

# Is Culturally Sensitive Cognitive Behavioral Therapy an Empirically Supported Treatment?: The Case for Hispanics

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## ABSTRACT

In this paper we reviewed the literature to determine what “culturally sensitive” interventions (whereby “culturally sensitive” was defined as any study that included a specific focus on the cultural group of interest) can be considered well-established, beneficial treatments for use with Hispanic populations. Despite several hundred publications on Hispanics and cultural sensitivity over the past several decades, only 12 peer-reviewed articles that evaluated empirically supported treatments for the mental health disorders most commonly diagnosed among Hispanics were identified. These studies had significant methodological limitations and few employed the “gold standard” designs associated with randomized clinical trials. From this review we concluded that 1) the ratio of non-empirical to experimental publications is quite high; 2) there is evidence that Hispanics may be effectively treated using conventional cognitive behavioral therapy; 3) there is little evidence that cultural adaptations result in consistently improved effect sizes; and 4) cultural adaptations do not show expected homogeneity regarding cultural tailoring, suggesting that the construct of Hispanic culture is poorly understood.

*Key words:* cultural sensitivity, Hispanics, therapy outcome, efficacy.

### *Novelty and Significance*

#### *What is already known about the topic?*

- Cultural considerations are important in terms of the administration of psychological services to Hispanics/Latinos.
- The administration of evidence-based interventions are necessary to ensure positive treatment outcomes.

#### *What this paper adds?*

- Via an extensive review and critical analysis of the literature, it was determined that the ratio of non-empirical to experimental publications is quite high.
- Moreover we identified that Hispanics may be effectively treated using conventional CBT; there is little evidence that cultural adaptations result in consistently improved effect sizes; and cultural adaptations do not show expected homogeneity regarding cultural tailoring, suggesting that the construct of Hispanic culture is poorly understood.

The field of clinical psychology experienced an important shift in recent decades and is increasingly influenced by an orientation toward evidence-based practice (Chambless & Ollendick, 2001; Lilienfeld & O'Donohue, 2007; Ollendick, 2012). A large focus of this movement has been on changing service delivery so that empirically supported treatments (ESTs) are delivered to clients and treatments without outcome research demonstrating their effectiveness and safety are not (Chambless & Ollendick, 2001). The focus on ESTs is consistent with recent health reform legislation such as the Affordable Care Act, which emphasizes efficient, effective health care interventions in an attempt

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to improve safety, costs, and outcomes (Wendell, O'Donohue, & Serratt, 2014). At the heart of ESTs is the randomized controlled trial (RCT). Indeed for an intervention to achieve EST status there must be evidence that it is superior to a placebo (or other treatment) or equal to an already established EST (via at least two RCTs or a series of single-case design experiments conducted by different investigators: Task Force, 1995; Dobson & Dobson, 2006). Cognitive behavioral therapy (CBT) is at the core of the EST movement as there is substantial evidence that CBT is effective for treating a number of mental health conditions (Chambless & Ollendick, 2001).

The EST movement is not without critiques. Indeed there have been numerous debates regarding the overall value of the EST movement (e.g., Beutler, 1998; Goldfried & Wolfe, 1998); what exactly constitutes “empirically supported” (Borkovec & Costonguay, 1998; Herbert, 2003); how therapies that have achieved this status should be labeled (e.g., “empirically validated”, “evidenced based” etc.: Duncan & Reese, 2013); and to what extent ESTs generalize to ethnic minority individuals due to the alleged underrepresentation of such individuals in the original outcome research (Bernal & Scharró del Río, 2001). In fact, some have asserted generalizability of ESTs to cultural minorities may be limited because of the majority culture values and assumptions represented in these therapies (Benish, Quintana, & Wampold, 2011) and the dependent measures used to assess the outcomes of these therapies may not be appropriate -and perhaps even detrimental- when used with cultural minorities (Cardemil, 2010).

One means of addressing these concerns has been to focus on treatments that have undergone some modification with the goal of improving the cultural sensitivity of the intervention. Several authors (e.g., Bernal, Jiménez Chafey, & Domenech Rodríguez, 2009; Falicov, 2009; Kreuter & Skinner, 2000; Barrera *et al.*, 2013) have attempted to explicate how treatments should be adapted and modified based on putative cultural values (see Table 1 for a list of associated definitions). As illustrated in Table 1 there are several terms (e.g., tailored, adapted etc.) that are used to refer to a treatment that has been modified based on cultural values and under each of these terms there is some variation in how the treatment is modified. Our review of the literature revealed that works on culturally modified treatments are largely theoretical and speculative and

Table 1. Terminology.

