasekar, Patel, & Lam, 2016). Two additional interventions specifically described their adaptations as minimal (Palmer et al., 2011; Pat-Horenczyk, Shi, Schramm-Yavin, Bar-Halpern & Tan, 2015).

Table 31

Specific Context and Content Adaptations for Communities of Asian/Pacific Islander Ancestry

Context and Content Adaptation	Number of Culturally Adaptation Interventions
Not Addressed	4
Values: Collectivism, Emotional Control and Tradition	14
Idioms/Expressions/Metaphors/Folk Stories	7
Spirituality/Religion	7
Bridging Concepts and Explanatory Models	5
Acculturation, Minority Stress, Intergenerational Conflict	5
Somatic Expression	3
Translation	3

Values: Collectivism, emotional control and tradition. Adaptations that relate to traditional Asian values, collectivism, and prioritization on emotional control and restriction of affect were made by 14 intervention teams. These teams suggest that non-adapted treatments that emphasize emotional release or affective expression are likely incongruent with commonly held values that emphasize collective harmony through holding one's emotions. Hwang (2006a), rather than focusing treatment on "assertiveness," stress "code switching" allowing for flexible adaptation to challenges, including cross-cultural values conflicts, while validating interdependence at home (Hwang, 2006a, p. 298). Hall, Hong, Zane, and Meyer (2011), adapting ACT and mindfulness-based therapy for Asian Americans, emphasize incorporation of an interdependent view of the self through "we" rather than "I" language and emphasize the

positive strengths of indirect coping rather than direct emotional expression (e.g., the strength of remaining respectful and reserved in the face of conflict; Hall et al., 2011, p. 217). Additionally, they structure mediation and ACT metaphors and exercises as a way to benefit the self in the context of others, help the client better identify and prioritize social group norms and values and to flexibly apply these values depending on the group she is in at the moment. Choi et al. (2012) offer a culturally attuned Internet treatment for depression amongst Chinese Australians, reframing skills such as assertiveness in a form that promotes cultural values of respect and interpersonal harmony, rather than individual autonomy. Pan et al. (2011) also adapt CBT for Chinese American with phobia to include a culturally congruent model of healing that is congruent with values that include an emotional control strategy. In an HIV medication compliance intervention in China, adhering to medication is framed as congruent with collectivistic values, in that adhering to a regular medication timetable will allow the client to pursue what is personally and interpersonally significant to them, such as being able to carry out familial obligations (Shiu et al., 2013). The seven reviewed Pakistan-based interventions all adhere to the same adaptation strategy including integrating a family member into therapy and including an additional session for the whole family at the start of therapy (Aslam, Ifran, & Naeem, 2015; Habib, Dawood, Kingdon, & Naeem, 2015; Naeem, Waheed, Gobbi, Ayub, & Kingdon, 2011; Naeem et al., 2014; Naeem, Saeed, et al., 2015; Naeem, Gul et al., 2015; Zadeh & Lateef, 2012). For a preventive health intervention in Samoan-American faith communities, gender-specific support groups were utilized rather than individual interventions (Cassel, Braun, Ka'opua, Soa, & Nigg, 2014). Finally, Cassel et al. (2004) highlight the importance of elevating and embracing tradition (e.g., traditional healthy foods, cultural meals) in a health promotion intervention with Samoan American faith communities.

Idioms/images/metaphors. Adaptation of idioms, metaphors, and visual images was described by seven intervention teams (Choi et al., 2012; Wong, 2008). For example, a multi-intervention team of researchers applying adapted CBT interventions in Pakistan, finding Urdu equivalents of CBT "jargon" was a consistently used cultural adaptation (Aslam et al., 2015; Habib et al., 2015). Hinton et al. (2004) and Hinton et al. (2009) offered adapted CBT for PTSD for refugees of Cambodia and Vietnam in which, for example, visualizations as part of relaxation training incorporated cultural images, e.g., a lotus blooming as "an image encoding key Asian cultural values of flexibility" (Hinton et al., 2004, p. 430). Fung (2015) made cultural adjustments to ACT metaphors and exercises.

Spirituality/religion. Incorporating spirituality and religion was utilized by Fung (2015) as well as the seven interventions of culturally adapted CBT (Ca-CBT) in Pakistan (Aslam et al., 2015; Habib et al., 2015; Naeem et al., 2011; Naeem et al., 2014; Naeem, Saeed, et al., 2015; Naeem, Gul, et al., 2015; Zadeh & Lateef, 2012). Specifically, Ca-CBT in Pakistan (Massood et al., 2015) describes incorporating a spiritual element in case formulation, accepting spiritual healing practices and theories of illness, and using religious practices like bead counting or prayer to engage in activity and thought monitoring, for example re-introduction of Salat (Muslim five times daily prayer) as behavioral activation. Fung (2015) piloted a program co-facilitated by a Buddhist monk and a psychiatrist for treatment resistant depression and PTSD among Cambodian refugees. In this cultural adaptation of ACT, dharma talks and direct instruction by the monk were incorporated.

Bridging concepts and explanatory models. Adaptations to bridge explanatory illness models between Eastern and Western theories of function/dysfunction were described by five intervention teams. For a depression intervention with Chinese Australians, Choi et al. (2012)

place stronger emphasis on addressing myths about depression. Naeem, Saeed, et al., 2015 offer a 'Psychosociospiritual' model of illness that addresses cultural beliefs about illness as divine punishment and a cultural mistrust of the medical establishment with psychological interventions offered in a social format, rather than pharmacological therapy (p. 241). Hwang (2006a) offers the concept of "cultural bridging" of concepts, for example bridging CBT relaxation training to Chinese cultural traditions for rebalancing Qi, such as meditation or Qi Gong. He stresses the utility of bridging concepts, particularly at the start of treatment to reduce anxiety about Western treatment.

Acculturation, minority stress, intergenerational conflict. Adaptations that incorporate issues related to acculturation, minority stress, and intergenerational conflict were addressed by four intervention teams (Hwang, 2006a; Hodges & Oei, 2007; Masood et al., 2015; Zhou, Chen, Cookston, & Wolchik, 2014). For example, an adaptation of a parenting program for Asian American divorced mothers included modules to address shame, parent-child acculturation differences and the challenges of discipline, and renegotiating relationships with in-laws and extended family members after divorce (Zhou et al., 2014). Masood et al. (2015) also incorporated themes of family role expectations, for example between wives and mothers-in-law. Pan et al. (2011) included an assessment of acculturation in the pre-therapy orientation phase of treatment.

Somatic expression. Adjusting treatment to focus on somatic expression of symptoms was a cultural adaptation employed by three teams spanning interventions for Pakistani (Aslam et al., 2015), Vietnamese (Hinton et al., 2004), Cambodian (Hinton et al., 2009), and Chinese American clients (Hwang et al., 2006a). For example, Hinton and colleague's preliminary research (2006) into cultural expression of PTSD symptomatology for Cambodian and

Vietnamese refugees highlights specific cultural manifestations not accounted for by DSM-5 criteria, specifically headache and otrthostatis; addressing these somatic expressions forms the basis of their intervention.

Language translation. Translating materials (e.g., homework, outreach materials, displayed materials) into the native language(s) of the client was described by three intervention teams (Choi et al., 2012; LaBreche et al., 2016; Weiss et al., 2011).

Engagement. Of the total, six research teams did not address engagement strategies (Hall et al., 2011; Hinton et al., 2004; Hodges & Oei, 2007; Weiss et al., 2011; Zhou et al., 2014).

Table 32

Specific Engagement Adaptations for Communities of Asian/Pacific Islander Ancestry

Engagement Adaptation	Number of Cultural Adaptations
Not Addressed	6
Extended Family and Community Involvement	10
Translation and Use of Language	10
Addressing Barriers	7
Orienting to Treatment	5
Communication/Instructional Style	5
Leadership (Non-mental health)	3
Technology	1

Extended family and community involvement. Involving family and/or important community influencers in the treatment was an adaptation employed by ten research teams. In Pakistan, the seven reviewed adaptations included a family member throughout treatment to attend sessions and help with homework; the interventions include a special session just for the family member (Aslam et al., 2015; Habib et al., 2015; Naeem et al., 2011; Naeem et al., 2014; Naeem, Saeed, et al., 2015; Naeem, Gul, et al., 2015). Designing interventions for Chinese

American, Hwang et al. (2006a) suggested that inclusion of a family member may be advisable and should be discussed with the client. Cassel et al. (2014) included the community pastor in a health-promotion intervention based in a Samoan American faith community. The pastor's role was to support and encourage program participation as well as preach about the relationship between health and spirituality. LaBreche et al. (2016), promoting health within Pacific Islander Communities in Southern California, similarly identify community members as "Program Champions" to motivate others for program participation.

Translation and use of language. Language was addressed by ten intervention teams. Translation was addressed by three studies, including using a live translator (Fung, 2015; Hinton et al., 2009) and using an idiomatic translation process rather than a direct literal translation process (Naeem, Saeed, et al., 2015). Translating materials (e.g., homework, outreach materials, displayed materials) into the native language(s) of the client was described by three intervention teams (Choi et al., 2012; LaBreche et al., 2016; Weiss et al., 2011). A pair of interventions addressed adaptations to word choices and use of language with the goal of decreasing the stigma associated with mental health, for example using the terms wellness or stress rather than depression (Chu et al., 2012) "impractical thoughts" rather than "maladaptive thoughts" (Hodges & Oei, 2007, p. 909), or describing the intervention as a program rather than as therapy (Masood et al., 2015). Additionally, one intervention made adaptations to accommodate variation in degree of written literacy, such as pictorial rather than numerical Likert scales (Chu et al., 2012).

Addressing barriers. Barriers addressed by the interventions in this review included travel and transportation, privacy and confidentiality, and competing responsibilities. A postpartum depression intervention with South East Asian women living in Britain addressed the desire for privacy and confidentiality in a small immigrant community as a barrier to treatment.

One adaptation made was to devise culturally specific vignettes for the participants to discuss, to reduce the pressure on personal disclosure (Masood et al., 2015). Privacy and confidentiality were also emphasized in an adaptation for phobic Asian Americans (Pan et al., 2011). Additional adaptations were made to the time of day of the intervention to accommodate family and household responsibilities, provision of childcare, and provision of appropriate prayer facility (Masood et al., 2015). For an HIV medication adherence intervention in China, nurse counselors discuss and problem solve potential barriers to appointment adherence (Shiu et al., 2013). Four research teams made treatment-setting adaptations. Two interventions were delivered within inpatient programs (Habib et al., 2015; Pat-Horenczyk et al., 2015). Cassel et al. (2014) co-located their intervention within a church. Aslam et al. (2015) shortened the length of treatment to reduce attendance barriers.

Orienting to treatment. Orienting to treatment was an engagement strategy emphasized by four research teams. Providing detailed explanations of Western-style interventions and additional psychoeducation about Western disease and healing models was considered an important strategy to demystify the psychotherapy process, reduce stigma, and avoid premature drop out. Chu et al. (2012) specifically address a longer pre-therapy introduction for their intervention with Chinese older adults. Hwang (2006b) and Hwang (2006a) echo this, suggesting an early focus on establishment of concrete, achievable goals that can be accomplished early in treatment. An intervention for chronic depression in Hong Kong included mini-lectures and detailed explanations of exercises, concepts, and worksheets to provide an ongoing explanation and rationale for treatment (Wong, 2008). For Pan et al. (2011) the primary adaptations in the intervention were made to the pre-therapy portion, placing particular emphasis on orienting the clients to treatment through extensive psychoeducation.

Communication/instructional style. Within this review, five research teams made note of differences in communication style between the West and Asia. Fung (2015) offers an adapted ACT co-facilitated by a Cambodian monk and makes note of the Monk's more directive style including advice giving and a stricter emphasis on the correct approach (i.e., for meditation). In a school-based smoking cessation program for Chinese youth, modifications were made substituting interactive peer-leader-led activities for a more didactic instructional style. Wong (2008) similarly directed an active stance by facilitators in structuring sessions for a CBT for Depression program in Hong Kong. Pre-therapy education is offered including, among other topics, discussion about the collaborative nature of the provider/client relationship for an adapted CBT for depression intervention with first generation, Chinese American older adults (Chu et al., 2012). Pan, Huey, and Hernandez (2011) adapted role and communication style, having the therapist adopted an authoritative stance by making directive statements to clients (e.g., "Let's have you try that step now"), rather than nondirective queries (e.g., "Would you like to try this step"; Pan et al., 2011, p. 13).

Leadership (non-mental health). Modifying the leadership of the program by incorporating non-mental health professionals as facilitators was an adaptation utilized by three intervention designers. An ACT-based treatment-resistant PTSD intervention for Cambodian women refugees and survivors of the Khmer Rouge in Canada was co-facilitated by a Western psychiatrist and a Cambodian monk (Fung, 2015). A public health, health-promotion intervention for Asian American communities used professional health care workers (usually nurses) who were bilingual community members to deliver the intervention (Kim, Yang, & Hwang, 2016). Nurses were also used for a HIV medication adherence intervention in China (Shiu et al., 2013).

Technology. One program was designed for Internet delivery to reduce barriers to accessing care with Chinese Australians (Choi et al., 2012).

Development and equivalence processes. Development and equivalence processes were not addressed by three research teams (Choi et al., 2012; Hall et al., 2011; Hinton et al., 2004).

Table 33

Specific Development and Equivalence Processes Adaptations for Communities of Asian/Pacific Islander Descent

Equivalence Process	Number of Cultural Adaptations
Not Addressed	3
Use of Adaptation Theory	11
-Hwang	2
Top Down Approach	5
Cultural Consultation/Review	3
Integrated Top Down/Bottom Up	14
Fidelity	5

Fidelity. Within this review, five interventions addressed fidelity efforts. Pan et al. (2011) describe efforts to preserve the original mechanisms of action from the non-adapted intervention including length, theory, and mechanism of change (Pan et al., 2011). Fung (2015) ensured all aspects of the ACT matrix were reviewed in a culturally adapted ACT intervention for Cambodian refugee women living in Canada. Intervention teams described ongoing supervision from experts in the non-adapted intervention (Naeem et al., 2011; Pat-Horenczyk et al., 2015).

Adaptation theory referenced. Adaptation theory was referenced by 11 intervention teams (Habib et al., 2015; LaBreche et al., 2016; Masood et al., 2015; Naeem et al., 2011; Naeem et al., 2014; Naeem, Saeed, et al., 2015; Naeem, Gul, et al., 2015; Shiu et al., 2013;

Zadeh & Lateef, 2012; Zhou et al., 2014). Hwang's model for adaptations with Asian Americans was specifically mentioned by two researchers (Chu et al., 2012; Hall et al., 2011).

Integrated top down/bottom up. Within this review, 14 intervention designs integrated researcher/clinician driven knowledge and community-generated knowledge; focus groups and/or qualitative data analysis formed the basis of generating community knowledge (Aslam et al., 2015; Habib et al., 2015; Hinton et al., 2009; Masood et al., 2015; Naeem et al., 2011; Naeem et al., 2014; Naeem, Saeed, et al., 2015; Naeem, Gul, et al., 2015; Zadeh, and Lateef, 2012; Zhou et al., 2015). Specifically, a community participatory approach guided four studies (Cassel et al., 2014; Chu et al., 2012; Kim et al., 2016; LaBreche et al., 2016).

Top down/researcher driven. Research and/or clinically derived knowledge formed the basis for five adaptations (Hodges & Oei, 2007; Hwang et al., 2006a; Shiu et al., 2013; Weiss, et al., 2011; Wong, 2008).

Cultural consultation/review. Cultural consultants were used by three teams to review the interventions materials after their creation (Choi et al., 2012; Palmer et al., 2011; Pat-Horenczyk et al., 2015).

Therapist cultural competence. Cultural competence was not addressed in 15 interventions (Aslam et al., 2015; Cassel et al., 2014; Choi et al., 2012; Hall et al., 2011; Hinton et al., 2009; Kim et al., 2016; LaBreche et al., 2016; Palmer et al., 2011; Pat-Horenczyk et al., 2015; Naeem et al., 2014; Naeem, Saeed, et al., 2015; Naeem, Gul, et al., 2015; Zadeh & Lateef, 2012; Zhou et al., 2015). In two additional studies, cultural competence was referenced although specific adaptations within this domain were not described (e.g., general suggestions about cultural sensitivity, cultural knowledge) (Masood et al., 2015; Weiss et al., 2011).

Table 34

Specific Cultural Competence Adaptations for Communities of Asian/Pacific Islander Descent

Cultural Competence Adaptation	Number of Cultural Adaptations
Not Addressed	15
Not Specified	2
Ethnic Matching	3
Vertical Relationship	6
Adjustment of Goals	1

Vertical relationship. Utilizing the vertical relationship between therapist and client (e.g., presenting a more authoritative or directive counseling style rather than a collaborative or Socratic approach) was an adaptation in six interventions (Habib et al., 2015; Pan et al., 2011; Wong, 2008). Chu, Huynh, and Areán (2012) adapt the standard approach in problem-solving therapy to be more congruent with traditional Chinese value of hierarchy and respect; as such, therapists solve a first problem with their client, offering specific suggestions or resources. Similarly, therapists stimulate brainstorming with therapist-assisted questions. Hodges and Oei (2007) include explicit advice giving in their CBT adaptation for Chinese and Chinese American adults, acknowledging, "collectivism requires that if help is requested then advice is given, otherwise counsellor perceived as impersonal and afraid of accepting responsibility" (p. 908). Naeem et al. (2011) provide the foundation for all of the additional Pakistan CBT adaptations, however only the original article specifically refers to cultural competence adaptations. They explain:

> Another patient when asked, "What is wrong with you and how can we help you", replied, "You are the doctor, you tell me what is wrong with me". Some traditional healers can diagnose patients by just looking at them, and patients' expectations can be determined by their experience with these healers. Discussions with colleagues in Pakistan revealed that patients think mental illnesses are due to religious causes (for example sins) or even material deprivation. Magic spells, evil eye and bad luck can be

> described as the cause of an event or even an illness. The therapist needs to be careful when working with dysfunctional beliefs; for example, dependence on others, seeking the approval of others, especially parents, or sacrificing in favour of a family member might be seen as positive values in Pakistani culture. Patients might not feel comfortable with commonly used therapy techniques like "Socratic dialogue". Similarly, assertiveness can be considered as rudeness and so some modifications were made to deal with this issue. (Naeem et al., 2011, p. 172)

Adjustment of goals. Adapting a CBT intervention to enhance HIIV medication compliance in China, Shiu et al. (2013) adapt the goal of the intervention away from fostering the patient's belief that the medication promotes health, as in the original intervention, but rather, to find a place for HIV medication within their cultural framework of health and illness.

