Cultural Adaptations of

Evidence-Based Interventions

for Latinx Populations

Cultural Adaptations of Evidence-Based Interventions for Latinx Populations is a publication produced by the National Hispanic and Latino Mental Health Technology Transfer Center (National Hispanic and Latino MHTTC). The main goals of the publication are to help educators and supervisors train clinicians to culturally adapt existing evidence-based treatments (EBTs) for the Latinx population they serve; describe an array of cultural adaptation models, frameworks and methods; highlight the benefits and challenges of undertaking cultural adaptations; and provide recommendations and resources to culturally adapt and implement an existing EBT.

National Hispanic and Latino
MHTTC Mental Health Technology Transfer Center Network
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The National Hispanic and Latino MHTTC recognize the complexities associated with gender and ethnic identification. With the intention of both facilitating a fluent reading of the text and supporting an inclusive and respectful language, this document uses terms that are linguistically neutral and inclusive of diverse gender groups and identities. In this document, we also use the term Latinx to encompass ethnic identity as well as non-binary gender identification.

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Institute of Research, Education, and Services in Addiction (IRESA)

The Institute of Research, Education, and Services in Addiction (IRESA) of the Universidad Central del Caribe leads the National Hispanic and Latino MHTTC. The Center serves as a national subject matter expert and a key resource for the workforce and communities seeking to address mental illness prevention, treatment, and recovery support to reduce health care disparities among Hispanic and Latino populations across the United States and its territories. In partnership with state and local governments, mental health providers, consumers and family organizations, Hispanic stakeholders, Substance Abuse Mental Health Services Administration (SAMHSA) regional administrators, and the MHTTC Network, the Center seeks to accelerate the adoption and implementation of mental health-related evidence-based practices.

National Hispanic and Latino Mental Health Technology Transfer Center

The mission of the National Hispanic and Latino Mental Health Technology Transfer Center is to provide high-quality training and technical assistance to improve the capacity of the workforce serving Hispanic and Latino communities in behavioral health prevention, treatment, and recovery. We disseminate and support the implementation of evidence-based and promising practices to enhance service delivery, promote the growth of a diverse, culturally competent workforce, and bridge access to quality behavioral health services. We are committed to increasing health equity and access to adequate culturally and linguistically grounded approaches.

The School-Based Mental Health Project (SMH)

The School-Based Mental Health Project (SMH) of the National Hispanic and Latino MHTTC works specifically with schools, organizations, and professionals to strengthen their capacity to provide culturally and linguistically responsive school mental health services. This initiative facilitates training, technical assistance, and capacity-building efforts led by experts in the field. Our goal is to increase awareness to attend to Latino students' mental health needs, promote the implementation of school mental health services that are culturally appropriate, encourage the use of promising and evidence-based practices, and disseminate information on practical strategies and implementation efforts of mental health services within a cultural context.

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Introduction

In order to help overcome utilization barriers among US Latinxs, there is an urgent need for mental health treatment intervention programs that are congruent with this community's culture-related values, views, and behaviors. While many Evidence-Based Treatments (EBTs) address mental health illness (Substance Abuse and Mental Health Services Administration, 2017), few take into account the specific lived experience of Latinxs. Moreover, EBTs developed for one Latinx group may not generalize to other Latinx groups of varied national origins, geographies (e.g., rural/urban), historical characteristics (e.g., immigrant/non-immigrant or refugee), religious affiliations, and socioeconomic backgrounds. Unfortunately, disparities in mental health status and in treatment access and quality continue to afflict Latinx populations. Research has documented low levels of initial engagement into services and lower rates of completion of recommended treatments (Alegría et al., 2016). One study of non-citizen Latinxs reported that only 32% of Latinxs with a psychiatric disorder in the past 12 months received services (Lee et al., 2014). Underutilization of needed services can increase disease burden among Latinxs (Alegría et al., 2016). Culturally adapting EBTs that are not designed for Latinx populations may help increase service utilization and improve treatment outcomes. This toolkit describes cultural adaptations, how to implement them, and their potential impact. It is geared to professionals engaged in training and educating behavioral health care providers.