Term	Definition	Reference
Cultural Adaptation	“...the systematic modification of an evidence-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client’s cultural patterns, meanings, and values”	Bernal, Jimenez-Chafey, & Domenech Rodriguez (2009, p. 362)
Cultural Attunement	Changes are made to improve reach and engagement. Core treatment components are not modified.	Falicov (2009)
Culturally Tailored	Interventions are modified after assessment of the individual’s presentation and are matched based on the individual’s endorsement of cultural dimensions.	Kreuter and Skinner (2000)
Culturally Targeted	Interventions are modified based on cultural characteristics of a group and assumes homogeneity across the target population.	Kreuter and Skinner (2000)
Other terminology	Barrera <i>et al.</i> , 2013 specify that other terms including <i>culturally sensitive, culturally enhanced, culturally appropriate, culturally informed, culturally grounded, culture specific, and culturally focused</i> are used to describe “deliberate efforts to increase the appeal and effectiveness of interventions that are used with subcultural groups” (p. 197).	Barrera <i>et al.</i> (2013)

data that actually show that these recommendations resulted in improved outcomes for Hispanics are much less prevalent (Huey, 2013). Thus in this paper we reviewed the literature to determine what “culturally sensitive” interventions (whereby “culturally sensitive” was defined as any study that included a specific focus on the cultural group of interest) can be considered well-established, beneficial treatments for use with Hispanic populations. Because the literature on cultural sensitivity is vast, we limited the scope of our review to Hispanics as this group constitutes one of the largest minorities in the United States (the latest census Hispanics account for more than half of the total United States population growth in the past decade and constitute the largest and fastest growing minority group in the country; U.S. Census Bureau, 2012). Despite this limitation, future reviews should investigate similar questions for other cultural groups.

### CULTURALLY SENSITIVE INTERVENTIONS FOR HISPANICS

Generally speaking, advancements with regard to cultural sensitivity have been slow. The cultural sensitivity literature is focused on putative ethnic differences and their relationship to mental health (e.g. Cardemil, 2010; Chavez, Cornelius, & Jones, 1986; Conner, Koeske, & Brown, 2009; Falicov, 1996; Givens, Houston, Van Voorhees, Ford, & Cooper, 2007; Leaf, Bruce, & Tischler, 1986; Snowden, 1998). Outcome data from well-designed studies relevant to the success and limitations of proposed solutions to the barriers cultural minorities experience in accessing behavioral health services are sparse (Benuto & Leany, 2011). In fact, despite that over 40 years ago, Sue (1977) provided specific recommendations on how to culturally modify mental health interventions, most of the literature on cultural sensitivity remains based in theory that has not been tested for its putative benefits.

A few authors have attempted to review the literature on psychological interventions with a wide variety of minorities. First, Griner and Smith (2006) conducted a meta-analysis across 76 studies that examined a culturally adapted intervention and found a moderate weighted average effect size ( $d = .45$ ). They reported that interventions targeted to a specific cultural group were four times more effective than interventions provided to groups consisting of clients from a variety of cultural backgrounds. It is important to note, however, that the authors indicated that the interventions conducted in the clients' native language were twice as effective as interventions conducted in English. The latter assertion qualifies the first finding, as it is implausible to expect treatment gains if the client and therapist cannot communicate well. Therefore half the gains observed in this meta-analysis may simply be due to delivering the therapy in an appropriate language, leaving a relatively small effect for the other adaptations. Moreover, these authors provided very little information regarding what constituted a culturally “adapted” treatment and noted that many types of putative cultural adaptations were not explicitly described within the studies they included in their meta-analysis. This limited the validity of the attribution of improved outcomes to cultural tailoring. Furthermore, Griner and Smith did not limit their examination to ESTs. This is problematic as it can be difficult to understand the differential effects of cultural tailoring when there is little evidence to support the efficacy of the treatment itself. Interestingly Griner and Smith

reported that studies that had higher percentages of Hispanic/Latino participants had effect sizes of greater magnitude than studies with few Hispanic/Latino participants. The authors suggested that level of acculturation may account for this finding.

Similarly Horrell (2008) examined the effectiveness of CBT with adult ethnic minority clients. Her review of the literature was not limited to Hispanics (she also reviewed research on individuals residing in the United States of Asian and African descent) but is discussed here as she did review literature with Hispanic participants. She identified 12 relevant studies and concluded that CBT appeared to be an effective treatment for use with clients from ethnic minority backgrounds. However, she failed to examine differential effectiveness, i.e., whether and special cultural adaptations resulted in increased efficacy or effectiveness or if "standard" treatments (i.e., those with no cultural adaptations) were just as effective. Thus Horrell's review does not provide information regarding gains or disadvantages of culturally modifying a treatment. While Smith, Rodríguez, and Bernal's (2011) meta-analysis of 65 experimental and quasi-experimental studies ( $N= 8,620$ ) was also not explicitly focused on Hispanics (32% of the participants were Hispanic) they did identify a medium effect size indicating that those who received a culturally adapted treatment typically experienced superior outcomes than patients in control groups.