Ethnic matching. Ethnic matching was a strategy employed by three interventions (Fung, 2015; Hinton et al., 2004; Hinton et al., 2009).

Reported outcomes and results. Of the studies reviewed, eight did not describe results. The remaining studies described their results in terms of statistical analysis of symptom reduction as measured by standardized assessment instruments, self-report measures of participant satisfaction, completion rates among participants, and maintenance of therapeutic gains over time.

Table 35

Type of Results Reported for Adaptations for Communities of Asian/Pacific Islander Descent

Type of Result reported	Number of Cultural Adaptations
Not reported/not available yet	8
Symptom Reduction/Behavior Change	14
Participant Satisfaction	6
Maintenance of Results	3
Completion Rates	2

Symptom reduction. Of the total, 14 studies reported positive results in terms of statistically significant symptom reduction (Aslam et al., 2015; Choi et al., 2012; Chu, Huynh, &

Areán, 2012; Habib et al., 2015; Hinton et al., 2004; Hinton et al., 2009; Naeem et al., 2011; Naeem, Saeed, et al., 2015; Naeem, Gul, et al., 2015; Naeem et al., 2014; Pan et al., 2011; Pat-Horenczyk et al., 2015; Weiss et al., 2011; Wong, 2008; Zadeh & Lateef, 2012). Of these, Pan et al., (2011) study is particularly valuable within the field of cultural adaptations as their research design compared single session culturally adapted and standardized CBT for phobic Asian Americans in a randomized clinical trial. There are few studies that compare adapted versus non-adapted interventions, so this is a particularly useful contribution. Their study found that OST-CA was superior to OST, particularly for less acculturated clients.

Participant satisfaction. Studies reported results in terms of participant satisfaction, measured through treatment questionnaires and qualitative and anecdotal response (Choi et al., 2012; Chu et al., 2012; Fung, 2008; Massod et al., 2015; Naeem, Saeed, et al., 2015; Pat-Horenczyk et al., 2015).

Completion rates. Intervention success was measured in terms of completion rates for two adaptation research teams (Choi et al., 2012; Chu et al., 2012).

Maintenance. Success was measured, by three teams, in terms of persistence of improvements at post-intervention intervals (Choi et al., 2012; LaBreche et al., 2016; Naeem, Saeed et al., 2015).

Exemplar adaptations. Of the 26 interventions reviewed, only four described adaptations across all four domains of the model. The most commonly excluded domain was cultural competence, particularly for international interventions in which it was likely assumed that the therapist would belong to the same cultural tradition as the participants. Following is a description of a post-partum depression intervention for South Asian immigrant women living in Britain.

Table 36

Exemplar Adaptation for South Asian/Asian/Asian American Community

Citation	Context	Engagement	Equivalence	Cultural Competence
Masood, Y., Lovell, K., Lunat, F., Atif, N., Waheed, W., Rahman, A., … Husain, N. (2015). Group psychological intervention for postnatal depression: a nested qualitative study with British South Asian women. *BMC Women's Health, 15*, 109. http://doi.org/10.1186/s12905-015-0263-5	Incorporation of themes drawn from qualitative data: volatile relationships with husbands, "politics" within family (e.g., mother in law), role expectations. keeping "face, honor, cultural illness origin beliefs (e.g., punishment from God). Incorporation of religious texts and practices (e.g., Salat as behavioral activation). Provides education from religious texts, re-introduction of Salat (5 times daily prayer) as behavioral activation. Use of 'Psychosociospiritual' model.	Decrease stigma within family unit by packaging as "maternal health" rather than maternal depression. Language adjustments (e.g., "programme" rather than "therapy," "facilitator" rather than "mental health worker"). Accomodating concerns about privacy and confidentiality within a small community with culturally specific case vignettes, designed to reduce the pressure of speaking in a group about personal issues. Arrangements for childcare, prayer space, and attention to time of day to accommodate household responsibilities.	Integration of top-down and bottom-up knowledge, use of focus groups, adaptation theory referenced, clearly outlined stage-based adaptation framework.	Addresses knowledge-based requirements for therapists, e.g., understanding cultural and religious practices, norms, and values.

Discussion. The 26 interventions reviewed here cover a very broad and heterogeneous swath of the global population. As such, the interventions themselves offer an eclectic range of target problems. Of the 26 total studies reviewed, 15 address Asian populations living as minority communities within English-speaking, Western, pluralistic societies, such as Europe, Canada, the United States, and Australia. The remaining 11 interventions address Asian populations in their countries of origin, spanning China, Singapore, and Pakistan. While this review covers a broad geographic and diagnostic picture, there are areas of common thought. Within the Context domain, 14 intervention teams offer adaptations that relate to traditional Asian values, collectivism, and prioritization on emotional control and restriction of affect. These teams suggest that non-adapted treatments that emphasize emotional release or affective expression are likely incongruent with commonly held values that emphasize collective harmony

through holding one's emotions. Within the Engagement domain, involving family and/or important community influencers in the treatment was an adaptation employed by ten research teams as was language adaptations, including translation. Within the domain of Therapist Cultural Competence, utilizing the vertical relationship between therapist and client (e.g., presenting a more authoritative or directive counseling style rather than a collaborative or Socratic approach) was the most common adaptation (six interventions). Within the domain of Equivalence and Development, focus groups and/or qualitative data analysis formed the adaptations for 14 intervention designs.

That therapist cultural competence was the most frequently not-addressed domain within this review is an area for further attention, especially as this omission is not fully accounted for by international interventions that assume an ethnic match.

Additional Studies

As academic databases were searched four times over the course of a 12-month period for peer reviewed articles, books, and dissertations published between 2000-2017, a body of adaptations began to develop that did not fit into the existing categories. Attempts were made to thoroughly search for global adaptations, not already found through the other ethnic group categories. Various keyword combinations of "Evidence Based" and "Cultural Adaptation" were used along with various descriptors, including "Caribbean," "Middle East," and "Refugee." These searches yielded a total of 12 studies not already reviewed, although only one study met criteria for inclusion as a cultural adaptation (Schulz et al., 2006). Schulz et al. (2006) offer a case example study of an adaptation of Cognitive Processing Therapy (CPT) with Bosnian refugees. Among the 11 excluded studies that were not cultural adaptations, there were culturally specific interventions for the Caribbean, Jamaica, Lebanon, and refugee-specific

psychotherapy techniques. Additionally, a non-adapted clinical trial of Coping Cat in Brazil, a qualitative study identifying barriers to care in Arab countries, a theoretical framework for understanding refugee trauma, a review of treatment outcomes for refugees, and a theoretical paper hypothesizing the applicability of interventions to refugee communities generally, were identified and excluded.

Integration of Group Level Results

In total, one hundred eighty-seven (N = 187) studies were collected through database searches over a 12-month period. Of those, 30 studies were better classified as culturally specific interventions; an additional 56 interventions were not cultural adaptations and did not meet criteria for inclusion (e.g., guidelines of community-specific therapy, common-elements/transdiagnostic approaches to global mental health, qualitative studies, etc.). A total of 101 cultural adaptations of evidence based psychotherapy and psychosocial interventions were reviewed for the following communities Indigenous Peoples (16), People of African ancestry (36), Latino/a/x: (20), Asian and Pacific Islander ancestry (26). Domains of adaptation were analyzed for thematic frequency across population groups to determine whether specific themes of adaptation generalize across population groups. To the extent that thematic frequency or consistency may indicate importance, this analysis may guide clinicians and researchers in adaptation design. Again, adaptations are not mutually exclusive; most interventions contain multiple adaptations within a given domain.

Thematic analysis by domain.

Table 37

Context and Content Adaptations Across Groups

Adaptation	%ile
Overall Context and Content Adaptations	95%
Values	59%
Language/Visuals	53%
Contextually Specific Issues	48%
Religion and Spirituality	27%
Culturally Relevant Explanatory Models	12%
Literacy	9%
Elimination of Western Concepts deemed inappropriate	5%

In terms of Context and Content adaptations, 95% of adaptations addressed the domain of Context and Content. The largest aggregate theme within that domain was adaptations to include the values of the community (59%). Of Context and Content adaptations, 53% addressed language and visuals adaptations including translation, idioms, metaphors, stories, names, and representational images. The third largest aggregate theme (48%) were adaptations designed to address contextually specific issues including all or some of the following: experience of oppression, discrimination, within group differences, acculturation, cultural ontology of symptoms and symptom expression, minority stress, historical trauma, and intergenerational conflict. The fourth substantial theme (27%) was adaptations to address religion and spirituality. Remaining themes included: culturally relevant explanatory models (12%), literacy (9%), and adaptation or elimination of Western concepts deemed inappropriate for the community (5%). It is clear from this review that content and context adaptations can and often do include both shallow and deep changes. Additionally, given that cultural values was the dominant adaptation theme, it is evident that adaptation requires investment of knowledge,

respect, and resources into indigenous and culture-specific approaches to human psychology (Bernal et al., 1995; Hwang, 2006b; Lau, 2006; Barrera & González-Castro, 2006), in order to develop the requisite cultural knowledge to adequately make values-based adaptations.

Table 38

Engagement Adaptations Across Groups

Adaptation	%ile
Overall Engagement Adaptations	83%
Structural Barriers and Flexibility	33%
Inclusion of extended family/community members	28%
Community-Based Interventionists	26%
Stigma reducing word choices	22%
Co-location within (non-mental health) community setting	15%
Orientation	13%
Technology	13%
Communication Style Adjustments	18%
Mistrust	3%

In terms of Engagement, there appears to be less consensus across populations about type of engagement adaptations. While many of the themes reported above appear across population categories, their relative frequency varies substantially according to population group. The most frequent theme reported in each population group is: Community-Based Settings (Indigenous, 63%); Structural Barriers (African American, 47%); Structural Barriers/Flexibility (Latino/a/x, 47%); Extended Family and Community Involvement and Translation and Use of Language (Asian, 38% each). Out of 101 studies, 17% did not address engagement strategies. The largest aggregate theme within the Engagement domain (33%) addressed Structural Barriers and the need for logistical Flexibility. Of Engagement adaptations, 28% addressed including extended family members and/or important community figures into the intervention. Within Engagement adaptations, 25% utilized Community-Based Interventionists, who are most often not mental

health professionals. Adapting language for stigma reducing word choices was addressed by 22% of all interventions. Interventions (19%) addressed co-locating the intervention within a Community Setting not otherwise associated with mental health. Adjusting Communication Style was addressed by 18% of total interventions. In terms of Communication Style, it is worth noting that Communication Style adaptations are very specific to the community being served, for example communication style-based engagement adaptations for African Americans stressed a collaborative and validating style, whereas adaptations for Asian, Asian American, and Pacific Islander communities emphasized a vertical instructional style. Orienting clients unfamiliar to therapy was an adaptation addressed by 13% of reviewed studies and an additional 13% included Technology. The remaining 3% addressed issues of mistrust between the community (African Americans) and mental health providers.

Table 39

Equivalence and Development Adaptations Across Groups

Adaptation	%ile
Overall Equivalence and Development Processes Adaptations	94%
Integration of research and community perspectives	60%
Use of adaptation literature	46%
Provisions for fidelity	37%
Clinician/researcher driven process	19%
Community-driven process	2%
Cultural Review/Consultation Process	3%

Within the domain of Equivalence and Development Processes, a clear majority of intervention designers (60%) utilize an integrated process that balances knowledge generated from research and clinical judgment with community perspectives. Only 6% of interventions did not address their equivalence and development processes. Adaptation theory literature was

widely cited, referenced by 46% of reviewed studies. Of the total, 37% of reviewed studies articulated provisions for ensuring fidelity to the original (non-adapted) intervention. A solely bottom-up approach, in which the intervention impetus originated from the community, was only referenced by 2% of the studies. Whereas 19% of interventions reported a top-down researcher or clinician led adaptation process. Lastly, 3% of interventions cited a cultural consultation and review process. It is worth noting that this review includes multiple case studies as well as descriptions of pilot programs targeting a population niche for which there is little empirical data (e.g., Khmer Rouge survivors, Latina migrant farmworkers in Colorado), thus resulting in reliance on the clinical experience and judgment of the authors. Additionally, many of the foundational works of adaptation theory was also developed from the theorists' years of experience both belonging to ethnoculturally diverse communities and serving them as psychologists. While the consensus in the literature is strong that clinical/researcher knowledge should be balanced with community-generated perspectives, these case studies and small pilot interventions also offer valuable insights into underserved and under-researched communities.

Table 40

Cultural Competence Adaptations Across Groups

Adaptation	%ile
Overall Cultural Competence Adaptations	65%
Aspects that relate to engagement with the broader community (Ongoing Investment in the Community, 2%; Use of Community Broker, 1%; Cultural Knowledge Acquisition, 1%; Community-Based Interventionist, 21%);	25%
Aspects that relate to personal characteristics of the therapist (Matching of Ethnicity, Language, National Origin, 19%)	19%

(continued)

Adaptation	%ile
Aspects that relate to interpersonal processes (Utilizing Vertical Relationship: 6%; Adjustment of Goals: 1%; Addressing Skepticism and Past Negative Experiences: 5%); Dynamic Sizing Efforts, 5%; Non-Hierarchical Collaboration, 2%).	18%
Aspects that relate to systems and professional standards and norms (APA guidelines, 2%; Assessment of Agency Competence: 1%; Self Disclosure and Gifts: 6%).	9%
Aspects that relate to attitudes and self-reflection (Awareness of Differences, 3%; Anti-Racism, 1%);	4%

Lastly, is the domain of Cultural Competence. The domain of cultural competence was (relative to the others) utilized less consistently, with 35% of interventions not addressing this domain and an additional 2% of interventions with unspecified adaptations to cultural competence. The construct of cultural competence is heterogeneous and contains many different personal, intrapersonal, interpersonal, professional, and systemic aspects. Within the 65% of interventions that did address this domain, four themes were emergent: aspects of cultural competence adaptations that relate to engagement with the broader community; aspects that relate to personal characteristics of the therapist; aspects that relate to interpersonal processes; aspects that relate to systems and professional standards and norms; and aspects that relate to attitudes and self-reflection.

Only personal characteristics, that is matching interventionist and client (on the basis of ethnicity, language and/or national origin) was addressed across all four populations in this review; matching was addressed by 19% of interventions. However, the largest aggregate category of cultural competence adaptation was within aspects that relate to engagement with the broader community *(Ongoing Investment in the Community, 2%; Use of Community Broker, 1%; Cultural Knowledge Acquisition, 1%; Community-Based Interventionist, 21%).* Use of a community-based interventionist was the most-utilized cultural competence intervention, and

likely overlaps considerably with the construct of matching. Adaptations to traditional interpersonal processes accounted for 18% of the total number of cultural competence interventions; aspects that relate to attitudes and beliefs of the therapist (e.g., anti-racism, awareness of differences), accounted for 9% and the remaining 4% related to standards, policies, and systems.

Overall, 38% of all interventions reported adaptations across all four domains of the cultural competence model. Of the total, 93% of adaptations addressed the domain of Context and Content. Engagement and Equivalence and Development domains were addressed by 83% of interventions. The domain of Cultural Competence was addressed by 65% of interventions.

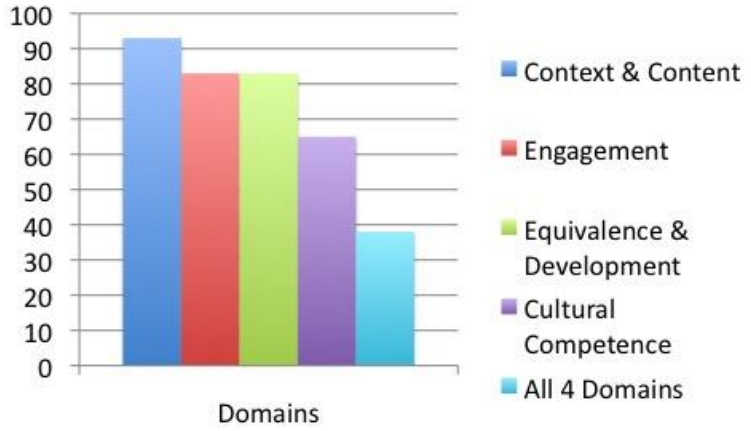


Figure 4. Domains addressed across groups.

One possible explanation for the relative under-utilization of the cultural competence domain is that "matching" presupposes a level of implicit cultural competence, and, additionally, that interventions within relatively ethnically homogenous countries may not require the same protections against cross-cultural miscommunication and mis-attunement as interventions designed for ethnocultural minority groups within multicultural societies in which members of the dominant group are the likely care providers (e.g., United States).

Chapter 5: Discussion

The primary aims of this dissertation were (a) to perform a comprehensive literature review and critical analysis of current (2000-2015) culturally adapted psychotherapy and psychosocial intervention approaches; and (b) to offer an overview of existing culturally adapted psychological interventions by disorder or target problem, ethnic group, and theoretical approach (e.g., cognitive behavioral, psychodynamic, behavioral, etc.). Additionally, this dissertation aims to offer an integrative model for the cultural adaptations of empirically supported psychological interventions that can be used to both inform professional practice and further scientific inquiry. The culturally adapted interventions reviewed in this dissertation were analyzed within the framework of this model, which served as an opportunity for refinement of the model. In terms of the four-part model of cultural adaptations proposed by this dissertation, analysis of 101 cultural adaptations suggests that the model is a coherent framework that can adequately capture the many dimensions of cultural adaptation.