What is Cultural Adaptation?

Cultural adaptations are systematic changes to existing treatment processes or protocols that incorporate the values, beliefs, assumptions, and language(s) of the culture or group in order to make the treatments more accessible, relevant, and effective (Bernal et al., 2009; Bernal & Domenech Rodríguez, 2012). Professional guidelines consider the best treatment to be one that reflects the client's needs and expectations within their cultural context (American Psychological Association [APA], 2006). Culture refers to systems of knowledge, concepts, values, norms, and practices that are learned and transmitted across generations and that are continually recreated and reshaped by individuals and groups (American Psychiatric Association, 2013; Betancourt & Lopez, 1993). Culture includes language, religion and spirituality, family structures, life-cycle stages, ceremonial rituals, customs, ways of understanding health and illness, as well as moral, political, economic, and legal systems. Cultures are open, dynamic systems that undergo continuous change over time; in the contemporary world, most individuals and groups are exposed to multiple cultures, which they use to shape their own identities and make sense of experience.

Cultural adaptations generally refer to the modification made to a treatment manual and/or intervention processes whereas cultural competence refers to the characteristics of the clinician and health care system that lead to improved accessibility, relevance, and effectiveness of treatment across cultures and that are not tied to a specific therapeutic modality. For individual providers, cultural competence has been conceptualized as a life-long process (Cross et al., 1989) of learning about the self in a cultural context, building knowledge about others' cultures, and developing skills to work effectively with diverse people (Sue, 1998). While the definitions of cultural competence can vary, this "tripartite model" of self-awareness, knowledge of others, and skill is a key element of most definitions (Tehee et al., 2020). Although cultural competence is an older concept than cultural adaptation, empirical research on cultural adaptations has become a cornerstone of the evidence in favor of cultural competence (Soto et al., 2019).

Culturally Adaptation: Models and Impact on Treatment

There are several models and frameworks of cultural adaptation that were reviewed by Domenech Rodríguez and Bernal (2012b). Newer models can also be found in the literature (Barrera et al., 2017). While there are many models that overlap substantially, there are two that are most often cited, the Ecological Validity Framework (Bernal et al., 1995) and Resnicow and colleagues' (2000) Cultural Sensitivity Framework.

The Ecological Validity Framework (Bernal et al. 1995) attends to eight areas for cultural adaptation of a treatment: language, metaphors, goals, concepts, persons, content, context, and methods (Bernal et al., 1995; Bernal & Saez-Santiago, 2006). These areas cover provider, client, and cultural characteristics. For example, cultural adaptations to content might be evidenced in the incorporation of the unique social, political, and historical context of the cultural group into the treatment protocol. Cultural adaptations to goals are framed within the client's cultural worldview. A meta-analysis of cultural adaptations guided by the Ecological Validity Framework examined the relative contribution of the eight adaptation areas and found that adaptations for language, metaphors, goals, and methods showed specific gains in outcomes compared to treatments without these adaptations (Soto et al., 2019). Trials that reported a more comprehensive set of cultural adaptations were more efficacious than programs with fewer cultural adaptations (Soto et al., 2019).

Resnicow and colleagues' (2000) Cultural Sensitivity Framework offers two broad categories of adaptation: surface and deep. Surface adaptations attend to fit with cultural characteristics that are easily observed but not necessarily substantive (e.g., reference to music, food, locations) to mental health outcomes. Deep adaptations incorporate contextual factors known to influence the mental health outcome. A recent meta-analysis examined the impact of surface and deep adaptations of cognitive-behavioral interventions for depression in Latinx populations and found that deep adaptations result in better outcomes when compared to surface or no adaptations (Escobar & Gorey, 2018).

There is a large number of meta-analyses of cultural adaptations that clinicians and educators may find relevant when considering the fit of an EBT with a population (e.g., low-income immigrant Latinxs) and context (e.g., treatments for anxiety). Generally, these meta-analyses document improved efficacy for culturally adapting treatments. See Appendix A for a list of meta-analyses.