In a more thorough investigation Benish, Quintana, and Wampold (2011) examined the relative efficacy of culturally adapted vs. unadapted psychotherapy via meta-analysis. Their focus was unique as they looked at the adaptation of the explanation of illness (e.g., how the possible cause of the client's presenting concern was explained to them). They found that culturally adapted psychotherapy was more effective than un-adapted psychotherapy by  $d= .32$  for primary measures of psychological functioning. Interestingly they found that adapting the explanation of the client's illness was the sole moderator ( $d= .21$ ) for the differences observed in adapted vs. un-adapted psychotherapy. In their conclusions they emphasized the importance of examining "ingredients" and their relationship to outcome as opposed to only focusing on outcome. It is important to note that Benish and colleagues did not limit their analysis to studies focused on Hispanics although Hispanics did constitute 26.7% of their sample. In addition, this study is interesting because it is atypical in therapy for the client's belief about the cause of their presenting concern to be a focus in treatment as the conditions for valid causal inference are not met.

More recently, Barrera *et al.* (2013) provided what they called "a progress report" on the cultural adaptations of more general behavioral health interventions, i.e., interventions associated with behavioral medicine such as treatment compliance for diabetes. They suggested that cultural adaptation consists of five stages (i.e., information gathering, preliminary design, preliminary testing, refinement, and final trial) and that culturally enhanced interventions are more effective in improving health outcomes (e.g., diabetes, HIV, nutrition etc.) than care as usual or other control conditions. However, little to no information was given on differential effect sizes of culturally tailored interventions or the methodological adequacy of the studies. Barrera (2013) suggested that several different approaches can be taken to create interventions having cultural elements to boost program appeal, appropriateness, or efficacy. These approaches included: 1) a

sequential research-driven process that is focused on developing an understanding of risk factors for a defined population and then proceeds to intervention design, outcome research, and dissemination; 2) an investigator-initiated approach whereby investigators specify the theory-based structure for the intervention and community members add cultural components; 3) community-initiated indigenous frameworks whereby community members and their organizations create interventions that are subsequently empirically evaluated; and 4) cultural adaptations of evidence-based interventions. It is important to note that there are variations in the cultural adaptation literature in terms of terminology and definitions (Barrera *et al.*, 2013). See Table 1 for the definitions associated with each of these.

Out of the all of the papers we reviewed, we found that Huey (2014) provided the most comprehensive evaluation of culturally modified treatments given his focus on the cultural tailoring procedures used. Specifically, Huey discussed how cultural factors can be addressed in therapy by either *explicitly* tailoring treatments (i.e., there is direct reference to a client's ethnicity/race in treatment) or *implicitly* tailoring treatment (i.e., there is no apparent mention in treatment and the client may be unaware that the treatment is culturally tailored). Huey identified 10 randomized trials of culturally tailored versus generic psychotherapies for ethnic minorities and conducted a meta-analysis. He found that cultural tailoring effects were small and non-significant. He hypothesized that these results may be because 1) symptom reduction may not be the variable of greatest interest and that treatment engagement may be a better outcome variable; 2) that tailoring might have delayed rather than immediate effects on outcomes (although longer-term follow-up data generally does not support this); 3) that acculturation may act as a confound whereby cultural tailoring may be most effective for those who are not very acculturated; 4) that references to the client's ethnic background could paradoxically be iatrogenic by eliciting reactance or stigma (and therefore implicit interventions may be the route to take); 5) that some cultural adaptations are not carried out in a high quality matter; 6) that methodological flaws muddle results; and 7) that the core treatments may be ineffective -not the "tailored" components.

In sum, the review articles discussed above do not offer consistent, let alone conclusive, evidence regarding whether or not "culturally" sensitive interventions can be deemed as well-established, beneficial treatments for use with cultural minorities. It might be the case that part of the inconsistency in results is due to including multiple minorities for a wide variety of presenting concerns. Moreover, the cultural modifications made to the therapies were not consistent (e.g., adapted vs. tailored etc.) across these publications. Thus, the following review is focused on a single cultural group, with a set of disorders, and examines the nature of the cultural adaptations that have been made for this group.

### *Search Strategy*

To determine what "culturally" sensitive interventions can be deemed well-established, beneficial treatments for use with Hispanics the extant literature on treatment outcomes for Hispanic/Latinos was reviewed. We limited the focus of this paper to the use of CBT with Hispanics because CBT is at the forefront of the EST movement.