Refinement of the Model and Implications for Cultural Competence

The four-domain construction of this dissertation's cultural adaptation model was maintained through review and analysis of 101 adaptations. However, the definitions and descriptions of the domains were refined through the analysis process to better capture adaptation as it is currently being executed in the primary literature. For example, the domain of Engagement was refined to more clearly conceptualize adaptations as occurring under the umbrella concept of addressing barriers to treatment and contributors to treatment failure.

Knowledge. As this review demonstrates, cultural adaptation rests upon cultural knowledge. A clinician or researcher cannot successfully incorporate a community's beliefs and values if those beliefs and values are unknown to her. This review suggests that development of

cultural knowledge is critical, across all four adaptation domains as cultural knowledge dictates the values, communication and interpersonal norms, contextually relevant issues, perceived trustworthiness of care, and barriers to treatment within a given ethnocultural niche. In current cultural competence models, beliefs and attitudes are foundational to knowledge and skill (e.g., Sue, 1998). Cultural adaptation, then, may be better understood as an application of the "knowledge and skills" components of cultural competence. Psychologists need to augment their mainstream theoretical learning with investment of knowledge, respect, and resources into indigenous and culture-specific approaches to human psychology (Barrera & González-Castro, 2006; Bernal et al., 1995; Hwang, 2006; Lau, 2006). As infinite knowledge is not possible, psychologists need to be trained to develop skills in knowledge acquisition. In this regard clinical psychologists can benefit from the leadership of our colleagues in counseling and community psychology and place the authority for determining what constitutes requisite cultural knowledge with the community, rather than the provider or reseacher.

Global applicability. The global database presented in this review is quite small. Further research into the construct of cultural competence and its global relevance could help clarify if this model is better suited to guide and describe adaptation efforts within the United States, rather than globally. This model offers particular utility to clinicians in the United States who can use the four-part model to ensure that each domain of adaptation is addressed for a local community, for example through the creation of a clinical tool based off of this model such as a checklist. This seems like a reasonable extension of the current project that is both doable and potentially useful. This model also has implications for training of psychologists. This model could enhance cultural competence training by providing a framework for clinical decision-

making for psychology trainees whose training in ESTs may leave them unequipped for the underserved clinical settings in which they work.

Multi-focal view of aspects of cultural competence. This dissertation contributes to a multi-focal understanding of cultural competence. This dissertation identifies five aspects of cultural competence that may have implications for continuing to refine and operationalize how this clinical skill is understood, taught, and demonstrated, those are: Engagement with the Broader Community; Personal Characteristics of the Interventionist; Interpersonal Processes; Systems, Standards, and Norms; and Attitudes and Self-Reflection. As mentioned, it may be that, within the subset of the field that engages in adaptation, beliefs and attitudes are more firmly integrated into professional and personal identity. These additional components may provide more illumination into how knowledge and skills is operationalized and utilized when beliefs and attitudes are already foundational. Recent current events (e.g., the 2016 presidential election) may be contributing to a Zeitgeist shift in which the often-invisible (to White people) mechanisms of racism and White supremacy have achieved a cognitive-dissonance-inducing visibility, contributing to a willingness on the part of White psychologists to "get woke" in their lives as well as in their clinical practice and research. Cultural competence training of psychologists would benefit from increased attention to aspects of cultural competence that go beyond clinician attitude and personal stance to include more training in developing flexible interpersonal processes, benchmarks for competence in terms of both cultural knowledge and competence in acquisition of such knowledge, training in engagement with the broader (non-clinical) community, and training in assessment of systems issues and professional standards and norms.

Importance of context. This review is consistent with past literature, such as the study by Chu and Leino (2017) that found, among the 45 cultural adaptations reviewed, 60% required additions to the core intervention elements. In this review, contextual themes relevant to the intended community were demonstrated to be a significant aspect of Context and Content adaptations. There were some common themes, for example, for African American and Native American communities, Culture and Context adaptations frequently included issues related to historical trauma and the legacy of mistrust between the community and public systems. Interventions geared towards the Latino/a/x and Asian American communities often addressed immigration history, acculturation, and bicultural stressors. Adaptations for African American and Latinx communities often addressed discrimination, racism, and oppression.

At the same time, many context adaptations were uniquely specific to the ecological niche being served and defied thematic categorization or consistency. Seminal Native American psychologist, Joseph Gone, emphasizes, as does the current review, that it is not enough to merely include general concepts into a traditional framework. At the level of research, if "empirical verification is the feature that distinguishes science from philosophy." (Kim, 2000, p. 282), then research questions (including clinical intervention design, effectiveness, and efficacy) must begin from an indigenous epistemology. Gone (2004) describes,

> The careful formulation of local ethnopsychology within the framework of cultural psychology thus encompasses multiple relevant content areas, including the complex relationships between culture, language, and mind; the experiential foundations of self and personhood; the nuanced diversity of emotional experience and expression; the conceptual underpinnings of health, illness, and healing; and research reflexivity (i.e., attention to how the knower constructs the known). (Gone, 2004, p. 15)

It is worth noting that not all Content and Context adaptations are additive. Multiple teams highlighted unhelpful or contraindicated aspects of Western/non-adapted interventions so clinicians and researchers need to be vigilant to potential iatrogenic effects of psychological

intervention and be amenable to removal of problematic constructs. Again, I turn to Gone, who exhorts psychologists to attend to "miscommunications, standoffs, breakdowns, and failures in the course of therapeutic intervention, because such mishaps may signify subtle and implicit incommensurability between therapeutic models and local ethnopsychology" (Gone, 2004, p. 16). Further, the onus for monitoring such incompatibilities is delineated as part of the professional duties of the psychologist.

Here, again, I turn back to the multi-focal view of cultural competence and the development of the skill of engaging with the larger (non-clinical) community and the importance of collaboration and consent. As contextual issues vary considerably by community, it follows that the Development and Equivalency consensus view of adaptation theorists which is overwhelmingly endorsed by the researchers within this review, is that meaningful adaptation has to include community-based wisdom, most often generated through some kind of collaborative process (Barrera & González-Castro, 2006; Bernal et al., 1995; Hwang, 2006b). This echoes the words of Gone (2004) who calls for deliberate strategies for creating interventions that have face validity and accountability to the community for whom they are designed and specifically describes the importance of working collaboratively with community members and undertaking critical analysis of the measurement of outcomes to include both confirming and disconfirming evidence of effectiveness.

While contextual issues vary by communities, a through-line across interventions for all reviewed communities within the United States is an emphasis on validating the experience of cultural strain, emphasizing and utilizing the strengths, values, and meaning-making systems of the culture, and/or deepening the connection to the cultural community as a source of support and wellbeing. As these are not well understood within mainstream psychology (either in theory

or technique) as critical mechanisms of therapeutic action, clinicians, researchers, and training programs may need to re-think their treatment and intervention constructs to demonstrate cultural competence and clinical effectiveness in psychological intervention with ethnoculturally diverse communities.

Evidence revisited. This dissertation is unlikely to set to rest the conflicts within the field of psychology about the applicability of empirically supported treatments for use with ethnoculturally diverse communities. However, it is worth revisiting the construct of evidence in light of this analysis. Firstly, it is worth noting that the dominance of the empirically supported treatments construct means that interventions and adaptations that are based in evidence but lack the requisite two independent randomized controlled trials makes many excellent adaptations and interventions invisible because of lack of resources to do a systematic study or publish results. The case studies included within this review highlight the range of valuable evidence that exists, particularly when serving a complex, ecological niche, such as Khmer Rouge-surviving Cambodian refugees living in Canada, or mothers who are migrant farmworkers working in the rural American West. It is unlikely that the adaptations contained in those studies will ever make their way into an RCT and therefore will not ever be considered empirically supported treatments, but by using the broader and more inclusive category of evidence based intervention, consistent with the mandate for evidence based practice, perhaps a larger range of studies, research methodologies, and client voices will be available for meaningful consultation in guiding treatment decisions. We should not ignore the significance of these distinctions, nor pretend that utilizing the "gold standard" is a professionally neutral position.

Public health role models. The many public health intervention adaptation models described within this review may offer a valuable blueprint for future psychological intervention

development research. Public health interventions contain, within the intervention itself, an adaptation process that ensures appropriate tailoring for the target community. Imagine the impact on diverse communities if interventions that currently enjoy wide dissemination, such as ACT, CPT, or TF-CBT contained within them a similar model of localizing adaptation process and implementation. Public health models guarantee community participation in several key ways. Firstly, community-based and lay facilitators are recruited to engage otherwise hard-to-reach communities. Within some HIV prevention public health interventions, for example, a key component of the intervention is a series of vignettes and coordinated visual materials which are designed to attract attention, prompt personal recognition, provide a teaching lesson, and facilitate discussion of prevention behaviors. Vignettes are created collaboratively by the community-based lay facilitators as well as researchers/outside clinicians. This collaboration ensures accuracy of idiom, language, naming, and contextually specific issues. Within psychological service provision, particularly within institutions, this could take the form of a community review board made up of community members and patients who have an oversight role or a research review board, a common practice in Community Psychology. It is encouraging to see traditional Clinical Psychology institutions instating such a practice, such as a pilot program at the Colorado VA in which a board of veterans reviews and has oversight over all IRB applications involving veteran research subjects (Wendleton, 2017).

Next steps. Much of the current commentary on cultural adaptation delineates between engagement and adapted elements (Chu & Leino, 2016; Gonzales, 2017). This model may offer a valuable addition to the construct, incorporating Engagement as an adaptation domain. Because of the integrated inclusion of Engagement strategies, the model may be a valuable starting point for the development of a cultural adaptation checklist. Such a checklist could have

clinical applicability, aiding clinicians in a clinical decision making process. A similar checklist could also be valuable for researchers, similar to the quality assessment tools such as STROBE (www.strobe-statement.org) used to strengthen reporting in research studies by outlining a checklist of items to be included in articles.

The interventions collected within this review face a population-impact dissemination problem. In a recent special issue of *Prevention Science* "Challenges to the Dissemination and Implementation of Evidence-Based Prevention Interventions for Diverse Populations," Nancy Gonzales (2017) offers commentary on the fact that EBIs have yet to deliver on their population-level impact due to implementation and dissemination inconsistencies and problems. She articulates a challenge to the fidelity debate, in light of real-world realities, that "a static intervention model should [not] be the end goal" and focusing on dynamic, real-world delivery models that make adaptations at all stages of translation (e.g., pre-implementation, implementation, sustainability; Gonzales, 2017, p. 690).

A program like that designed by Bruce Chorpita (PracticeWise) provides online database of interventions searchable by a variety of demographic, problem type, and symptom filters. This allows practitioners to find the intervention that has the most research support in terms of effectiveness. Creation of a similar database for studies like those within this review would be an ambitious, but highly valuable contribution towards wider implementation and dissemination of culturally adapted interventions.

Limitations

This study has several limitations. There is a high likelihood that relevant articles were missed through oversight, the limitation of searching for articles only in the English language, or inadequacy of search criteria. Additionally, this study lacks internal validity because a single

reader was responsible for all coding. Further research could enhance the internal validity of this study with the introduction of additional and independent coders. Additionally, international and domestic studies were considered together, divided on ethnocultural basis. Analyzing these studies independently would likely yield different domain and aggregate themes. Analyzing domestic and international studies separately could also help clarify the significance of cultural competence as a construct in global health settings. For example, data could be re-assessed comparing the US-based and global interventions to see if they differ in terms of relative frequency of cultural competence aspects.

Additionally, while throughout this dissertation, emphasis has been paid to the global regions that lack adaptation of evidence based treatments; there is an alternative position. It is worth considering if, perhaps, this is a good thing, rather than a deficit. Perhaps caution should be taken in considering whether Western/North American/US-based research and theory should be imposed upon other countries and cultural contexts. Given the history of colonialism, imperialism, and dominance as lived out through the relationships between, for example, the global North and the global South, psychologists have an ethical obligation to examine carefully their willingness to participate in the globalizing of American psychology.

Emerging Author Perspectives and Conclusion

My scholarly pursuits and clinical training experiences have left me with the view that, despite guidelines offered by the APA in recent years, mainstream psychology remains undecided (even dismissive) about the importance of culture in psychological intervention. My reading of literature from allied health professions such as public health and nursing suggest that other professions have managed a more successful integration of culture into practice without the same level of difficulty and discord and about 20 years faster. What accounts for this

difference? Why do psychologists struggle to change their practices? One reason that occurs to me is the failure to adequately reckon with and educate future psychologists about the history of abuses, civil rights violations, and oppressive practices codified by theory and practice. And also, psychology's well-documented history of harm is not confined to the past. One of the most recent and glaring examples of psychology's failure to critically interrogate itself in terms of its basic adherence to ethical principles is APA's collusion and participation in human torture (Summers, 2008). This important, recent example caused public embarrassment and likely causes discomfort among current practicing psychologists, as suggested by its noticeable absence from contemporary doctoral psychology pedagogy. This discomfort reflects the cognitive dissonance created when psychologists attend to the fact that psychology as a field can and does engage in deeply unethical behavior. If we, as psychologists, truly believe in the ethical principles of beneficence and non-malfeasance and strive to live up to the power and authority entrusted to them, then a critical, interrogatory self-examination of psychological principles and practices should be part of the metacompetence (and formal education) of all psychologists. The recent APA requirement for doctoral programs to include a course on the history of psychology could, if appropriately framed, provide a reminder that epistemic violence is woven into the fabric of psychology, no less true today than 100 years ago. As stated elegantly by Thema Bryant-Davis (2017), there is no healing without recognition. Perhaps, by illuminating and interrogating the rigid limitations of the episteme of psychological science, we can open our theory and our research inquiry to the many forms of healing practiced by members of the human family and deliver the beneficence and non-malfeasance of psychological service that we owe the public trust.

In conclusion, there is an overwhelming body of evidence that compels psychologists to center culture in case conceptualization and intervention. Cultural adaptation is one avenue towards that goal. Gone cautions psychologists against a reductionistic view of multiculturalism, "there is simply no such thing as a Generokee (i.e., generic American Indian) ethnopsychology available to guide the work of clinicians…in any specific way. Thus, a clear advantage lies in the professional commitment to serving a….community. (Gone, 2004, p. 16). Gone argues that, when working cross culturally (or across the cultural encapsulation of the field of psychology), it is only through close and ongoing collaboration with the community "can the subtle ideological dangers of neocolonialism be overcome" (Gone, 2004, p.16). As suggested by this analysis, any meaningful cultural adaptation rests on cultural knowledge and respect. Shallow adaptations may be initiated by psychologists who lack deep knowledge of the community that they are working within, however, it is unlikely that deeper adaptations, incorporating values, contextual issues, and interpersonal processes will be successful without investment in the indigenous wisdom, ethnopsychology, and traditions of the intended community. One argument against cultural adaptation is that it is too costly and time-consuming to be practical. Swapping out pictures on a PowerPoint, or changing the names in a vignette is not overly costly or burdensome. Neither is holding a pre-intervention orientation session for clients unfamiliar with Western psychotherapy. I can imagine a future scenario in which these "shallow" adaptations are seen as routine. However, in order for the integration of culture into psychology to expand beyond the window-dressing of non-binding exhortations offered without practical guidance or requirement, psychologists must begin to invest, seriously, in wisdom traditions outside of their own in order for meaningful adaptation to occur. While, no doubt, there is hard work that lies ahead, the presence of 101 cultural adaptations of evidence based interventions suggests that

there is a strong and growing community of researchers and clinicians who, while trained within the evidence based practice model, have not abandoned the critical theory revolution started over 40 years ago. These collected interventions, as well as the 30 culturally specific interventions not included in this review, forms a robust body of culturally tailored interventions that contribute towards bending the arc of psychology towards justice and wellbeing for all our patients. To better serve all communities, adaptation must become a clinical competency for psychologists, and it is my humble hope that this dissertation provides some direction for that developing that important skill set.

REFERENCES

Agazzi, H. (2010). Adaptation of a behavioral parent-training curriculum for Hispanic caregivers: HOT DOCS Español. *Infant Mental Health Journal, 31*(2), 182 – 200. https://doi.org/10.1002/imhj.20251

Aguilera, A., Garza, M. J., & Muñoz, R. F. (2010). Group cognitive-behavioral therapy for depression in Spanish: Culture-sensitive manualized treatment in practice. *Journal of Clinical Psychology, 66*(8), 857-67. http://doi.org/10.1002/jclp.20706

American Psychological Association (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58*, 377–402. https://doi.org/10.1037/0003-066x.58.5.377

American Psychological Association. (2006). Evidence-based practice in psychology. *American Psychologist, 61*(4), 271-285. https://doi.org/10.1037/0003-066x.61.4.271

American Psychological Association. (2016). Summary report, graduate study in psychology 2017: Student demographics. Retrieved from http://www.apa.org/education/grad/survey-data/2017-student-demographics.aspx

American Psychological Association. (2017). *Multicultural Guidelines: An ecological approach to context, identity, and intersectionality.* Retrieved from: http://www.apa.org/about/policy/multicultural-guidelines.pdf

Andrews, J. O., Felton, G., Wewers, M.E., Waller, J., & Tingen, M. (2007). The effect of a multi component smoking cessation intervention in African American women residing in public housing. *Research in Nursing and Health, 30*(1):45-60. https://doi.org/10.1002/nur.20174

Arnett, J. J. (1998). The neglected 95%: Why American psychology needs to become less American. *American Psychologist, 63*(7), 602-614. https://doi.org/10.1037/0003-066x.63.7.602

Aslam, M., Irfan, M., & Naeem, F. (2015). Brief culturally adapted cognitive behaviour therapy for obsessive compulsive disorder: A pilot study, *Pakistan Journal of Medical Sciences, 31*(4), 874-879. http://dx.doi.org/10.12669/pjms.314.7385

Barrera, M., & González-Castro, F. (2006). A heuristic framework for the cultural adaptation of interventions. *Clinical Psychology: Science and Practice, 13*(4), 311–316. https://doi.org/10.1111/j.1468-2850.2006.00043.x

Baumann, A. (2014). Parent Management Training-Oregon model (PMTO™) in Mexico City: Integrating cultural adaptation activities in an implementation model. *Clinical Psychology: Science and Practice, 21*(1), 32 – 47. https://doi.org/10.1111/cpsp.12059

Barnett-Page, E. & Thomas, J. (2009). Methods for the synthesis of qualitative research: A critical review. *BMC Medical Research Methodology 9*(59), 1-11. doi:10.1186/1471-2288-9-59

Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth: a direct-comparison meta-analysis. *Journal of Counseling Psychology 53*(3), 279. https://doi.org/10.1037/a0023626

Bennett, S. T., & Babbage, D. R. (2014). Cultural adaptation of CBT for aboriginal Australians. *Australian Psychologist, 49*, 19-21. http://doi.org/10.1111/ap.12029

Bennett, S. T. M. (2009). *Te huanga o te ao Maori: Cognitive Behavioural Therapy for Maori clients with depression: Development and evaluation of a culturally adapted treatment programme* (Doctoral dissertation). Retrieved from Research Gate database:

https://www.researchgate.net/

Bennett-Levy, J., Wilson, S., Nelson, J., Stirling, J., Ryan, K., Rotumah, D., & Beale, D. (2014). Can CBT be effective for aboriginal Australians? Perspectives of aboriginal practitioners trained in CBT. *Australian Psychologist, 49*(1), 1–7. http://doi.org/10.1111/ap.12025

Bent-Goodley, T. B. (2005). An African-centered approach to domestic violence. *Families in Society, 86(*2), 197-206. https://doi.org/10.1606/1044-3894.2455

Bernal, G. & Domenech Rodriguez, M. (2009). Advances in Latino family research: Cultural adaptations of evidence-based interventions. *Family Process, 48*(2), 169-178.