Moving Forward with Cultural Adaptations

A number of treatment interventions have been culturally adapted in research contexts based on cultural adaptation models or frameworks and following a systematic process of data collection, testing, and manualization. These are formal cultural adaptations. Several of these culturally adapted treatments will be described in this toolkit. However, individual providers or clinical programs can also use the models described in the previous section to conduct informal cultural adaptations for their clients based on their own cultural competence. This informal process is desirable when there is no formally adapted treatment that fits the client's characteristics or clinical picture or when the provider or program is unable to access existing formal cultural adaptations. Even when clinicians follow cultural adaptation models or frameworks and use their best cultural competence skills to make changes to treatments, treatment decisions can be challenging. To illustrate the process of selecting among formal cultural adaptations or developing informal adaptations, we present a case vignette with multiple avenues for cultural adaptation. In each avenue, the treatment is culturally adapted based on client context and preferences.

Case Vignette

Carlos Ramírez is a 45-year-old man. He is a married Spanish-monolingual father of two children, who is currently unemployed. His wife of 13 years, María de los Angeles (40 years old), and their two children, Antonio (15 years old) and Ramón (17 years old) migrated from their country of origin six years ago (all names are pseudonyms).

On one particular evening, Carlos and his spouse had an argument over the fact that she did not return several of his phone calls while she was at work. María de los Angeles is not allowed personal calls at work and Carlos knows this. She reported that when Carlos returned home from work, he became angry and intimidating towards her. He had been drinking and appeared intoxicated. Carlos became increasingly verbally belligerent and menacing. Ultimately, Carlos left the home when María de los Angeles threatened to call 911 as she feared for her and her son's safety. She ultimately did not call because the family is undocumented and she feared negative repercussions for the family. She instead called a relative who told her "sé una buena mujer y haz lo que diga tu esposo" (be a good wife and do what your husband tells you to do). Antonio witnessed the altercation. Ramón, the older sibling, was not home at the time of the incident. The following day, María de los Angeles told her husband that if he did not seek help, she and the children would leave him.

Carlos begrudgingly agreed to attend the intake evaluation at a local community mental health agency. Both, Carlos and María de los Angeles attended. The couple reported that they enjoyed their life in their home country, but that they were motivated to migrate to secure better opportunities for their children. They had heard many great things about life in the United States and decided to "poner nuestra fe en Dios" (place our faith in God). They reported that in some ways they see the advantages of living in the United States, but that it was not like what they had thought or heard about from other people: "la vida aquí puede ser muy dura" (life here can be very hard) and at least over there "es nuestra tierra" (it's our country). Carlos stated that his main reason for presenting to the evaluation was the fear that his wife would leave him. He also was concerned that she may call the police. He reported that the police "nos tratan como criminales" (treat us like criminals).

María de los Angeles had the idea to migrate to the United States, but it was Carlos who made the final decision and executed the plan. The family arrived in New York with tourist visas and from there moved to Florida. Carlos got a job as a mechanic and lost it last year when the shop closed. During the period Carlos was employed, María de los Angeles stayed home and cared for the children. The family relocated to Connecticut because María had a cousin "de confianza" (trusted) who could help them get jobs. Soon after arriving, María de los Angeles was hired at a grocery store. Carlos continued to struggle to find a job. He felt that his wife's employment interfered with her responsibilities at home and he was uncomfortable with the new friendships she was making at work. He also blamed his wife for the family's migration and for their current financial and legal situation.

In interviewing María de los Angeles separately with her and Carlos' consent, it seems that Carlos has always had a temper, been controlling, and drunk excessively at times, but that it has become much worse since moving to the United States. However, this "problema de los nervios" (mental health issue, literally "problem with his nerves") started about 20 years ago, when Carlos witnessed the murder of his best friend by a local gang, and almost lost his life in that same incident. She stated that from that point forward, he became increasingly irritable and hostile. He also started to mistrust others and to suffer from nightmares, which disrupted his sleep significantly. Since his friend's murder, Carlos has avoided talking about what happened or seeing many of his friends from those years. María de los Angeles stated that he did see a doctor who prescribed a medication, but that he refused to take it, stating "eso es para gente débil" (that is for weak people). From her description, he was known as "muy fuerte" (very strong) by his friends and neighbors, and thus well respected, just like his father. Carlos was employed as a mechanic in his home country and made all the decisions for the family.