Specifically we reviewed the reports put forth by Chambless and the Division 12 Task Force (1995; 1996; 1998) and identified that Chambless et al. (1995; 1996; 1998) listed a derivative of CBT for several disorders. Thus each of the studies reviewed involved a CBT-based treatment. It is important to note that we did not limit our search to CBT that had been modified via a cultural adaptation. While our goal was to determine what “culturally” sensitive interventions are well-established, beneficial treatments for use with Hispanics, we reviewed all studies where there was an express focus on Hispanics and CBT-relevant treatment. Thus we reviewed and included all studies for which there was a CBT-based treatment and the focus was on Hispanics. Because no single-subject designs on ESTs with Hispanics were identified in our initial search, a subsequent search specifically for single-subject designs and/or case studies was conducted.

As a result of the above steps, several searches within the PsyInfo database using the following key terms were conducted: Hispanic, Latino, cultural sensitivity, sensitivity, [cultural] adaptation, treatment, treatment outcome, cognitive behavioral therapy, behavior therapy, and cognitive therapy. Relevant abstracts and the reference sections of relevant resources that were identified were also reviewed. Several hundred articles related to ethnic differences in prevalence rates were identified but not included in this review of the literature. Specific to this review of the literature, while multiple manuscripts and book chapters were identified that provided background information on cultural sensitivity and/or treatment guidelines for use with Hispanics, our specific interest rested in treatment outcome studies that included CBT as a component.

#### *How is cultural sensitivity research carried out?*

Twelve relevant treatment outcome studies were identified (relevant meta-analyses are discussed earlier in this manuscript). It is important to note that across most of the studies reviewed the authors of the studies specified that the treatment was administered in Spanish, English, or in accordance with the preference of the participant. The methodologies used in these studies were reviewed to determine what “culturally sensitive” interventions can be deemed as well-established, beneficial treatments for use with Hispanics. Through this process it was observed that researchers who focus on cultural sensitivity conduct research with Hispanics in a number of ways. We chose to organize the literature we reviewed by research strategy/design as methodology is an important determinant in the allocation of EST status. A critical examination of all studies reviewed follows.

#### *Examining the Effectiveness of Standard CBT with Hispanics*

First, several researchers simply examined the effectiveness of using CBT treatment as usual (not tailored in any way to be culturally sensitive) with Hispanics either with (Kataoka *et al.*, 2003) or without a control group (Gelman, Lopez, & Foster, 2005; Organista *et al.*, 1994). Other researchers compared CBT (again, not modified to be “culturally sensitive”) against other treatment(s) (i.e., Alcoholics Anonymous [AA] vs. CBT vs. Motivational Enhancement Therapy [MET]: Arroyo *et al.*, 2003; CBT vs. a Supportive/Exploratory Intervention: Foster, 2007; CBT vs. Interpersonal Therapy

[IPT] vs. Waitlist Control: Rosello, 1999; Family CBT vs. Individual CBT vs. Waitlist Control: Gil *et al.*, 2004).

Results from these studies generally indicated that standard CBT is an effective means of treating mental health conditions with Hispanics. There were three RCTs (see Table 2) that included a waitlist control group where increased treatment gains (effect sizes were mostly moderate) for Hispanic participants as compared to waitlist controls were observed. A more detailed description of study characteristics and results can be found Tables 2, 3, and 5. It is important to note that in general, these researchers did not provide an analysis of the *relative* effectiveness of these standard CBT interventions by using data or benchmarks of therapy outcome with other populations. Thus, from these studies it is not possible to determine whether these standard CBT interventions are less, more, or equivalently effective with Hispanics vs. non-Hispanics. However, these studies do suggest that standard CBT with no cultural adaptations can produce some positive outcomes for Hispanics.

#### *Comparing Treatment as Usual with Hispanics vs. Non-Hispanics*

Second, a few researchers (Pina *et al.*, 2003; Gallagher *et al.*, 2008; see Table 3 for study details) examined the efficacy of using treatment as usual (not modified to be culturally sensitive) is with Hispanics vs. the effectiveness with the majority culture. Both Pina *et al.* (2003) and Gallagher *et al.* (2008) found that similar treatment gains occurred regardless of ethnicity; Hispanics fared just as well in treatment as non-Hispanics (see Table 4 for study details). Pina *et al.* (2003) participants were individuals with phobic and anxiety disorders whereas Gallagher *et al.* (2008) utilized a CBT with a group of individuals caring for a family member with dementia. While participants were not diagnosed as depressed, statistically significant reductions in Center for Epidemiology Studies-Depression Scale (CESD) scores were observed. The findings discussed above and summarized in Tables 3 and 4 suggest the current very limited evidence shows that culturally modifying treatments may not be necessary as Hispanics appear to fair just as well as do individuals from the majority culture.