Bernal, G., Bonilla, J., & Bellido, C. (1995). Ecological validity and cultural sensitivity for outcome research: Issues for cultural adaptation and development of psychosocial treatments with Hispanics. *Journal of Abnormal Child Psychology, 23*(1), 67–82. https://doi.org/10.1007/bf01447045

Bernal, G., & Domenech, R. M. M. (2012). *Cultural adaptations: Tools for evidence-based practice with diverse populations.* Washington, DC: American Psychological Association.

Bernal, G., & Domenech Rodríguez, M. M. (2014). *Tailoring treatments to patient's race and ethnicity*. In G. P. Koocher, J. C. Norcross and B. A. Green (Eds.), *Psychologists' desk reference* (3rd ed.), (pp. 310-313). New York and London: Oxford.

Bernal, G., Jiménez-Chafey, M. I., & Domenech Rodríguez, M. M. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology: Research and Practice 40*(4), 361-368. https://doi.org/10.1037/a0016401

Bernal, G., & Saez-Santiago, E. (2006, March 1). Culturally centered psychosocial interventions.

Journal of Community Psychology, 34(2), 121-132. https://doi.org/10.1002/jcop.20096

BigFoot, D. S. (1989). *Parent training for American Indian families*. (Doctoral dissertation). Retrieved from Research Gate.

BigFoot, D. S. P. D., & Funderburk, B. W. P. D. (2011, October 1). Honoring children, making relatives: The cultural translation of parent-child interaction therapy for American Indian and Alaska Native families. *Journal of Psychoactive Drugs, 43*(4), 309-318. https://doi.org/10.1080/02791072.2011.628924

BigFoot, D. S. & Schmidt, S. R. (2010). Honoring the children, mending the circle: TF-CBT. *Journal of Clinical Psychology In Session, 66*(8), 847—856. https://doi.org/10.1002/jclp.20707

Boyd-Ball, A. J. (2003). A culturally responsive, family-enhanced intervention model. *Alcoholism: Clinical and Experimental Research, 27,8* 1356-1360. https://doi.org/10.1097/01.alc.0000080166.14054.7c

Boysen, G. A., & Vogel, D. L. (2008). The relationship between level of training, implicit bias, and multicultural competency among counselor trainees. *Training and Education in Professional Psychology, 2*(2), 103-110. https://doi.org/10.1037/1931-3918.2.2.103

Brave Heart, M. Y., Chase, J., Elkins, J., & Altschul, D. B. (2011). Historical trauma among indigenous peoples of the Americas: Concepts, research, and clinical considerations. *Journal of Psychoactive Drugs*, *43*(4), 282–290. https://doi.org/10.1080/02791072.2011.628913

Breland-Noble, A. M. (2012). Community and treatment engagement for depressed African American youth: The AAKOMA FLOA pilot. *Journal of Clinical Psychology in Medical Settings*, *19*(1), 41–48. http://doi.org/10.1007/s10880-011-9281-0

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist, 32*(7), 513-531. http://dx.doi.org/10.1037/0003-066X.32.7.513

Bruner, J. (March 01, 2008). Culture and mind: Their fruitful incommensurability. *Ethos, 36*(1), 29-45.

Bryant-Davis, T. (2017). Healing requires recognition: The case for race-based traumatic stress. *The Counseling Psychologist, 35*(1), 135-143.

Carpenter-Song, E., Alverson, H., Chu, E., Drake, R.E., Ritsema, M., & Smith, B. (2010). Ethno-cultural variations in mental illness discourse: Implications for collaborative treatment and therapeutic alliances. *Transcultural Psychiatry, 47*, 224-251. https://doi.org/10.1177/1363461510368906

Cassel, K. D., Braun, K., Ka'opua, L., Soa, F., & Nigg, C. (2014). Samoan body and soul: Adapting an evidence-based obesity and cancer prevention program. *Qualitative Health Research, 24*(12), 1658–1672. http://doi.org/10.1177/1049732314549021

Centers for Disease Control (July 10, 2003). *HIV prevention community planning: An orientation guide.* Retrieved from https://stacks.cdc.gov/view/cdc/26531

Charles, L. L. (2007). Cultural competency as a relational process: scenes from a family therapy training context in the Philippines. *Qualitative Inquiry, 13*(8), 1160-1176. https://doi.org/10.1177/1077800407308226

Choi, I., Zou, J., Titov, N., Dear, B. F., Li, S., Johnston, L., Andrews, G. & Hunt, C. (2012). Culturally attuned Internet treatment for depression amongst Chinese Australians: A randomised controlled trial. *Journal of Affective Disorders, 136*(3), 459–468. http://doi.org/10.1016/j.jad.2011.11.003

Chowdhary, N., Sikander, S., Atif, N., Singh, N., Ahmad, I., Fuhr, D. C., & Patel, V. (2014). The content and delivery of psychological interventions for perinatal depression by non-specialist health workers in low and middle income countries: A systematic review. *Best Practice and Research Clinical Obstetrics and Gynaecology*, *28*(1), 113–133. http://doi.org/10.1016/j.bpobgyn.2013.08.013

Christopher, J. C. (2001). Culture and psychotherapy: Towards a hermeneutic approach. *Psychotherapy*, *38*(2), 113-128. https://doi.org/10.1037//0033-3204.38.2.115

Chu, J. & Leino, A. (2017). Advancement in the maturing science of cultural adaptations of evidence-based interventions. *Journal of Consulting and Clinical Psychology*, *85*(1), 45-57. 10.1037/ccp0000145.

Chu, J. P., Huynh, L., & Areán, P. (2012). Cultural adaptation of evidence-based practice utilizing an iterative stakeholder process and theoretical framework: Problem solving therapy for Chinese older adults. *International Journal of Geriatric Psychiatry*, *27*(1), 97–106. http://doi.org/10.1002/gps.2698

Coard, S. (2004) Towards culturally relevant preventive interventions: The consideration of racial socialization in parent training with African American families. *Journal of Child and Family Studies, 13*(3), 277 – 293. https://doi.org/10.1023/b:jcfs.0000022035.07171.f8

Coard, S. I., Foy-Watson, S., Zimmer, C., & Wallace, A. (2007). Considering culturally relevant parenting practices in intervention development and adaptation: A randomized controlled trial of the black parenting strengths and strategies (BPSS) program. *The Counseling Psychologist*, *35*(6), 797–820. http://doi.org/10.1177/0011000007304592

Cole, M. (1996). *Cultural Psychology: A once and future discipline.* Cambridge, MA: Harvard University Press.

Comas-Díaz, L. (2016). Mujerista Psychospirituality. In T. Bryant-Davis and L. Comas-Díaz (Eds.) *Womanist and mujerista psychologies: Voices of fire, acts of courage.* Washington, DC.: American Psychological Association: https://doi.org/10.1037/14937-007

Comas-Díaz, L. (2005). Becoming a multicultural psychotherapist: The confluence of culture, ethnicity, and gender. *Journal of Clinical Psychology/InSession, 61*(8), 973–981. https://doi.org/10.1002/jclp.20170

Cozolino, L. (2010). *The neuroscience of psychotherapy: Healing the social brain*. (2nd ed). New York, NY: W. W. Norton.

Creswell, J.W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches.* (3rd ed). Thousand Oakes, CA: Sage Publications.

Davey, M. P., Kissil, K., Lynch, L., Harmon, L. R., & Hodgson, N. (2012). Lessons learned in developing a culturally adapted intervention for African-American families coping with parental cancer. *Journal of Cancer Education, 27*(4), 744–751. http://doi.org/10.1007/s13187-012-0398-0

Davey, M. P., Kissil, K., Lynch, L., Harmon, L. R., & Hodgson, N. (2013). A culturally adapted family intervention for African American families coping with parental cancer: Outcomes of a pilot study. *Psycho-Oncology*, *22*(7), 1572–1580. http://doi.org/10.1002/pon.3172

Department of Veterans Affairs. (2015, June 22), PTSD and Psychotherapy: Putting veterans at ease. Retrieved from http://www.blogs.va.gov/VAntage/20933/ptsd-psychotherapy/).

Dingwall, K. M., Puszka, S., Sweet, M., & Nagel, T. (2015). Like drawing into sand:

Acceptability, feasibility, and appropriateness of a new e-mental health resource for service providers working with Aboriginal and Torres Strait Islander people. *Australian Psychologist, 50*(1), 60-69. http://doi.org/10.1111/ap.12100

Dixon-Woods, M., Fitzpatrick, R., & Roberts, K. (2000). Including qualitative research in systematic reviews: opportunities and problems. *Journal of Evaluation in Clinical Practice, 7*(2), 125–133. https://doi.org/10.1046/j.1365-2753.2001.00257.x

Domenech Rodríguez, M. M., Baumann, A. A., & Schwartz, A. L. (2011). Cultural adaptation of an evidence based intervention: From theory to practice in a Latino/a community context. *American Journal of Community Psychology*, 47(1), 170–186. DOI 10.1007/s10464-010-9371-4

Dumas, J. E., Arriaga, X. B., & Moreland Begle, A. (2011). Child and parental outcomes of a group parenting intervention for Latino families: A pilot study of the CANNE program. *Cultural Diversity and Ethnic Minority Psychology, 17*(1), 107-115, http://doi.org/10.1037/a0021972

Dutton, M. A., Bermudez, D., Matás, A., Majid, H., & Myers, N. L. (2013). Mindfulness-based stress reduction for low-income, predominantly African American women with PTSD and a history of intimate partner violence. *Cognitive and Behavioral Practice, 20*(1), 23–32. http://doi.org/10.1016/j.cbpra.2011.08.003

Erwin, Patricia L. (2014). Culturally relevant programming in action: A case study of a marriage education program for African American couples, *Adult Education Research Conference*. Retrieved from http://newprairiepress.org/aerc/2014/papers/27

Escoffery, C. (2016, December). *A Scoping study of program adaptation frameworks for evidence-based interventions.* Presented at 9th Annual Conference on the Science of Dissemination in Health, Washington DC.

Evans-Campbell, T. (2010) *Indian child welfare practice within urban American Indian/Native American communities* in *Mental health care for urban Indians: Clinical insights from Native practitioners.* In T. M. Witko (Ed.). Washington, DC: American Psychological Association. https://doi.org/10.1037/11422-002

Fago, D.P. (2009). Comment: The empirically supported treatment debate: Toward a dialectical rapprochement. *Psychotherapy Theory, Research, Practice, Training, 46*(1), 15-18. https://doi.org/10.1037/a0015134

Falicov, C. J. (2009). Commentary: On the wisdom and challenges of culturally attuned treatments for Latinos. *Family Process, 48*(2), 292-309. doi:10.1111/j.1545-5300.2009.01282.x

Falzon, L., Davidson, K. W., & Bruns. D. (2010). Evidence searching for empirically supported psychology practice. *Professional Psychology Research and Practice, 41*(6), 550-557. https://doi.org/10.1037/a0021352

Fung, K. (2015). ACT: Western adoption of Buddhist tenets? *Transcultural Psychiatry*, *52*(4), 561–576. https://doi.org/10.1177/1363461514537544

Futterman, D., Shea, J., Besser, M., Stafford, S., Desmond, K., Comulada, W. S., & Greco, E. (2010). Mamekhaya: A pilot study combining a cognitive-behavioral intervention and mentor mothers with PMTCT services in South Africa. *AIDS Care, 22*(9), 1093–1100. http://doi.org/10.1080/09540121003600352

Gallardo, M. E., Johnson, J., Parham, T. A., & Carter, J. A. (2009, October 1). Ethics and multiculturalism: Advancing cultural and clinical responsiveness. *Professional Psychology: Research and Practice, 40*(5), 425-435. https://doi.org/10.1037/a0016871

Geertz, C. (1973). *The interpretation of cultures: Selected essays.* New York, NY: Basic Books.

Gilbert, D.J., Harvey, A.R., & Belgrave, F.Z. (2009). Advancing the Afrocentric paradigm shift discourse: Building toward evidence-based Afrocentric interventions in social work practice with African Americans. *Social Work, 54*(3), 243-252.

Gonzales, N.A. (2017). Expanding the cultural adaptation framework for population-level impact. *Prevention Science, 18*(6), 689-693. http://doi.org/10.1107/s11121

González-Prendes, A. A., Hindo, C., & Pardo, Y. (2011). Cultural values integration in cognitive-behavioral therapy for a Latino with depression. *Clinical Case Studies*, *10*(5), 376–394. http://doi.org/10.1177/1534650111427075

Gone, J. P. (2004). Mental health services for Native Americans in the 21st century United States, *Professional Psychology: Research and Practice*, *35*(1), 10–18.

Goodkind, J. R., Lanoue, M. D., Milford, J., & Haley, J. A. (2010). Adaptation and implementation of cognitive behavioral intervention for trauma in schools with American Indian youth. http://doi.org/10.1080/15374416.2010.517166

Graves, S. L. J., Herndon-Sobalvarro, A., Nichols, K., Aston, C., Ryan, A., Blefari, A…Prier, D. (2016). Examining the effectiveness of a culturally adapted social-emotional intervention for African American males in an urban setting. *School Psychology Quarterly*, *32*(1), 1–13. http://doi.org/10.1037/spq0000145

Gray, J.S. & Rose, W.J. (2012). Cultural adaptation for therapy with American Indians and Alaska Natives. *Journal of Multicultural Counseling and Development*, *40*(2), 82-92.

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health interventions: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training, 43*(4), 531–548.

Guthrie, R. (1998). *Even the rat was white: A historical view of psychology* (2nd ed.). Boston, MA: Allyn and Bacon.

Habib, N., Dawood, S., Kingdon, D., & Naeem, F. (2015). Preliminary evaluation of culturally adapted CBT for psychosis (CA-CBTp): Findings from developing culturally-sensitive CBT Project (DCCP). *Behavioural and Cognitive Psychotherapy, 43,* 200–208. http://doi.org/10.1017/S1352465813000829

Hall, G. C. N., Hong, J. J., Zane, N. W. S., & Meyer, O. L. (2011). Culturally competent treatments for Asian Americans: The relevance of mindfulness and acceptance-based psychotherapies. *Clinical Psychology: Science and Practice, 18*(3), 215-231. http://doi.org/10.1111/j.1468-2850.2011.01253.x

Harrell, S.P. (2015). Culture, wellness, and world "PEaCE": An introduction to person-environment-and-culture-emergence theory. *Community Psychology in Global Perspective, 1*(1), 16-49.

Harrell, S.P., & Gallardo, M.E., (2008). Community and the socio-political system in the development of a multicultural worldview. In J. K. Asamen, M. L. Ellis, and G. Berry (Eds.), *Handbook of child development, multiculturalism, and media*. Thousand Oaks, CA: Sage Publications.

Highfield, L., Hartman, M. A., Mullen, P. D., Rodriguez, S. A., Fernandez, M. E., & Bartholomew, L. K. (2015). Intervention mapping to adapt evidence-based interventions for use in practice: Increasing mammography among African American women. *BioMed Research International*, *18*(1), 1-11. http://doi.org/10.1155/2015/160103

Hinton, D. E., Pham, T., Tran, M., Safren, S. A., Otto, M. W., & Pollack, M. H. (2004). CBT for Vietnamese refugees with treatment-resistant PTSD and panic attacks: A pilot study. *Journal of Traumatic Stress*, *17*(5), 429–433.

Hinton, D. E., Hofmann, S. G., Pollack, M. H., & Otto, M. W. (2009). Mechanisms of efficacy of CBT for Cambodian refugees with PTSD: Improvement in emotion regulation and orthostatic blood pressure response. *CNS Neuroscience and Therapeutics*, *15*(3), 255–263. http://doi.org/10.1111/j.1755-5949.2009.00100.x

Hinton, D. E., Hofmann, S. G., Rivera, E., Otto, M. W., & Pollack, M. H. (2011). Culturally adapted CBT (CA-CBT) for Latino women with treatment-resistant PTSD: A pilot study comparing CA-CBT to applied muscle relaxation. *Behaviour Research and Therapy* *49*(1), 275-280. http://doi.org/10.1016/j.brat.2011.01.005

Hodges, J., & Oei, T. P. S. (2007). Would Confucius benefit from psychotherapy? The compatibility of cognitive behaviour therapy and Chinese values. *Behaviour Research and Therapy*, *45*(5), 901–914. http://doi.org/10.1016/j.brat.2006.08.015

Holt, C. L., Tagai, E. K., Scheirer, M. A., Santos, S. L. Z., Bowie, J., Haider, M., . . . Whitehead, T. (2014). Translating evidence-based interventions for implementation: Experiences from Project HEAL in African American churches. *Implementation Science*, *9*(1), 66-79. http://doi.org/10.1186/1748-5908-9-66

Hovey, J. D., Hurtado, G. & Seligman, L. D. (2014) Findings for a CBT support group for Latina migrant farmworkers in Western Colorado. *Current Psychology*, *33*(3), 271-281. doi:10.1007/s12144-014-9212-y

Hurt, T. R., Beach, S. R., Stokes, L. A., Bush, P. L., Sheats, K. J., & Robinson, S. G. (January 01, 2012). Engaging African American men in empirically based marriage enrichment

programs: lessons from two focus groups on the ProSAAM project. *Cultural Diversity and Ethnic Minority Psychology, 18*(3), 312-5.

Hwang, W.C. (November 01, 2006a). Cognitive-behavioral therapy with Chinese Americans: Research, theory, and clinical practice. *Cognitive and Behavioral Practice, 13*(4), 339-340.

Hwang, W. (2006b). The psychotherapy adaptation and modification framework: Application to Asian Americans. *American Psychologist, 61*(7), 702– 715.

Interian, A., Allen, L. A., Gara, M. A., & Escobar, J. I. (2008). A pilot study of culturally adapted cognitive behavior therapy for Hispanics with major depression. *Cognitive and Behavioral Practice*, *15*(1), 67–75. http://doi.org/10.1016/j.cbpra.2006.12.002

Interian, A., Martinez, I., Rios, L. I., Krejci, J., & Guarnaccia, P. J. (2010). Adaptation of a motivational interviewing intervention to improve antidepressant adherence among Latinos. *Cultural Diversity and Ethnic Minority Psychology, 16*(2), 215-225. http://doi.org/10.1037/a0016072

Israel, T., Gorcheva, R., Walther, W. A., Sulzner, J. S., & Cohen, J. (2008). Therapists' helpful and unhelpful situations with LGBT clients: An exploratory study. *Professional Psychology: Research and Practice, 39*(3), 361-368. doi: 10.1037/0735-7028.39.3.3612008-07318-015.

Jackson, K. (2010). Native American youth and culturally sensitive interventions: A systematic review. *Research on Social Work Practice*, *20*(3), 260 – 270.

Jalal, B., Samir, S. W., & Hinton, D. E. (2017). Adaptation of CBT for traumatized Egyptians: Examples from culturally adapted CBT (CA-CBT). *Cognitive and Behavioral Practice*, *24*(1), 58-71. http://doi.org/10.1016/j.cbpra.2016.03.001

Joseph, R. P., Pekmezi, D., Dutton, G. R., Cherrington, A. L., Kim, Y. I., Allison, J. J., & Durant, N. H. (2016). Results of a culturally adapted internet-enhanced physical activity pilot intervention for overweight and obese young adult African American women. *Journal of Transcultural Nursing*, *27*(2), 136–146. http://doi.org/10.1177/1043659614539176

Kawahara, D.M., & Espin, O.M. (Eds.). (2007). *Feminist Reflections on Growth and Transformation : Asian American Women in Therapy.* New York, NY: Taylor and Francis.

Kazdin, A. E. (2008). Evidence-based treatments and delivery of psychological services: Shifting our emphases to increase impact. *Psychological Services*, *5*(3), 201-215. doi:10.1037/a0012573

Keel, T. D. (2013). Religion, polygenism and the early science of human origins. *History of the Human Sciences*, *26*(2), 3-32.

Kelley, L. P., & Blashfield, R. K. (2009). An example of psychological science's failure to self-correct. *Review of General Psychology*, *13*(2), 122-129. doi:10.1037/a0015287

Kim, U. (2000). Indigenous, cultural, and cross-cultural psychology: A theoretical, conceptual, and epistemological analysis. *Asian Journal of Social Psychology*, *3*(3), 265-287.

Kral, M. J. (2008). Psychology and anthropology: Intersubjectivity and epistemology in an interpretive cultural science. *Journal of Theoretical and Philosophical Psychology*, *28*(1), 257-275.

Kratochwill, T. R., McDonald, L., Levin, J. R., Young, B.-T. H. & Demaray, M. K. (2004). Families and schools together: An experimental analysis of a parent-mediated multi-

family group program for American Indian children. *Journal of School Psychology, 42*(5), 359-383.

Kwate, N. O. (2001). Intelligence or misorientation? Eurocentrism in the WISC-III. *Journal of Black Psychology*, *27*, 221-238.

Kwate, N. O. a. (2005). The heresy of African-centered psychology. *The Journal of Medical Humanities*, *26*(4), 215–35. doi:10.1007/s10912-005-7698-x

LaBreche, M., Cheri, A., Custodio, H., Fex, C. C., Foo, M. A., Lepule, J. T., & Tanjasiri, S. P. (2016). Let's Move for Pacific Islander communities: An evidence-based intervention to increase physical activity. *Journal of Cancer Education*, *31*(2), 261–267. http://doi.org/10.1007/s13187-015-0875-3

Lakes, K., Lopez, S. R., Garro, L. C. (2006). Cultural competence and psychotherapy: applying anthropologically informed conceptions of culture. *Psychotherapy: Theory, Research, Practice, Training*, *43*(4), 380–396.

Latham, T. P., Sales, J. M., Boyce, L. S., Renfro, T. L., Wingood, G. M., DiClemente, R. J., & Rose, E. (2010). Application of ADAPT-ITT: Adapting an evidence-based HIV prevention intervention for incarcerated African American adolescent females. *Health Promotion Practice*, *11*(1), 53S–60S. http://doi.org/10.1177/1524839910361433

Lau, A. S. (2006). Making the case for selective and directed cultural adaptations of evidence-based treatments: Examples from parent training. *Clinical Psychology: Science and Practice*, *13*(4), 295–310.

LaVeist, T. A., Diala, C., & Jarrett, N. C. (2000). Social status and perceived discrimination: Who experiences discrimination in the health care system, how, and why?. In C. J. R. Hogue, M. A. Hargraves, & K. C. Collins (Eds.), *Minority health in America: Findings*

and policy implications from the Commonwealth Fund Minority Health (pp. 194–208). Baltimore, MD: Johns Hopkins University Press.

Le, H. N., Zmuda, J., Perry, D. F., & Muñoz, R. F. (2010). Transforming an evidence-based intervention to prevent perinatal depression for low-income Latina immigrants. *American Journal of Orthopsychiatry, 80*(1), 34–45. http://doi.org/10.1111/j.1939-0025.2010.01005.x

Le, T. N., & Gobert, J. M. (2015). Translating and implementing a mindfulness-based youth suicide prevention intervention in a Native American community. *Journal of Child and Family Studies, 24*(1), 12-23.http://doi.org/10.1007/s10826-013-9809-z

Lee, C. S., López, S. R., Hernández, L., Colby, S. M., Caetano, R., Borrelli, B., & Rohsenow, D. (2011). A Cultural adaptation of motivational interviewing to address heavy drinking among Hispanics. http://doi.org/10.1037/a0024035

Levant, R.F. (2005). *Report of the 2005 Presidential Task Force on Evidence-Based Practice.* Washington, DC: American Psychological Association. Retrieved from http://www.apa.org/practice/guidelines/evidence-based-statement.aspx

Lewin, A., Hodgkinson, S., Waters, D. M., Prempeh, H. A., Beers, L. S., & Feinberg, M. E. (2015). Strengthening positive co-parenting in teen parents: A cultural adaptation of an evidence-based intervention. *Journal of Primary Prevention, 36*(3), 139–154. http://doi.org/10.1007/s10935-015-0388-1

Liddle, H. (2006). An empirically supported and culturally specific engagement and intervention strategy for African American adolescent males. *The American Journal of Orthopsychiatry, 76*(2), 215–225.

Lightfoot, A. F., Taggart, T., Woods-Jaeger, B. A., Riggins, L., Jackson, M. R., & Eng, E. (2014). Where is the Faith? Using a CBPR approach to propose adaptations to an evidence-based HIV prevention intervention for adolescents in African American faith settings. *Journal of Religion and Health*, *53*(4), 1223–1235 http://doi.org/10.1007/s10943-014-9846-y

Lillard, A. (1998). Ethnopsychologies: Cultural variations in theories of mind. *Psychological Bulletin*, *123*(1), 3-32. doi:10.1037/0033-2909.123.1.3

Mahoney, M. J. (1977). Publication prejudices: An experimental study of confirmatory bias in the peer review system. *Cognitive Therapy and Research*, *1*(2), 161–175.

Mandler, G. (2011). Crises and problems seen from experimental psychology. *Journal of Theoretical and Philosophical Psychology*, *31*(4), 240-246. doi:10.1037/a0023968

Markus, H.R., & Kitayama, S. (2010). Cultures and selves: a cycle of mutual constitution. *Perspectives on Psychological Science, 5*(4), 420–430.

Marsella, A.J. (2015). Trends, changes, challenges in North American (Eurocentric) psychology: Rethinking assumptions, practices, and organization in socio-political contexts. *Journal for Social Action in Counseling and Psychology*, *7*(1), 143-152.

Masood, Y., Lovell, K., Lunat, F., Atif, N., Waheed, W., Rahman, A., …. Husain, N. (2015). Group psychological intervention for postnatal depression: a nested qualitative study with British South Asian women. *BMC Women's Health*, *25(*15), 109-132. http://doi.org/10.1186/s12905-015-0263-5

Mazzeo, S. E., Kelly, N. R., Stern, M., Palmberg, A. A., Belgrave, F. Z., Tanofsky-Kraff, M…. Bulik, C. M. (2013). LIBER8 design and methods: An integrative intervention for loss of

control eating among African American and White adolescent girls. *Contemporary Clinical Trials, 34*(1), 174–85. http://doi.org/10.1016/j.cct.2012.10.012

McMullen, J., O'Callaghan, P., Shannon, C., Black, A., & Eakin, J. (2013). Group trauma-focused cognitive-behavioural therapy with former child soldiers and other war-affected boys in the DR Congo: A randomised controlled trial. *Journal of Child Psychology and Psychiatry and Allied Disciplines. 54(*11), 1231–1241. http://doi.org/10.1111/jcpp.12094

Myers, L. J., & Speight, S. L. (2010). Reframing mental health and psychological well-being among persons of African descent: Africana/Black psychology meeting the challenges of fractured social and cultural realities. *Journal of Pan African Studies, 3*(8), 66-82.

Miller, J. G. (2002) Bringing culture to basic psychological theory—beyond individualism and collectivism: comment on Oyserman et al., (2002). *Psychological Bulletin, 128*(1), *97*–109.

Miller, L. D., Laye-Gindhu, A., Bennett, J. L., Liu, Y., Gold, S., March, J. S., . . . Waechtler, V. E. (2011). An effectiveness study of a culturally enriched school-based CBT anxiety prevention program. *Journal of Clinical Child and Adolescent Psychology, 40*(4), 618-629. http://doi.org/10.1080/15374416.2011.581619

Miranda, J., Bernal, G., Lau, A., Kohn, L., Hwang, W.-C., & LaFromboise, T. (2005). State of the science on psychosocial interventions for ethnic minorities. *Annual Review of Clinical Psychology, 1,* 113-142.

Mkenda, S., Olakehinde, O., Mbowe, G., Siwoku, A., Kisoli, A., Paddick, S.-M…..Ogunniyi, A. (2016). Cognitive stimulation therapy as a low-resource intervention for dementia in sub-Saharan Africa (CST-SSA): Adaptation for rural Tanzania and Nigeria. *Dementia, 17*(4), 515 – 530. http://doi.org/10.1177/1471301216649272

Moore, H. A., Acosta, K., Perry, G., & Edwards, C. (2010). SPLITTING THE ACADEMY: The emotions of intersectionality at work. *Sociological Quarterly, 51*(2), 179-204.

Moran, J.R. & Bussey, M. (2007). Results of an alcohol prevention program with urban American Indian youth. *Child and Adolescent Social Work Journal, 24*(1), 1-21.

Morsette, A., Swaney, G., Stolle, D., Schuldberg, D., van den Pol,R., & Young, M. (2009). Cognitive behavioral intervention for trauma in schools (CBITS): School-based treatment on a rural American Indian reservation. *Journal of Behavior Therapy and Experimental Psychiatry 40*(1),169-178.

Muñoz, R.F., and Mendelson, T. (2005). Toward evidence-based interventions for diverse populations: The San Francisco General Hospital prevention and treatment manuals. *Journal of Consulting and Clinical Psychology, 73*(5), 790-799.

Murray, L. K., Dorsey, S., Skavenski, S., Kasoma, M., Imasiku, M., Bolton, P., & Bassm Cohen, J. A. (2013). Identification, modification, and implementation of an evidence-based psychotherapy for children in a low-income country: The use of TF-CBT in Zambia. *International Journal of Mental Health Systems, 7*(1), 12-24. http://doi.org/10.1186/1752-4458-7-24.

Naeem, F., Waheed, W., Gobbi, M., Ayub, M., & Kingdon, D. (2011). Preliminary evaluation of culturally sensitive CBT for depression in Pakistan: Findings from developing culturally-sensitive CBT project (DCCP). *Behavioural and Cognitive Psychotherapy, 39*(2), 165–173. http://doi.org/10.1017/S1352465810000822

Naeem, F., Sarhandi, I., Gul, M., Khalid, M., Aslam, M., Anbrin, A…..Ayub, M. (2014). A multicentre randomised controlled trial of a carer supervised Culturally adapted CBT

(CaCBT) based self-help for depression in Pakistan. *Journal of Affective Disorders*, *15*(6), 224-227. http://doi.org/10.1016/j.jad.2013.10.051

Naeem, F.,Saeed, S., Irfan, M., Kiran, T., Mehmood, N., Gul, M…..Kingdon, D. (2015). Brief culturally adapted CBT for psychosis (CaCBTp): A randomized controlled trial from a low income country. *Schizophrenia Research*, *164*(1), 143–148. http://doi.org/10.1016/j.schres.2015.02.015

Naeem, F., Gul, M., Irfan, M., Munshi, T., Asif, A., Rashid, S….Ayub, M. (2015). Brief Culturally adapted CBT (CaCBT) for depression: A randomized controlled trial from Pakistan. *Journal of Affective Disorders*, *17*(7), 101–107. http://doi.org/10.1016/j.jad.2015.02.012

Naeem, F., Phiri, P., Munshi, T., Rathod, S., Ayub, M., Gobbi, M. & Kingdon, D. (2015) Using cognitive behaviour therapy with South Asian Muslims: Findings from the culturally sensitive CBT project. *International Review of Psychiatry, 27*(3), 233-246. http://dx.doi.org/10.3109/09540261.2015.1067598

Nagayama Hall, G.C. Ibaraki, A.Y., Huang, E.R., Marti, C.N., and Stice, E. (2016). A meta-analysis of cultural adaptations of psychological interventions, *Behavior Therapy*, *47*(6), p.993-1014. http://dx.doi.org/10.1016/j.beth.2016.09.005

Nobles, W. N. (2013). Shattered consciousness, fractured identity: Black psychology and the restoration of the African psyche. *Journal of Black Psychology, 39(3),* 232-242.

Nobles, W. N. (2015). From Black psychology to Sakhu Djaer: Implications for the further development of a pan African Black psychology. *Journal of Black Psychology, 41*(5), 399 – 414.

Nobles, W. W., & Goddard, L. L. (1993).Toward an African- centered model of prevention for African American youth at high risk. In L. L. Goddard (Ed.), *An African-centered model of prevention for African American youth at high risk* (pp. 115–129). Rockville, MD: U.S. Department of Health and Human Services/Public Health Service/Substance Abuse and Mental Health Services Administration.

Nowrouzi, B., Manassis, K., Jones, M., Bobinski, T., & Mushquash, C. (2014). Translating anxiety-focused CBT for youth in a First Nations context in northwestern Ontario. *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 24*(1), 33-40.

Obasi, E. M., Speight, S. L., Rowe, D. M., Clark, L, & Turner-Essel, L. (2012). The association of Black psychologists: An organization dedicated to social justice. *Counseling Psychologist, 40*(5), 656-674.

Palmer, P. H., Xie, B., Lee, L., Chou, C. P., Sun, P., Hemingway, B., & Johnson, C. A. (2011). The China Seven Cities Study (CSCS) consortium: Adapting evidence-based prevention science from west to east. *Translational Behavioral Medicine*, *1*(2), 283–288. http://doi.org/10.1007/s13142-011-0036-0

Pan, D., Huey, S. J., and Hernandez, D. (2011). Culturally adapted versus standard exposure treatment for phobic Asian Americans: Treatment efficacy, moderators, and predictors. *Cultural Diversity And Ethnic Minority Psychology, 17*(1), 11-22. doi:10.1037/a0022534

Papas, R. K., Sidle, J. E., Martino, S., Baliddawa, J. B., Songole, R., Omolo, O. E….Maisto, S. A. (2010). Systematic cultural adaptation of cognitive-behavioral therapy to reduce alcohol use among HIV-infected outpatients in Western Kenya. *AIDS and Behavior, 14*(3), 669–678. .http://doi.org/10.1007/s10461-009-9647-6

Parra Cardona, J. R., Domenech-Rodriguez, M., Forgatch, M., Sullivan, C., Bybee, D., Holtrop,

K….Bernal, G. (2012). Culturally adapting an evidence-based parenting intervention for Latino immigrants: The need to integrate fidelity and cultural relevance. *Family Process, 51*(1), 56-72. http://doi.org/10.1111/j.1545-5300.2012.01386.x

Pat-Horenczyk, R., Shi, C. S. W., Schramm-Yavin, S., Bar-Halpern, M., & Tan, L. J. (2015). Building Emotion and Affect Regulation (BEAR): Preliminary evidence from an open trial in children's residential group homes in Singapore. *Child and Youth Care Forum, 44*(2),175–190. DOI: http://doi.org/10.1007/s10566-014-9276-8

Patel, V., Chowdhary, N., Rahman, A., & Verdeli, H. (2011). Improving access to psychological treatments: Lessons from developing countries. *Behaviour Research and Therapy, 49*(9), 523–528. http://doi.org/10.1016/j.brat.2011.06.012

Poulson, M., Vandenhoudt, H. S., Wyckoff, S., Obong, C. O., Ochura, J., C., Otwoma, N. J…. Miller, K. (2010). Evaluation of a U.S. evidence-based parenting intervention in rural western Kenya: From Parents Matter! to Families Matter!, *AIDS Education Prevention, 22*(4), 328–343. doi:10.1521/aeap.2010.22.4.273

Pena-Purcell, N. C., Jiang, L., Ory, M. G., & Hollingsworth, R. (2015). Translating an evidence-based diabetes education approach into rural African- American communities: The "wisdom, power, control" program. *Diabetes Spectrum, 28*(2), 106–115. http://doi.org/10.2337/diaspect.28.2.106

Pick, S., Poortinga, Y. H., & Givaudan, M. (2003). Integrating intervention theory and strategy in culture-sensitive health promotion programs. *Professional Psychology: Research and Practice, 34*(4), 422-429. http://doi.org/10.1037/0735-7028.34.4.422

Piper-Mandy, E., & Rowe, D. (2010). Educating African-centered psychologists: Towards a comprehensive paradigm. *The Journal of Pan African Studies, 3*(8), 6-22.