#### *Culturally Adapted/Modified Cognitive Behavioral Therapy*

Third, researchers examined the efficacy of a “culturally modified” treatment with Hispanics either without a control group (Gelman *et al.*, 2005; Aguilera *et al.*, 2010) or with an alternative treatment (i.e., treatment as usual) to determine if the culturally sensitive treatment had superior effects (i.e., Hinton *et al.*, 2011; Burrow-Sánchez & Wrona, 2011). These studies are discussed at some length below and the relevant details for these studies can be found in Tables 3 and 5. In addition, the substance of these cultural adaptations is also discussed.

Gelman *et al.* (2005) piloted a 12-session CBT (group treatment) protocol for depression with five Latinas in New York City. According to the authors the treatment protocol was originally developed at the San Francisco General Hospital by Muñoz, Aguilar, and Guzmán (1986) and was described as created specifically for Latinos although the description of how this treatment varies from traditional CBT was vague. Gelman



Table 2. Randomized Controlled Trial (RCT) with Waitlist Control.

Authors	Disorder	Sample (N)	Outcome Measure	Treatment Details	Modifications Made	Results
Rossello, 1999	Depression	Puerto Rican Adolescents (71)	CDI-PHCSSCS; SASCA; FEICS; CBCL	RCT: Culturally Modified CBT vs. IPT vs. WLC-12 weekly 1-hour sessions.	None	CBT & IPT significantly reduced depressive symptoms when compared to WL condition.
Kataoka et al., 2003	Trauma-related depression &/or PTSD	Hispanic children in 3 <sup>rd</sup> to 8 <sup>th</sup> grade (198)	Life Events Scale; Child PTSD Symptom Scale; CDI	RCT: Trauma-focused CBT vs. WLC.	Treatment was administered in Spanish by "bilingual" & "bicultural" social workers. It does not appear that a cultural modification was made.	Significant reduction in symptoms for treatment group only.
Gil et al., 2004	Substance Use Disorders	Hispanic and African American Juvenile Offenders (213)	Timeline Follow Back; PRQ	RCT: Brief motivational, CBT: Individual vs. Family format vs. WLC.	None	There were significant reductions in alcohol and marijuana use for all ethnic groups from baseline to post-intervention.

Table 3. Randomized Controlled Trial (RCT) without Waitlist Control.

Authors	Disorder	Sample (N)	Outcome Measure	Treatment Details	Modifications Made	Results
Arroyo et al., 2002	Alcohol Use	Hispanics & Non-Hispanic Whites (205)	DrInC	RCT: Alcoholics Anonymous vs. CBT vs. MET.	None	CBT & MET produced similar effects for Hispanics and non-Hispanic Whites but AA produced superior effects for non-Hispanic Whites.
Foster, 2007	Depression	Hispanic women (91)	BDI; CES-D	RCT: CBT vs. Supportive/Exploratory Intervention-both interventions consisted of 16 weekly group sessions.	None	Positive clinical outcomes for depressive symptoms for both CBT and the supportive/exploratory intervention with gains maintained at 4-month follow-up.
Hinton et al., 2011	PTSD	Women (24)	PTSD Checklist; SCL; Nervios Scale; Emotion Regulation Scale.	RCT: Culturally Adapted CBT (CA-CBT) for PTSD vs. Applied Muscle Relaxation (AMR).	Barriers to treatment were identified and modifications were made accordingly; other "culture-specific" changes were made e.g., use of idioms, analogies.	Patients receiving CA-CBT improved significantly more than in the AMR condition.
Burrow-Sánchez & Wrona, 2012	Substance Use Disorders	Latino Adolescents (35)	Timeline Follow Back	RCT: Standard CBT (C-CBT) vs. Culturally Accommodated CBT (A-CBT) delivered in a 12-week group format.	Changes included developing a new module, <i>Ethnic Identity and Adjustment</i> , revising module content for more cultural congruence (e.g., changing hypothetical examples to match situations faced by Latino adolescents), and increasing the amount of contact therapists had with parents.	Similar retention; satisfaction rates; decreases in substance use; however, substance use outcomes were moderated by two cultural variables: ethnic identity and familism.



Table 4. Studies that Examined Treatments with Hispanics vs. Non-Hispanics.

Authors	Disorder	Sample (N)	Outcome Measure	Control Group	Treatment Details	Results
Pina <i>et al.</i> , 2003*	Phobic & Anxiety Disorders	Youth ages 6-16 (131)	Revised Children's Manifest Anxiety Scale	None	Exposure-Based PTSD.	Both groups experienced similar (and significant) treatment gains.
Gallagher <i>et al.</i> , 2008**	Depression & Stress associated with Care-giving (CWC)	Middle-aged and older women (184)	CES-D: Perceived Stress Scale; RMBPC-CB.	Minimal Telephone Based Control Condition.	Small Group Intervention.	Those in the CWC (regardless of ethnicity) showed greater improvement than those in the TSC.