Ponterroto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology, 52(2),* 126–136.

Ramos, Z., & Alegría, M. (2014). Cultural adaptation and health literacy refinement of a brief depression intervention for Latinos in a low-resource setting. *Cultural Diversity and Ethnic Minority Psychology, 20*(2), 293–301. http://doi.org/10.1037/a0035021

Rathod, S., Kingdon, D., Phiri, P., & Gobbi, M. (2010). Developing culturally sensitive cognitive behaviour therapy for psychosis for ethnic minority groups by exploration and incorporation of Service User's and Health Professionals views and opinions. *Behavioral Cognitive Psychotherapy, 38*(5), 511–533.

Rathod, S., Phiri, P., Harris, S., Underwood, C., Thagadur, M., Padmanabi, U., & Kingdon, D. (2013). Cognitive behaviour therapy for psychosis can be adapted for minority ethnic groups: A randomised controlled trial. *Schizophrenia Research, 143*(2), 319–326. http://doi.org/10.1016/j.schres.2012.11.007

Rennie, D. L., Watson, K. D., & Monteiro, A. M. (2002). The rise of qualitative research in psychology. *Canadian Psychology/Psychologie Canadienne, 43*(3), 179-189. doi:10.1037/h0086914

Reyes-Rodríguez, M. L., Bulik, C. M., Hamer, R. M., & Baucom, D. H. (2013). Promoviendo una Alimentación Saludable (PAS) design and methods: Engaging Latino families in eating disorder treatment. *Contemporary Clinical Trials, 35(1),* 52–61. http://doi.org/10.1016/j.cct.2013.01.005

Robinson, B. B. E., Galbraith, J. S., Lund, S. M., Hamilton, A. R., & Shankle, M. D. (2012). The process of adaptation of an intervention for HIV-positive African American men who have sex with men in two cities. *AIDS Education and Prevention, 24*(3), 206–227.

Rolf, J. E., Nansel, T. R., Baldwin, J. A., Johnson, J. L., & Benally, C. C. (2002). HIV/AIDS and alcohol and other drug abuse prevention in American Indian communities: Behavioral and community effects. In P. D. Mail, S. Heurtin-Roberts, S. E.Martin, & J. Howard (Eds.), *Alcohol use among American Indians: Multiple perspectives on a complex problem.* National Institute Alcohol Abuse and Alcoholism Research Monograph No. 37. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism.

Romero, D., & Chan, A. (June 06, 2005). Profiling Derald Wing Sue: Blazing the trail for the multicultural journey and social justice in counseling. *Journal of Counseling and Development, 83*(2), 202-213. https://doi.org/10.1002/j.1556-6678.2005.tb00597.x

Sáez-Santiago, E., Bernal, G., Reyes-Rodríguez, M. L., & Bonilla-Silva, K. (2012). Development and cultural adaptation of the Taller de Educación Psicológica Para Padres y Madres (TEPSI): Psychoeducation for parents of Latino/a adolescents with depression. In G. Bernal & M. M. Domenech Rodríguez (Eds.) *Cultural adaptations: Tools for evidence-based practice with diverse populations* (pp. 91-112). Washington, DC: American Psychological Association. doi:10.1037/13752-005

Saleh-Onoya, D., Braxton, N. D., Sifunda, S., Reddy, P., Ruiter, R., van den Borne, B., Pennick Walters, T….Wingood, G. M. (2008). SISTA South Africa: the adaptation of an efficacious HIV prevention trial conducted with African-American women for isiXhosa-speaking South African women. *SAHARA-J : Journal of Social Aspects of HIV/AIDS*, *5*(4), 186–191. http://doi.org/10.1080/17290376.2008.9724918

Santrock J. W. (2011). *Life-span development.* New York, NY: McGraw-Hill.

Saulsberry, A., Corden, M. E., Taylor-Crawford, K., Crawford, T. J., Johnson, M., Froemel, J…van Voorhees, B. W. (2013). Chicago Urban Resiliency Building (CURB): An internet-based depression-prevention intervention for urban African-American and Latino adolescents. *Journal of Child and Family Studies*, *22*(1), 150–160. http://doi.org/10.1007/s10826-012-9627-8

Sawyer-Kurian, K. M., & Wechsberg, W. M. (2012). Adapting an evidence-based HIV intervention for at-risk African American college women at historically black colleges and universities who use alcohol and drugs. *SAGE Open*, *2*(4), 1–13. http://doi.org/10.1177/2158244012464977\r10.3390/rel1010003

Schinke, S.P., Tepavac, L. & Cole, K.C. (2000) Preventing substance use among Native American youth: Three-year results. *Addictive Behaviors, 25*(3), 387-397. https://doi.org/10.1016/s0306-4603(99)00071-4

Schulz, P. M., Huber, L. C., & Resick, P. A. (2006). Practical adaptations of cognitive processing therapy with Bosnian refugees: Implications for adapting practice to a multicultural clientele. *Cognitive and Behavioral Practice*, *13*(4), 310–321. http://doi.org/10.1016/j.cbpra.2006.04.019

Schütte, U. (2016). Culturally sensitive adaptation of the concept of relational communication therapy as a support to language development: An exploratory study in collaboration with a Tanzanian orphanage. *South African Journal of Communication Disorders*, *63*(1), 13 pages. http://doi.org/10.4102/sajcd.v63i1.166

Schwartz, S. J., Unger, J. B. Zamboanga, B. L. & Szapocznik, J. (2010). Rethinking the concept of acculturation: Implications for theory and research. *American Psychologist, 65*(4), 237-251. doi: 10.1037/a0019330.

Shelton, K., & Delgado-Romero, E. A. (2013). Sexual orientation microaggressions: The experience of lesbian, gay, bisexual, and queer clients in psychotherapy. *Psychology Of Sexual Orientation And Gender Diversity*, *58*(2), 59-70. doi:10.1037/2329-0382.1.S.59

Shen, M. D., Forrest, L., & Elman, N. (2009). Training directors' conceptualizations of the intersections of diversity and trainee competence problems. *The Counseling Psychologist, 37*(4), 482-518. https://doi.org/10.1177/0011000008316656

Shiu, C.-S., Chen, W.-T., Simoni, J., Fredriksen-Goldsen, K., Zhang, F., & Zhou, H. (2013). The Chinese Life-Steps Program: A cultural adaptation of a cognitive-behavioral intervention to enhance HIV medication adherence. *Cognitive and Behavioral Practice, 20*(2), 202–212. http://doi.org/10.1016/j.cbpra.2012.05.005

Shweder, R. A. (March 01, 1999). Why Cultural Psychology? *Ethos, 27(1),* 62-73.

Simoni, J. M., Wiebe, J. S., Sauceda, J. A., Huh, D., Sanchez, G., Longoria, V., & Safren, S. A. (2013). A preliminary RCT of CBT-AD for adherence and depression among HIV-positive Latinos on the U.S.-Mexico border: The Nuevo Día study. *AIDS and Behavior, 17*(8), 2816-29. http://doi.org/10.1007/s10461-013-0538-5

Slife, B. D., & Reber, J. S. (2009). Is there a pervasive implicit bias against theism in psychology?. *Journal Of Theoretical And Philosophical Psychology*, *29*(2), 63-79. doi:10.1037/a0016985

Smedley, A. (1998). Race and the construction of human identity. *American Anthropologist, New Series, 100*(3), 690-702. https://doi.org/10.1525/aa.1998.100.3.690

Smith, T.B. &Trimble, J. (2015). *Foundations of multicultural psychology: Research to inform effective practice* (1st Edition). Washington DC: American Psychological Association.

Spring, B. (2007). Empirically supported practice, what it is, why it matters; what you need to know. *Journal of Clinical Psychology*, *63*(7), 611-631. https://doi.org/10.1002/jclp.20373

Springfield, S., Buscemi, J., Fitzgibbon, M. L., Stolley, M. R., Zenk, S. N., Schiffer, L….Odoms-Young, A. (2015). A randomized pilot study of a community-based weight loss intervention for African-American women: Rationale and study design of Doing Me! Sisters Standing Together for a Healthy Mind and Body. *Contemporary Clinical Trials*, *43*, 200–208. http://doi.org/10.1016/j.cct.2015.06.006

Steele, C. M. & Aronson, J. (1995). Stereotype threat and the intellectual test performance of African Americans. *Journal of Personality and Social Psychology*, *69*(5), 797-811.

Stewart, P. E. (2004). Afrocentric approaches to working with African American families. *Families in Society: The Journal of Contemporary Social Sciences*, *85*(2), 221–228. https://doi.org/10.1606/1044-3894.326

Sue, D. W. (1981). *Counseling the culturally different: Theory and practice.* New York, NY: Wiley.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal Of Multicultural Counseling and Development, 20(2),* 64-89. https://doi.org/10.1002/j.2161-1912.1992.tb00563.x

Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttal, E. (1982). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist, 10*(2), 45-52.

Sue, D.W., Carter, R.T., Casas, M., Fouad, N.A., Ivey, A.E., Jensen, M., LaFramboise, T., Manese, J.E., Ponterotto, J.G., & Vaszquez-Nutall, E. (1998) *Multicultural counseling competencies: Individual and organizational development.* Thousand Oaks, CA: Sage. http://dx.doi.org/10.4135/9781452232027

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62(*4), 271-286. doi:10.1037/0003-066X.62.4.2711751677310.1037/0003-066X.62.4.2712007-07130-001.

Sue, D.W., & Sue, S. (1972). Ethnic minorities: Resistance to being researched. *Professional Psychology, 3*(1), 11-17. https://doi.org/10.1037/h0021487

Sue, D. W., Torino, G. C., Capodilupo, C. M., Rivera, D. P., & Lin, A. I. (2009). How white faculty perceive and react to difficult dialogues on race: Implications for education and training. *Counseling Psychologist, 37*(8), 1090-1115. https://doi.org/10.1177/0011000009340443

Sue, S. (2009). Commentaries: Ethnic minority psychology: struggles and triumphs. *Cultural Diversity and Ethnic Minority Psychology, 15*(4), 409–415. https://doi.org/10.1037/a0017559

Sue, S., & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist, 42*(1), 37-45. https://doi.org/10.1037//0003-066x.42.1.37

Sue, S. & Zane, N. (2009). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *Asian American Journal of Psychology, S*(1), 3–14.

Taylor, M. (September 06, 1999). Changing what has gone before: The enhancement of an inadequate psychology through the use of an Afrocentric-feminist perspective with African American women in therapy. *Psychotherapy: Theory, Research, Practice, Training, 36(*2), 170-179. https://doi.org/10.1037/h0087731

Thomas, J. & Harden A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology 8*(45), 8-27. https://doi.org/10.1186/1471-2288-8-45

Thompson, V. L. S., Bazile, A., Akbar, M., & American Psychological Association. (2004). African Americans' perceptions of psychotherapy and psychotherapists. *Professional Psychology: Research and Practice, 35*(1), 19-26.

True, R.H., (2008). Feminist therapy for Asian American women? *Psychology of Women Quarterly, 32*(2), 219 – 220. https://doi.org/10.1111/j.1471-6402.2008.00426_1.x

Tolin, D. F., McKay, D., Forman, E.M., Klonsky, E.D., & Thombs, B.D., (2015). Empirically supported treatment: Recommendations for a new model. *Clinical Psychology Science and Practice, 22*(4), 317-338. doi:10.1111/cpsp.12122

United States Census (2015). *New census bureau report analyzes U.S. population projections.* Retrieved from https://www.census.gov/newsroom/press-releases/2015/cb15-tps16.html

United States Public Health and Human Services, *Mental health: Culture, race, ethnicity.* Surgeon General's Report. Office of the Surgeon General, SAMHSA.

Utsey, S. O., Payne, Y. A., Jackson, E. S., & Jones, A. M. (August 01, 2002). Race-related stress, quality of life indicators, and life satisfaction among elderly African Americans. *Cultural Diversity and Ethnic Minority Psychology, 8*(3), 224-233

Valsiner, J. (January 01, 2009). Cultural psychology today: Innovations and oversights. *Culture & Psychology, 15*(1), 5-39.

Verdeli, H., Clougherty, K., Bolton, P., Speelman, L., Ndogoni, L., Bass, J., Neugebauer, R., & Weissman, M., (2003). Adapting group interpersonal psychotherapy for a developing country : Experience in rural Uganda. *World Psychiatry 2(*2), 114-120.

Voss, H. S. C. (April 01, 2008). Effectiveness of cognitive-behavioral therapy with adult ethnic minority clients: A review. *Professional Psychology: Research and Practice, 39*(2), 160-168.

Walker, S.C., Whitener, R., Trupin, E.W., & Migliarini, N. (2015). American Indian perspectives on evidence-based practice implementation: Results from a statewide tribal mental health gathering. *Administration and Policy in Mental Health and Mental Health Services Research, 42*(1), 29–39. https://doi.org/10.1007/s10488-013-0530-4

Ward, E. C., & Brown, R. L. (2015). A culturally adapted depression intervention for African American adults experiencing depression: Oh happy day. *American Journal of Orthopsychiatry, 85*(1), 11–22. http://doi.org/10.1037/ort0000027

Watkins, C. E. (2012). Race/ethnicity in short-term and long-term psychodynamic psychotherapy treatment research: How "White" are the data?. *Psychoanalytic Psychology*, *29*(3), 292-307. doi:10.1037/a0027449

Weaver, H.N., and Jackson, K.F. (2010) Healthy living in two worlds: Testing a wellness curriculum for urban Native American youth. *Child and Adolescent Social Work Journal, 27*(3), 231-244.

Wechsberg, W. M., Luseno, W. K., Lam, W. K. K., Parry, C. D. H., & Morojele, N. K. (2006). Substance use, sexual risk, and violence: HIV prevention intervention with sex workers

in pretoria. *AIDS and Behavior, 10*(2), 131–137. http://doi.org/10.1007/s10461-005-9036-8

Wechsberg, W. M., Browne, F. a, Poulton, W., Ellerson, R. M., Simons-Rudolph, A., & Haller, D. (2011). Adapting an evidence-based HIV prevention intervention for pregnant African-American women in substance abuse treatment. *Substance Abuse and Rehabilitation, 2011*(2), 35–42. http://doi.org/10.2147/SAR.S16370

Weiss, B. J., Singh, J. S., & Hope, D. A. (2011). Cognitive-behavioral therapy for immigrants presenting with social anxiety disorder: Two case studies. *Clinical Case Studies, 10*(4) 324 –34. http://doi.org/10.1177/1534650111420706

Wendleton, L. (2017, June). Establishment and evaluation of a veteran engagement board to incorporate the veterans' perspective into research within the Veterans' Health Administration. In N. V. Mohatt (Chair) *Lessons from Applying Community Psychology Principles in Military and Veterans Mental Health Research.* Symposium conducted at the Biennial Conference of the Society for Community Action in Research, Ottawa, Canada.

Williams, J. (2017, June 21). Number of people in the world to rise to 8 billion by 2023, U.N. says. *Newsweek*. Retrieved from http://www.newsweek.com/population-world-earth-planet-people-628109

Witko, T. M. (Ed.). (2010). *Mental health care for urban Indians: Clinical insights from Native practitioners.* Washington DC: American Psychological Association.

Whaley, A. L. & Hall, B. N. (2008). The cultural/racial dimension of psychotic disorders in African American patients. *Journal of Black Psychology, 34*(4), 494-505.

Wong, D. F. K. (2008). Cognitive behavioral treatment groups for people with chronic

depression in Hong Kong: A randomized wait-list control design. *Depression and Anxiety*, *25*(2), 142–148. http://doi.org/10.1002/da.20286

Wood, J. J., Chiu, A. W., Hwang, W.-C., Jacobs, J., & Ifekwunigwe, M. (2008). Adapting cognitive-behavioral therapy for Mexican American students with anxiety disorders: Recommendations for school psychologists. *School Psychology Quarterly*, *23*(4), 515–532. http://doi.org/10.1037/1045-3830.23.4.515

Wrenn, C.G. (1962). The culturally encapsulated counselor. *Harvard Educational Review, 32*(4), 444-449.

Wu, E., El-Bassel, N., Donald McVinney, L., Fontaine, Y.-M., & Hess, L. (2010). Adaptation of a couple-based HIV intervention for methamphetamine-involved African American men who have sex with men. *The Open AIDS Journal*, *2010*(4), 123–31. http://doi.org/10.2174/1874613601004030123

Yeary, K. H. Hye-cheon K., Cornell, C. E., Prewitt, E., Bursac, Z., Tilford, J. M., Turner, J….Harris, K. (2015). The WORD (Wholeness, Oneness, Righteousness, Deliverance): Design of a randomized controlled trial testing the effectiveness of an evidence-based weight loss and maintenance intervention translated for a faith-based, rural, African American population using a community-based participatory approach. *Contemporary Clinical Trials*, *40*(2), 63–73. http://doi.org/10.1016/j.cct.2014.11.009

Zadeh, Z. F., & Lateef, M. (2012). Effect of cognitive behavioural therapy (CBT) on depressed female university students in Karachi. *Procedia - Social and Behavioral Sciences*, *69*(3), 798–806. http://doi.org/10.1016/j.sbspro.2012.12.001

Zhou, Q., Chen, S. H., Cookston, J. T., & Wolchik, S. (2014). Evaluating the cultural fit of the New Beginnings parent program for divorced Asian American mothers: A pilot study.

Asian American Journal of Psychology, *5*(2), 126–133. http://doi.org/10.1037/a0035519

APPENDIX A

Tables

Table A1

Characteristics of Indigenous Target Populations

Target Population	Number of Culturally Adapted Interventions
Native American/American Indian	11
+ Youth	10
+ Families	1
- Southwestern United States	2
- Montana	1
- Northeastern United States	1
- Wisconsin	1
- Urban-dwelling	2
International	4
First Nations (Canada)	2
+ Youth	2
Aboriginal Australian	2
+ Aboriginal Australian/Torres Straits Islanders	1
Maori	1

Table A2

Target Concerns of Interventions for Indigenous Groups

Target Disorder	Number of Culturally Adapted Interventions
Health Promotion/Primary Prevention	9
- General Mental Health	1
- HIV/Substance Prevention	1
- Poly-Substance Prevention	3
- Alcohol Prevention	1
- Suicide prevention	1
- Academic Performance/Behavior Improvement	2
Anxiety	1
Trauma/PTSD	5
Depression	1

Table A3

Theoretical or Programmatic Focus of Interventions in Indigenous Populations

Theoretical Basis	Number of Culturally Adapted Interventions
Cognitive Behavioral Therapy	8
-CBITS	2
-Trauma Focused-CBT	1
Behaviorism	2
Parent-Child Interaction Therapy (behaviorism/play therapy)	1
Mindfulness	1
Motivational Interviewing/Solution Focus	1
Other	3
-FAST	1
-Family Check	1
-Learning Theory	1

Table A4

Specific Context and Content Adaptations in Indigenous Community Studies

Context and Content Adaptation	Number of Cultural Adaptations
Not Addressed	1
Values: Identity, Community and Tradition	11
Stories, Metaphors	6
Spiritual Beliefs	5
Language	4
Visuals	3
Within Group Differences	3
Problematic Western Elements	2
Literacy	2

Table A5

Specific Engagement Adaptations in Indigenous Community Studies

Engagement Adaptation	Number of Cultural Adaptations
Not Addressed	2
Community Settings	10
Extended Family and Community Inclusion	4
Indigenous Researchers	4
Technology	3
Communication Style	3
Community Interventionists	3
Stigma Reduction	1

Table A6

Specific Development and Equivalence Adaptations in Indigenous Community Studies.

Equivalence Process	Number of Cultural Adaptations
Not Addressed	1
Integration of Top Down and Bottom Up Approaches	14
Adaptation Theory Referenced	7
Fidelity	4
Bottom Up – Community Driven	1

Table A7

Specific Cultural Competence Adaptations in Indigenous Communities.

Cultural Competence Adaptation	Number of Cultural Adaptations
Not Addressed	4
Ethnic Matching	3
Dynamic Sizing	2
Addressing Community Trauma and Skepticism	3
Cultural Knowledge Acquisition	1

Table A8

Results for Interventions with Indigenous Communities

Type of Result reported	Number of Cultural Adaptations
Not reported/not available yet	3
Symptom Reduction/Behavior Change	6
Participant/Stakeholder Satisfaction	6
Contraindications	2

Table A9

Exemplar Adaptations for Indigenous Communities

Citation	Context	Engagement	Equivalence	Cultural Competence
Rolf, J. E. et al. (2002). HIV/AIDS and alcohol and other drug abuse prevention in American Indian communities: Behavioral and community effects.	Goal of intervention: utilization of cultural resources	Trained locals in prevention techniques to deliver intervention; School based.	Adaptation design through multiple stages: focus groups with students and community members; piloted program, refined.	Addressed community skepticism, "Giving, not taking away " (e.g., as in data collection); use of indigenous staff; trained locals in intervention techniques.
Boyd-Ball, A.J. (2003) A Culturally Responsive, Family-Enhanced Intervention Model.	Incorporates historical trauma; cultural restoration is stated goal of intervention; stated goals; addition of 2 AI legends; welcome home ceremony	Intervention located within an inpatient program contracted by federally recognized tribe; training was offered to community aftercare workers from each youth's area of origin.	Researcher driven; utilized Native psychology experts to create framework for intervention. adaption to MI technique. adaptation of recruitment methods, tribal and treatment center agreements, referral contacts, and implementation of intervention and follow-up with adolescents and their families.	cultural restoration stated goal, heavily vested in indigenous wisdom systems
BigFoot, D. S. P. D., and Funderburk, B. W. P. D. (2011). Honoring Children, Making Relatives: The Cultural Translation of Parent-Child Interaction Therapy for American Indian and Alaska Native Families.	Re-naming techniques by utilizing AI/NA terms and concepts; used culturally specific model as theoretical basis of adaptation.	Adjustment in communication style; use of traditional syntax; adjustment in expectations of parental responsiveness to reflect culturally normative cadence; avoiding clinical terms, using AI concepts to explain treatment and therapist's role (e.g., lead drummer, beading).	Ensured fidelity by including PCIT developers/trainers in adaptation process.	Focus on getting buy-in and encouraging the parent's "natural voice." Directly addressed skepticism and history of racism/dominance.

Table A10

Characteristics of African Descended Target Population

Target Population	Number of Culturally Adapted Interventions
Africa	**11**
- South Africa	3
+ Women	3
+ Pregnant	1
+ Urban	1
- Zambia	1
+ Girls	1
-Democratic Republic of Congo	1
+ Boys age 7-13	1
+ former child soldiers	1
-Kenya	2
+ Adults	1
+ Families	1
+ Rural	1
- Tanzania	2
+ Children	1
+ Orphans	1
+ Older Adults	1
+ Rural	1
- Tanzania, Nigeria	1
- Egypt	1
- Uganda*	2
- Uganda, Pakistan, India*	1
+ Mothers	1
African Americans	**23**
+Low Income	8
+Urban	7
+Rural	3
+Faith-identified	4
+Men and Women (adults)	4
+Adolescents	6
+Adolescent Boys	*1*
+Adolescent Girls	*2*
-Incarcerated	*1*

(continued)

Target Population | Number of Culturally Adapted Interventions

+Youth	1
+Boys	*1*
+Families	3
+Married Couples (heterosexual)	1
+Men	2
+Men who have sex with men (MSM)	*2*
+Couples (Same Sex, MSM)	*1*
+Women	7
+History of Intimate Partner Violence (IPV)	*2*
+Pregnant	*1*
+Residing in Public Housing	*1*
+Parenting Caregivers (Mothers, Grandmothers)	*1*
+College Students	*2*
Multi Population Studies	5
Afro-Caribbean/Black British/South East Asian (Pakistani)	1
Black/White (Teen Girls)	1
African American/Latino Adolescent Boys	1
Uganda, Pakistan, India*	1
+ Mothers	1
Tanzania, Nigeria*	1

*counted once

Table A11

Target Concerns of Interventions for People of African Ancestry

Target Disorder	Number of Culturally Adapted Interventions
Depression	6
- Prenatal Depression	1
Parenting	2
PTSD/Trauma	5
Behavioral Problems (Youth)	1
Marriage Education	1
Substance Use	2
Binge Eating Disorder (Loss of Control Eating)	1
Health Promotion/Disease Prevention	18
-*HIV*	*10*
-*Weight Management*	*3*
-*Cancer Detection*	*2*
- *Diabetes Management*	*1*
- *Smoking Cessation*	*1*
- *Health-Related Stress and Coping*	*1*
Speech Delay	1
Dementia	1

Table A12

Theoretical Basis of Interventions for People of African Ancestry

Target Population	Number of Culturally Adapted Interventions
Social Cognitive Theory (SCT)	12
+ Social Cognitive Theory and Behaviorism	*1*
+ SCT + feminism	*3*
- Women's CoOp	*1*
- SCT + Theory of Gender and Power	*1*
- SCT + Feminist and Empowerment Theory	*1*
+ Diabetes Self Management Education (DSME)	*2*
Cognitive Behavioral Therapy (CBT)	7
+ CBT + Interpersonal Therapy (IPT)	*2*
+ CBT + Interpersonal Therapy (IPT) + Community Resiliency Model	*1*
Trauma Focused CBT (TF-CBT)	2
Cognitive Processing Therapy (CPT)	1
Relational Communication Theory (RCT)	1
Cognitive Stimulation Theory	1
Interpersonal Therapy (IPT)	1
Behaviorism	1
Dialectical Behavioral Therapy (DBT)	1
Mindfulness Based Stress Reduction (MBSR)	1
Parent Training	2
- Parenting the Strong-Willed Child (PSWC)	
-Family Foundations/Strong Foundations	*1*
Family Therapy	2
-Multidimensional Family Therapy (MDFT)	*1*
-Family Therapy/Child Support Group model	*1*
Motivational Theory	3
-Transtheoretical Stages of Change/Motivational Interviewing	*2*

(continued)

Target Population Number of Culturally Adapted Interventions

-Protective Motivation Theory	*1*
Social Skills Training (Strong Start)	1
Marriage Education (Prevention and Relationship Enhancement Program (PREP)	1

Table A13

Specific Context and Content Adaptations for Populations of African Descent

Context and Content Adaptation	Number of Cultural Adaptations
Language and Visuals	17
Incorporation of Faith/Spirituality, Music, and Traditional Practices	14
"Family" Feel: Food, Stories, Kinship, and Humor	12
Afrocentric/Collectivistic Values	11
Context adaptations	10
Oppression, Discrimination, and Stereotypes	8
Cultural Ontology of Symptoms and Treatment Rationale	7
Literacy	3
Problematic Western Concepts	3

Table A14

Specific Engagement Adaptations for Communities of African Descent

Engagement Adaptation	Number of Cultural Adaptations
Not Addressed	6
Addressing Structural Barriers	17
Community Interventionists	12
Extended Family and Community Involvement	9
Stigma Reduction	8
Orienting to the Process	6
Technology	6
Communication Style	6
Addressing Skepticism, Cultural Mistrust, Shaming within the Therapy	3

Table A15

Specific Development and Equivalence Adaptations in Interventions for Communities of African Ancestry

Equivalence Process	Number of Cultural Adaptations
Not Addressed	1
Integration of Top Down and Bottom Up	24
Fidelity	18
Adaptation Theory Referenced	17
Top Down Approach	6
Bottom Up Approach	1

Table A16

Specific Cultural Competence Adaptations for Populations of African Ancestry

Cultural Competence Adaptation	Number of Cultural Adaptations
Not Addressed	10
Community Interventionist	18
Ethnic Matching	7
Resolving Past Negative Experiences	2
Non-Hierarchical Collaboration	2
APA Guidelines	2
Community Investment	1
Self Disclosure and Gifts	1
Anti-Racism	1

Table A17

Type of Result Reported in Interventions for Communities of African Ancestry

Type of Result reported	Number of Cultural Adaptations
Not reported/not available yet	14
Symptom Reduction/Behavior Change	18
Participant Satisfaction	11
Low Attrition	9
Problems/Poor Outcomes	3
Replication	1

Table A18

Exemplar Adaptations for Communities of African Descent

Citation	Context	Engagement	Equivalence	Therapist CC
Coard, S. (2004). Towards Culturally Relevant Preventive Interventions: The Consideration of Racial Socialization in Parent Training with African American Families.	Adaptations include: inclusion of racial socialization, culturally affirming strategies, racism, instruction in racial identity development, and the African American–perspective use of we; African American language expression, common language; emphasis on values, collective responsibility, cooperation, and interdependence; use of African proverbs, sayings and affirmations, poems, quotes, symbols, and pledges; the use of prayer, role-playing, storytelling, and humor.	Collaborative approach with parents; communication style adaptations-- African American language expression, common language, use of "we"; extended family participation. Multiple efforts to facilitate engagement and reduce barriers, including providing dinner, reminder phone calls, and child care.	APA Cultural competency guidelines discussed. Ethnic matching; focus on credibility through regular interactions in the community.	Adaptation Theory guided intervention design including development of an initial qualitative pilot study. Fidelity ensured through ongoing consultation from original program developers.
Saleh-Onoya, D., Braxton, N. D., Sifunda, S., Reddy, P., Ruiter, R., van den Borne, B., … Wingood, G. M. (2008). SISTA South Africa: the adaptation of an efficacious HIV prevention trial conducted with African-American women for isiXhosa-speaking South African women. SAHARA-J : Journal of Social Aspects of HIV/AIDS, 5(4), 186–191. http://doi.org/10.1080/17290376.2008.9724918	Collectivistic language adaptations; more time in the curriculum allowed for discussions and exploration; names, terms, and regional slang common in South Africa were incorporated into the curriculum. Poetry by isiXhosa women was introduced to stimulate discussion about gender and cultural pride, the strengths of isiXhosa women role models, as well as the challenges of being an isiXhosa woman. Much of the discussion of the challenges reflected on the role of apartheid in disempowering isiXhosa women. Participants also discussed personal and community values that could facilitate safer sex practices. Focus on ethnic and gender pride, encouraging women to reflect on the positive aspects of their gender and cultural heritage, and built their self-esteem. Workshops ended with traditional Xhosa songs, as well as creating traditional bead jewelry (bracelets, necklaces and rings).	Reduction of number of overall sessions.	Stage model, integrating top down and bottom up knowledge through focus groups and meetings with key stakeholders (e.g., community members, nurses, physicians, clinics). Adaptation theory was used, specifically public health framework ADAPT-IIT. Fidelity ensured through identification of core elements for preservation. U.S. African-American health educators implemented a training program to train the South African facilitators, using a train-the-trainers strategy.	Non health/mental health facilitators were used; facilitators were black South African women who spoke and read isiXhosa fluently, had completed their secondary education and were selected based on their demonstrated communication skills and enthusiasm for the project, as well as prior experience working in the field of HIV prevention

(continued)

| Citation | Context | Engagement | Equivalence | Therapist CC |

Ward, E. C., and Brown, R. L. (2015). A culturally adapted depression intervention for African American adults experiencing depression: Oh Happy Day.	Afrocentric paradigm; use of prayer and spirituality, addresses discrepancies between professional and cultural views of depression; Incorporation of anger management module; addresses relationship between depression and health conditions.	Light meal is provided with soft background music is played, during which time participants share a meal together, check in, and bond with each other; use of group format; language changes from "sessions" to "classes."	Adaptation Theory referenced: Bernal's Stage Model; conducted series of descriptive research studies examining African Americans' beliefs about mental illness, perceptions of stigma, experiences in counseling, and treatment preferences.	Ethnic matching; encouragement of appropriate self-disclosure on the part of the therapist relevant to topics of discussion about their experiences of being African Americans.

Table A19

Characteristics of Latino/a/x Target Communities

Target Population	Number of Culturally Adapted Interventions
Latinos in the United States	18
- Primary Spanish Speaking	4
- 1st generation immigrants	2
- English speaking/ESL	3
- Parents/Caregivers	4
- Caribbean Latinas	1
- Men	1
- Mexican descent	4
+ Youth	1
+ Parents	2
+ Migrant Farmworkers	1
- Women	1
- Women	4
- Central American descent	1
- Latinos in Puerto Rico	1
- Youth	1
Mexico	2
- Youth	1

Table A20

Target Concerns of Interventions for Latino/a/x Communities

Target Population	Number of Culturally Adapted Interventions
Depression	9
- Postpartum depression	1
- Depression with comorbid anxiety	1
- Parents with depressed adolescent	1
Parent Management/Family Intervention	5
PTSD	1
HIV Prevention	1
Heavy Drinking	1
Bulimia Nervosa	1
Anxiety Disorders	2
- Social Anxiety Disorder	1

Table A21

Theoretical Basis of Interventions for Latino/a/x Communities

Target Population	Number of Culturally Adapted Interventions
Cognitive Behavioral Therapy	12
- CBT + Interpersonal Theory	1
Social Learning Theory	4
Motivational Interviewing	2
Behaviorism	2

Table A22

Specific Context and Content Adaptations in Latino/a/x Community Studies

Context and Content Adaptation	Number of Cultural Adaptations
Cultural Values – Simpatia, Familismo, Respeto	12
Translation, Idioms, and Dichos	12
Contextual Issues	10
Acculturation	5
Literacy Adaptations	4
Visuals	2
Spirituality	2

Table A23

Specific Engagement Adaptations for Latino/a/x Communities

Engagement Adaptation	Number of Cultural Adaptations
Not Addressed	4
Flexibility and Structural Barriers	10
Extended Family Involvement	5
Community Settings	5
Communication Style	4
Community Interventionists	4
Stigma Reducing Language	3
Technology	3
Orientation	2

Table A24

Specific Development and Equivalence Processes Adaptations for Latino/a/x Communities

Equivalence Process	Number of Cultural Adaptations
Not Addressed	1
Adaptation Theory Referenced	12
Fidelity	10
Top Down Approach – Researcher/Clinician Driven	8
Integration of Top Down and Bottom Up Approaches	9

Table A25

Specific Cultural Competence Adaptations for Latino/a/x Communities

Cultural Competence Adaptation	Number of Cultural Adaptations
Not Addressed or Only Linguistic Match	6
Ethnic Matching	5
Self Disclosure and Personalismo	5
Community Interventionist	3
Awareness of Differences	3
Ethnic Match of Researchers	2
Dynamic Sizing	1
Community Broker	1

Table A26

Type of Results Reported for Adaptations for Latino/a/x/ Communities

Type of Result reported	Number of Cultural Adaptations
Not reported/not available yet	4
Symptom Reduction/Behavior Change	9
Participant Satisfaction	7
Low Attrition	5
Reach of intervention	1

Table A27

Exemplar Adaptations for Latino/a/x Communities

Citation	Context	Engagement	Equivalence	Therapist CC
Domenech Rodríguez, M. M., Baumann, A. A., and Schwartz, A. L. (2011). Cultural Adaptation of an Evidence Based Intervention: From Theory to Practice in a Latino/a Community Context. American Journal of Community Psychology. http://doi.org/10.1007/s 10464-010-9371-4	Translated into Spanish, use of visual rather than written materials where possible to address literacy concerns, use of researcher and participant-generated Latino dichos, explicitly stated cultural values used to frame intervention goals, contextual issues were relevant to the treatment process in the form of examples, stated challenges to parents in parenting (e.g., fear of having children call CPS and having deportation be a possible consequence).	Delivered in a community context, family members were invited (brother, sister) as persons that co- parented even if they were not the biological parent or lived in the home; used drop-in rather than appointment format for assessment. Homework renamed as ‘‘practice assignments’’ to avoid alienating parents with negative view of the educational system. Groups scheduled on weekday evenings to accommodate work schedules and family responsibilities; dinner, childcare, and transportation provided when available.	The adaptation took place in stages: a pilot study to ensure feasibility, focus groups to establish appropriate format and goals, and a test of the intervention; utilized adaptation theory process model of Domenech-Rodriguez and Wieling (2004) and the ecological validity model (EVM) of Bernal et al.,. (1995). Fidelity efforts: treatment developer made intervention materials readily available and created training opportunities to support skills acquisition and promote implementation fidelity for the CAS, advocating for adherence to the components identified as mechanisms of change (e.g., core parenting practices) for the child outcomes	Use of community brokers to increase acceptability during needs assessment review. Ethnic matching.
Parra Cardona, J. R., Domenech-Rodriguez, M., Forgatch, M., Sullivan, C., Bybee, D., Holtrop, K., … Bernal, G. (2012). Culturally Adapting an Evidence-Based Parenting Intervention for Latino Immigrants: The Need to Integrate Fidelity and Cultural Relevance. Family Process. http://doi.org/10.1111/j. 1545-5300.2012.01386.x	Curricula, supportive materials, and research activities utilized in this study were adapted in order to ensure linguistic and cultural appropriateness, as well as cultural sensitivity in their delivery. Two culture-specific sessions were added addressing parental stress associated with being immigrants, economic difficulties, work exploitation, and the impossibility of traveling for extended periods of time to their home countries, and biculturality, and intergenerational conflict. The CAPAS- Enhanced intervention also includes brief reflections associated with the cultural relevance of each core PMTO component.	All sessions include full dinner for participants and their children, as well as childcare services; intervention delivered in the building of a local religious organization widely recognized and trusted by the Latino community.	Adaptation theory used, CBPAR approach, qualitative interviews. Fidelity: used original structure, i.e. manuals with detailed session agendas, objectives, exercises, role-plays, and group process suggestions.	Included paraprofessional interventionists who are community members and highly trusted by Latino parents. Ethnic matching: Latino research staff carried out recruitment, assessment, and intervention delivery. These professionals were also well matched on immigration, acculturation, and general stressors.