Notes: No cultural modifications were made to these treatment; \* = Data from this study was from 131 youths and their parents who had participated in one of two randomized clinical trials for phobic or anxiety disorders and who had been assigned to the treatment condition; \*\* = Within ethnic group, participants were randomly assigned to either a CBT-based small group intervention program called *Coping with Caring* or to a minimal telephone based control condition (TSC).

Table 5. Studies that Examined CBT with Hispanics.

Authors	Disorder	Sample (N)	Outcome Measure	Control Group	Treatment Details	Modifications Made	Results
Organista <i>et al.</i> , 1994	Depression	Hispanic Outpatients (175)	BDI	None	12 Sessions of Standardized CBT	None	Results from this study showed significant reductions in BDI scores although the authors noted that the reductions were not as substantial as the reductions documented in other (with mostly White samples) studies. Ethnicity did not predict treatment outcome.
Gelman <i>et al.</i> , 2005	Depression	Latinas (5)	BDI	NA	12 session CBT protocol for depression	Not explicitly described-it was specified as "redefined" and "tested for use with Hispanic populations"	Average of 12-point reduction on BDI scores
Aguilera <i>et al.</i> , 2010	Chronic Disease management within the context of depressive symptoms.	Spanish-speakers ranging in age from 37 to 74 (M= 50.5) (14)	CES-D and self-report.	NA	16 Week group treatment comprised of 4 modules: thoughts, activities, people/social, & health that was specifically created for Hispanics	"Simpata" and familism were themes that emerged and that were a focus of the group	Some participants experienced a reduction on the CES-D while improvements were also noted via participants verbal self-report.

*et al.* (2005) specified the treatment as a "...Spanish language intervention is offered at a county general hospital at no cost, making it affordable, available, and accessible to a population that often experiences significant structural barriers in accessing care..." and the "short-term, directive, problem-solving nature of cognitive behavioral principles are considered by many researchers and clinicians to be congruent with alleged Latino cultural expectations that mental health interventions provide concrete and immediate assistance" (p. 3). A review of the sources cited in Gelman *et al.* (2005) led us to the treatment manual (Muñoz, Aguilar, & Guzmán, 2000) which is available in Spanish. However a review of the treatment manual did not reveal a variation from what would be considered standard CBT as the manual content included a treatment plan with interventions that are consistent with CBT principles; cultural-specific or altered forms of CBT were not specifically noted within the manual.

Due to the small sample size and lack of a control group, statistical analyses regarding treatment effectiveness were not available. However, the authors noted substantial clinical improvement with an average reduction of 12-points on the BDI. From this study (with all its methodological limitations) the authors concluded that general CBT principles seem to work effectively with Hispanics who are experiencing depression. However, because it is not clear what was "culturally adapted" (i.e., how this treatment differed from standard CBT) this study does little to lend support to culturally adapted CBT being a well-established, beneficial treatment for use with Hispanics.

Aguilera *et al.* (2010) administered what they judged to be a culturally sensitive manualized CBT group treatment to 14 Latinos who were depressed. From the description of the treatment protocol and associated references it appears to be the same treatment used by Gelman *et al.* (2005) with an additional "health" module that was developed and incorporated into the treatment to address the primary care population that comprised the sample in this study. As described above in the discussion of the Gelman *et al.* (2005) study, it is not clear how this CBT intervention is different from standard, untailed, CBT for depression. Aguilera *et al.* (2010) discussed that during groups the concept of family came up frequently both as a source of stress and as a source of support. Aguilera *et al.* (2010) also indicated that they discussed the concept "simpatía" (defined as sharing in others' feelings while maintaining a dignity and respect toward others) as a highly frequent theme in the group. The authors also indicated that by "integrating simpatía into treatment, we targeted a culturally salient symptom of depression (isolation) by fostering each member's sense of belonging to the group." (p. 862)

Aguilera *et al.* (2010) noted that attendance was inconsistent and homework completion was minimal and that while the CES-D was used to monitor depressive symptoms they suggested it did not always reflect the patients' level of functioning and they cited several examples where this was the case (e.g., patients' verbally self-reported that they were doing better). Nonetheless, participants did experience an average of a 6.5-point decrease on the CES-D over the course of treatment. As with the Gelman *et al.* (2005) study the Aguilera *et al.* (2010) study also had a very small sample size, lacked any control groups, and it was unclear the extent to which treatment was "culturally adapted." While Aguilera and colleagues noted that themes arose that were consistent with traditional Hispanic values, they did not describe whether this came from the

clients or how or if treatment was adapted to accommodate this. Unfortunately given these limitations these results cannot be used to conclude that culturally adapted CBT as a well-established, beneficial treatment for use with Hispanics.