Table A28

Characteristics of Asian/Pacific Islander Descended Populations

Population Characteristics	Number of Culturally Adapted Interventions
Living In The West	15
Asian American	9
+ Women	1
+ Divorced	1
+ Mothers	1
- Cambodian-, Chinese-, Korean-, Laotian-, and Vietnamese-American	1
- Chinese American	3
+ Women	1
+ Older Adults	1
+ 1st generation	1
- "East Asian"	1
- First Generation Immigrants	1
- Pacific Islander - American	1
- Samoan American	1
Chinese-Australian	2
Southeast Asian-British	1
Refugees	3
-Vietnamese	1
- Cambodian	2
+ Khmer Rouge survivors	2
+ Women	1
Within Asian Countries	11
China	3
- Adults	2
- Youth	1
+ School-based	1
Singapore	1
- Youth	1
+ Residential Home Residents	1
Pakistan	7
- Urban	4
+ Women	1
+ College Students	1
- Non-urban	1
- Inpatient facility	1

Table A29

Target Concerns of Interventions for Communities of Asian/Pacific Islander Descent

Target Disorder	Number of Culturally Adapted Interventions
Depression	8
+ *Post-Partum Depression*	1
Preventive Health	5
- Medical Adherence	2
+ *HIV medication*	1
+ *Colorectal screening*	1
- Smoking Cessation	1
- Weight Management	1
- Physical Activity Level	1
Trans-diagnostic	4
Trauma	3
Psychotic-Spectrum	2
Obsessive Compulsive Disorder (OCD)	1
Parenting	1
Social Anxiety Disorder	1
Emotion Regulation	1

Table A30

Theoretical Basis for Interventions for Communities of Asian/Pacific Islander Descent

Theoretical Basis	Number of Culturally Adapted Interventions
Cognitive Behavioral Therapy (CBT)	19
+ Problem Solving Therapy	1
+ Mindfulness	1
Acceptance and Commitment Therapy	1
Mindfulness + Acceptance Theories	1
Social Learning Theory	1
Motivational Interviewing	1
Not stated	2
Person-Environment Transactional Model	1

Table A31

Specific Context and Content Adaptations for Communities of Asian/Pacific Islander Ancestry

Context and Content Adaptation	Number of Cultural Adaptations
Not Addressed	4
Values: Collectivism, Emotional Control and Tradition	14
Idioms/Expressions/Metaphors/Folk Stories	7
Spirituality/Religion	7
Bridging Concepts and Explanatory Models	5
Acculturation, Minority Stress, Intergenerational Conflict	5
Somatic Expression	3
Translation	3

Table A32

Specific Engagement Adaptations for Communities of Asian/Pacific Islander Ancestry

Engagement Adaptation	Number of Cultural Adaptations
Not Addressed	6
Extended Family and Community Involvement	10
Translation and Use of Language	10
Addressing Barriers	7
Orienting to Treatment	5
Communication/Instructional Style	5
Leadership (Non-mental health)	3
Technology	1

Table A33

Specific Development and Equivalence Processes Adaptations for Communities of Asian/Pacific Islander Descent

Equivalence Process	Number of Cultural Adaptations
Not Addressed	3
Use of Adaptation Theory	11
-Hwang	2
Top Down Approach	5
Cultural Consultation/Review	3
Integrated Top Down/Bottom Up	14
Fidelity	5

Table A34

Specific Cultural Competence Adaptations for Communities of Asian/Pacific Islander Descent

Cultural Competence Adaptation	Number of Cultural Adaptations
Not Addressed	15
Not Specified	2
Ethnic Matching	3
Vertical Relationship	6
Adjustment of Goals	1

Table A35

Type of Results Reported for Adaptations for Communities of Asian/Pacific Islander Descent

Type of Result reported	Number of Cultural Adaptations
Not reported/not available yet	8
Symptom Reduction/Behavior Change	14
Participant Satisfaction	6
Maintenance of Results	3
Completion Rates	2

Table A36

Exemplar Adaptation for South Asian/Asian/Asian American Community

Citation	Context	Engagement	Equivalence	Cultural Competence
Masood, Y., Lovell, K., Lunat, F., Atif, N., Waheed, W., Rahman, A., … Husain, N. (2015). Group psychological intervention for postnatal depression: a nested qualitative study with British South Asian women. *BMC Women's Health, 15*, 109. http://doi.org/10.1186/s12905-015-0263-5	Incorporation of themes drawn from qualitative data: volatile relationships with husbands, "politics" within family (e.g., mother in law), role expectations. keeping "face, honor, cultural illness origin beliefs (e.g., punishment from God). Incorporation of religious texts and practices (e.g., Salat as behavioral activation). Provides education from religious texts, re-introduction of Salat (5 times daily prayer) as behavioral activation. Use of 'Psychosociospiritual' model.	Decrease stigma within family unit by packaging as "maternal health" rather than maternal depression. Language adjustments (e.g.''programme'' rather than ''therapy'', ''facilitator'' rather than ''mental health worker''). Accommodating concerns about privacy and confidentiality within a small community with culturally specific case vignettes, designed to reduce the pressure of speaking in a group about personal issues. Arrangements for childcare, prayer space, and attention to time of day to accommodate household responsibilities.	Integration of top-down and bottom-up knowledge, use of focus groups, adaptation theory referenced, clearly outlined stage-based adaptation framework.	Addresses knowledge-based requirements for therapists, e.g., understanding cultural and religious practices, norms, and values.

Table A37

Context and Content Adaptations Across Groups

Adaptation	%ile
Overall Context and Content Adaptations	95%
Values	59%
Language/Visuals	53%
Contextually Specific Issues	48%
Religion and Spirituality	27%
Culturally Relevant Explanatory Models	12%
Literacy	9%
Elimination of Western Concepts deemed inappropriate	5%

Table A38

Engagement Adaptations Across Groups

Adaptation	%ile
Overall Engagement Adaptations	83%
Structural Barriers and Flexibility	33%
Inclusion of extended family/community members	28%
Community-Based Interventionists	26%
Stigma reducing word choices	22%
Co-location within (non-mental health) community setting	15%
Orientation	13%
Technology	13%
Communication Style Adjustments	18%
Mistrust	3%

Table A39

Equivalence and Development Adaptations Across Groups

Adaptation	%ile
Overall Equivalence and Development Processes Adaptations	94%
Integration of research and community perspectives	60%
Use of adaptation literature	46%
Provisions for fidelity	37%
Clinician/researcher driven process	19%
Community-driven process	2%
Cultural Review/Consultation Process	3%

Table A40

Cultural Competence Adaptations Across Groups

Adaptation	%ile
Overall Cultural Competence Adaptations	65%
Aspects that relate to engagement with the broader community *(Ongoing Investment in the Community, 2%; Use of Community Broker, 1%; Cultural Knowledge Acquisition, 1%; Community-Based Interventionist, 21%);*	*25%*
Aspects that relate to personal characteristics of the therapist *(Matching of Ethnicity, Language, National Origin, 19%)*	*19%*
Aspects that relate to interpersonal processes *(Utilizing Vertical Relationship: 6%; Adjustment of Goals: 1%; Addressing Skepticism and Past Negative Experiences: 5%); Dynamic Sizing Efforts, 5%; Non-Hierarchical Collaboration, 2%).*	*18%*
Aspects that relate to systems and professional standards and norms *(APA guidelines, 2%; Assessment of Agency Competence: 1%; Self Disclosure and Gifts: 6%).*	*9%*
Aspects that relate to attitudes and self reflection *(Awareness of Differences, 3%; Anti-Racism, 1%);*	*4%*

APPENDIX B

Figures

Figure B1. Evidenced based practice in psychology.

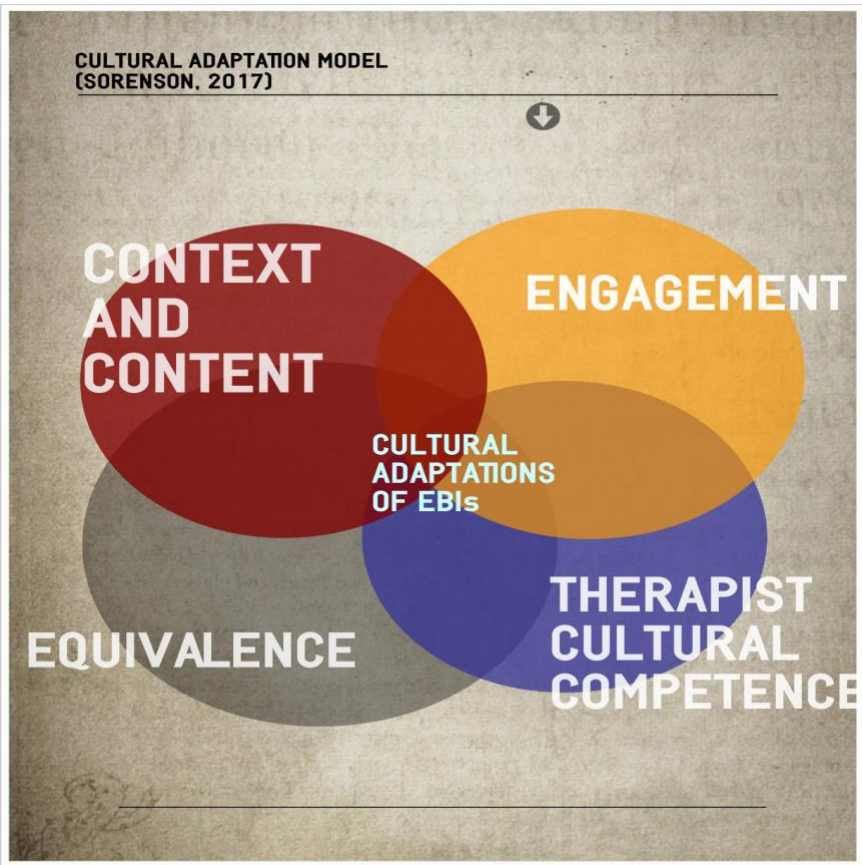


Figure B2. Cultural adaptation model (Sorenson, 2018).

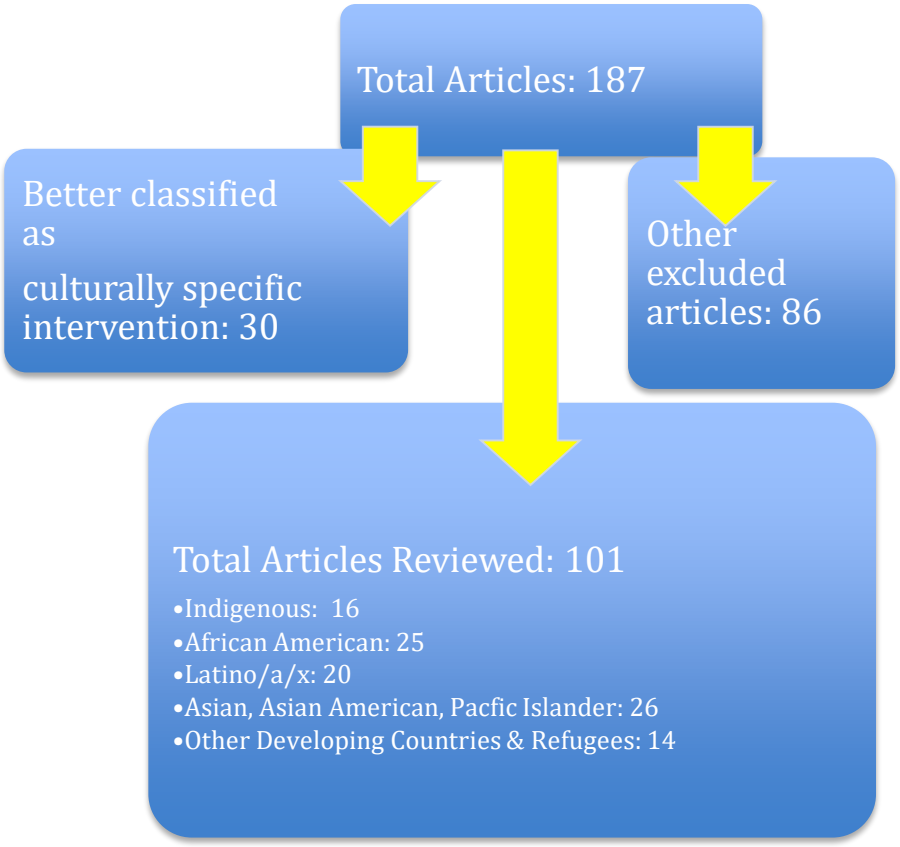


Figure B3. Flowchart of article selection.

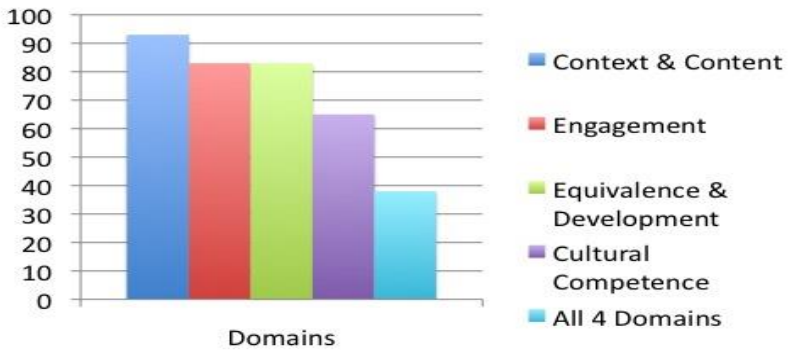


Figure B4. Domains addressed across groups.

APPENDIX C

IRB Documentation

GPS IRB NON-HUMAN SUBJECTS NOTIFICATION FORM FOR RESEARCH THAT DOES NOT INVOLVE HUMAN SUBJECTS

Investigator Name:___Caitlin Sorenson_____
Status: Faculty:_____ Graduate Student:___X
Faculty Chair (if applicable):_____Shelly Harrell_____
Proposal Research Title:___The Theory, Process, and Outcomes of Culturally Adapted Psychosocial and Psychotherapy Interventions_____

Per Pepperdine University Graduate and Professional School (GPS) Institutional Review Board (IRB) guidelines all proposed research that does not involve direct contact with human subjects requires a notification form be submitted for review.

Research that requires IRB review must meet the definition of human subject's research. The code of federal regulations provides the following definitions:

- **For the purposes of the IRB, research is defined as a systematic investigation designed to develop or contribute to generalizable knowledge.**
- **Human subject means a living individual about whom an investigator (whether professional or student) conducting research obtains**

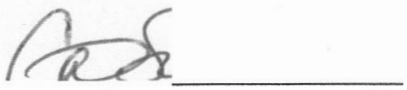
  (1) Data through intervention or interaction with the individual, or
  (2) Identifiable private information.

If your research does not involve the participation of human subjects **and** you are not using/collecting any data that has been obtained from individual participants, your research is not subject to IRB review and approval but does require the submission and filing of a non-human subjects notification form in the IRB office.

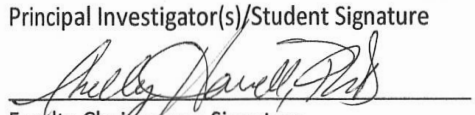
When submitting this notification form please include the following as separate documents:

- Signatures by ALL Principal Investigator(s) (student and/or faculty) and Faculty Chair when applicable.
- One page abstract outlining the study's research design and methodology.

I verify that this proposed research does not involve the use of human subjects, either directly or indirectly.



Principal Investigator(s)/Student Signature — Date: 6/15/2018



Faculty Chairperson Signature — Date: 6-15-2018