Unlike the studies described above, Hinton *et al.* (2011) did clearly articulate how CBT was culturally adapted (CA-CBT) in their study and they also compared CA-CBT to an alternative treatment (Applied Muscle Relaxation [AMR]) among 24 Latinas who were diagnosed with PTSD. Results from their study indicated that patients receiving group CA-CBT experienced a substantially larger reduction in symptoms than those patients who received group AMR. Hinton and colleagues asserted that CA-CBT is designed to address certain key treatment challenges in minority and refugee populations and includes adaptations of key CBT techniques for these groups. To adapt CBT for use with Latinos, Hinton *et al.* (2011) first identified key treatment barriers (e.g., poor English skills, minimal education, and lack of familiarity with Western psychological concepts) as well as presenting problems (prominent somatic complaints; culturally specific syndromes such as culturally unique idioms of distress and understanding of symptoms) and then developed what they took as appropriate means of addressing these in treatment (e.g., designing treatment to be easily understood by individuals who have little formal education, targeting somatic symptoms in multiple ways, etc.). They also identified key CBT techniques (e.g., modifying catastrophic cognitions about PTSD and anxiety symptoms) that could be adapted for treating this population including adding content that is specific to cultural syndromes, including culture-specific analogies, discussing culturally idioms of distress etc. Results from this study indicated that the CA-CBT group experienced statistically significant greater treatment gains than the AMR group as evidenced by lower anxiety scores on standardized measures (e.g., the PTSD Checklist).

While this study did have a larger sample size than those described above, the sample was still quite small. Most importantly the study had a serious confound in that two different treatments that both types of CBT therapies were utilized (a diverse array of CBT techniques including meditation, modifying catastrophic cognitions, educating about PTSD, positive reframing etc. vs. progressive muscle relaxation). In addition, exposure therapy has been continually documented to be the most effective therapy for PTSD (McLean & Foa, 2011; Institute of Medicine, 2012) and thus using progressive muscle relaxation as a control group raises an important issue.

The culturally adapted therapy also seemed to have more exposure elements than the progressive muscle relaxation control. It is possible that all differences in treatment outcome are due to the differences in the two CBT therapies delivered and not to any cultural adaptation. Applied muscle relaxation might have some general beneficial effects for anxiety (Hazlett-Stevens & Bernstein, 2012), but this technique has not demonstrated large treatment effects for the wide range of problems these authors indicate these clients presented with. Moreover, there were other methodological limitations that restrict the interpretation of these results including lack of blindness, therapeutic allegiance effects, and lack of follow up. Thus the results from this study *may* count towards the establishment of CA-CBT as a well-established, beneficial treatment for PTSD with Hispanics. However it is important to note that exposure therapy is considered to be the

EST of choice for PTSD. Thus it is not clear why CA-CBT was chosen as the explicit intervention for this study.

Burrow-Sánchez and Wrona (2011) investigated the efficacy of an empirically supported standard version of cognitive-behavioral substance abuse treatment (S-CBT) to a culturally accommodated version (A-CBT) with 35 Latino adolescents. The A-CBT was adapted by Burrow-Sánchez, Martínez, Hops, and Wrona (2011) who conducted a qualitative study in which they held a series of focus groups with stakeholders in the Latino community. The data collected during these focus groups were used to guide the integration of cultural variables into an EST (i.e., CBT) for substance abuse treatment. Specifically, they identified themes from the focus groups and developed cultural accommodation practices for each theme. For example, family was identified as a theme and subthemes related to family included parental involvement and support, family dynamics and values, and family risk factors. To address this theme role-plays were created that included relevant family situations and parent-clinician contact was increased. An additional theme that was identified was acculturation and to address this role-plays that were more relevant to Latino adolescents (e.g., the experience of racism) were created. Adolescents were randomly assigned to one of the two 12-week group-based treatment conditions. Results indicated that participants in both conditions experienced significant reductions in substance use after treatment and there was no differential improvement for the culturally adapted intervention. These results lend support to both standard and culturally accommodated CBT being an effective intervention for substance-abusing adolescents. However, these findings do not lend support to culturally accommodated CBT being superior to standard CBT.

#### **SUMMARY & CONCLUSIONS: EST STATUS OF CULTURALLY SENSITIVE CBT**

In this paper we reviewed the literature to try and establish whether or not culturally sensitive/modified (i.e., adapted, tailored etc.) CBT can be deemed as a well-established, beneficial treatment for use with Hispanics. The results of our literature review indicate that despite several decades of research and many theoretical papers emphasizing the need for cultural adaptations/tailoring etc., currently there is not sufficient data to show that culturally modified (i.e., adapted, tailored etc.) CBT merits EST status. In fact it remains unclear whether CBT produces superior outcomes over conventional CBT for Hispanics and there is some evidence that standard untailored CBT produces beneficial outcomes for Hispanics. Via our review of the literature we identified only 12 peer-reviewed manuscripts that investigated CBT with Hispanics. These 12 studies came with many basic methodological limitations and few employed the gold standard practices associated with randomized clinical trials. A number of limitations were noted across the studies we reviewed.

First, there is no consensus regarding what adaptations or modifications are necessary for a therapy to be culturally sensitive for Hispanics. Indeed it has been noted (e.g., by Burrow-Sánchez *et al.*, 2011) that rigorous standards and guidelines for what constitute cultural adaptations and the practices that should be employed are largely absent. This was evident across the 12 studies that we reviewed.

Second, while experts in the domain of cultural sensitivity continue to assert (e.g., Barrera *et al.*, 2013) that psychological therapies must be adapted/modified for cultural minorities, the modifications that are being made are largely on sociological/anthropological assumptions that are based on stereotypes rather than empirical information gained from careful studies of the Hispanic culture(s). Specifically, there is little consensus regarding what regularities about the Hispanic culture must be taken into account in therapy design and how these regularities should be used in the establishment of culturally sensitive interventions. While some experts have attempted to develop a scientifically sound means by which to adapt treatments (e.g., Burrow-Sánchez *et al.*, 2011) the adaptations movement still largely assumes that stereotypical assumptions apply to all Hispanics. This runs somewhat contrary to the APA's (2005) assertion (housed within their definition of evidence based practice of psychology [EBPP]) that psychological practice should include "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences."

Third, the process of acculturation needs to be taken into account and discussed. For example highly acculturated individual may not require a culturally modified intervention. In the studies we reviewed the Hispanic samples that were used were generally treated as fairly homogenous. In fact, little information was given regarding the details of the Hispanic sample studied (i.e., degree of assimilation, immigration status, language competencies, socioeconomic status, Hispanic subgroups). Arguably these characteristics could impact treatment outcome and could be important moderators. The need for a focus on acculturation is consistent with recommendations made by other experts in the field (e.g., Huey, 2014).

Finally, there was variability across the studies reviewed in terms of the study goals and in most instances the goal of the study was vague. The desired outcome of modifying an intervention to increase its cultural appropriateness may be improvements in access, acceptability of the treatment, engagement with the treatment, reduction of symptoms etc. The field needs to clarify with precision the desired outcome of culturally modified/sensitive treatments; this would allow improved assessment of the extant research on culturally modified interventions.

With regard to future directions, we recommend the following. With the APA's push towards culturally sensitive interventions and the issues identified above, it is important that the field work towards ensuring that ethnic minority groups do not suffer iatrogenic effects on account of cultural sensitivity. For example, our review of the literature revealed that standard untailored CBT produces beneficial outcomes for Hispanics. However, the message conveyed within the cultural sensitivity literature is that cultural groups may require culturally modified interventions. With the focus on ESTs in the field of clinical psychology, there needs to be an emphasis on Hispanics receiving ESTs particularly in the absence of evidence that these treatments do not create beneficial outcomes for this group. Thus our first recommendation is that Hispanics be administered CBT when required per EST recommendations as we found some evidence that CBT produces beneficial outcomes for Hispanics.

As discussed above, the adaptations movement still largely assumes that stereotypical assumptions apply to all Hispanics. Our second recommendation is that

clinicians be cautious of assuming that all stereotypes apply to all Hispanics, as this could be insulting or injurious to clients. Our third recommendation is with regard to ensuring that a culturally modified intervention is appropriately administered to clients who need it. Acculturation was not discussed in most of the studies that we reviewed however arguably acculturation would act as a strong determinant for the administration of culturally modified CBT vs. standard CBT (with individuals who are more acculturated being less likely to require culturally modified CBT). Our fourth recommendation is with regard to working with clients who come from multi-cultural backgrounds. With regard to how well therapists handle clients who have multi-cultural backgrounds, we identified a case study on a Gay Latino male who presented with anxiety and panic attacks (Glassgold, 2009). We noted that Glassgold nearly exclusively focused on the issue of the client's minority sexual orientation while largely ignoring the client's ethnic background. Perhaps this was reasonable given the client's presenting problems, but this still reveals the complicated issue of how these cultures relate to one another in a case involving multiple cultural backgrounds. Our final recommendation is that a consensus regarding what adaptations or modifications are necessary for a therapy to be culturally sensitive for Hispanics needs to be reached and with that the ratio of non-empirical to experimental publications needs to change.

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