María de los Angeles reports that she likes her job, as she finds that she can be herself and have a purpose outside of the family. She also feels empowered because she can contribute financially to the household. She reports taking great pride in being a mom, and much like her own mother and grandmother she is considered to be at times "difícil y terca (difficult and stubborn) because she pursues activities that are not necessarily accepted by some in her family, including her husband.

Carlos was raised in a large close-knit family that included both his parents and maternal grandparents under one roof. He is the eldest of six siblings, two of them male. His father and grandfather are described as hard-working men with bad tempers who drank excessively, but who were also "buenos proveedores" (good providers). Carlos described his mother as a good-natured and soft-spoken woman who loves her children and her home, and who "sabe su puesto como mujer" (knows her place as a woman). Both parents are alive and reside in their country of origin. Carlos' siblings also live near their parents and are said to be similar in character to him. When asked about his family, Carlos stated that they are important to him. While employed, he was able to send money to help support his elderly parents. Carlos has not been able to do so since he lost his job, which is contributing to increasing feelings of frustration and anger. He also mentioned that he misses his family in his home country, and though he has thought about returning there, he has decided not to, for fear of being seen as "un fracasado" (a failure).

Carlos attended school but dropped out in the 8th grade. He went on to work with one of his uncles in a garage fixing cars. He did well at work, learned how to be a good mechanic, and took pride in his work. He also got along well with his co-workers and friends (all men) and reportedly would go out drinking with them at the end of the day. On those occasions, he would drink in excess and would not return home until late at night.

The couple's children have had a difficult time adjusting to life in the United States. They both attend school and have displayed behavioral and academic problems, such as fighting with peers, talking loudly in the classroom, being defiant, and failing to turn in assigned classwork. As a result of these incidents, disciplinary actions have taken place at school, including detention and visits to the principal's office. As the difficulties have persisted, both children were referred to the school counselor who has contacted the parents for a meeting. This is a source of embarrassment for the parents, who feel intimidated about meeting with school officials. Antonio, the youngest, has expressed a strong desire to return and be with the rest of their family (especially his "abuelitos" [grandparents]) and friends back home. Ever since witnessing the altercation between his parents, Antonio rarely leaves his room and will not speak to his father. He told his mother that he felt embarrassed and guilty for not protecting her. In turn, Ramón is angry at his mother for spending time outside the house and often speaks out in favor of his father. The family attends church services regularly, but the eldest now refuses to attend.

conversation, he would benefit from counseling, Carlos became upset and stated "yo no estoy loco" (I'm not crazy). The intake coordinator concluded the intake session by explaining the focus on assessment in this initial session and encouraging them to return to discuss possible treatment alternatives and to begin the therapy. Carlos hesitantly agreed.

Course of Treatment in the Context of Culture

Cultural beliefs, values, and practices can heavily inform the kinds of treatments that would be appropriate for this family. Cultural notions of wellness and distress can influence clients' perspectives about who is the client, what is the problem, and what it would mean to be healed. This section covers the value of culturally relevant assessment, followed by potential treatment approaches for the Ramírez family and possible cultural adaptations to those interventions.

It is important to be aware that our choices as providers are influenced by our own cultural (including disciplinary) views, values, and practices, as well as the cultural perspectives of the client(s). The psychotherapy space holds the culture of the client and the clinician. Sue et al. (1998) emphasized the importance of clinicians becoming aware of their own assumptions, values, and biases, and of understanding and appreciating the client's cultural makeup. The development of self-awareness is an ongoing commitment the clinician makes to professional development, involving self-reflection, critical analysis, readings, and immersion in one's own community (Bridges & Dueweke, 2020; Ratts et al., 2016). This process also fosters a desire to advocate and learn about our clients beyond their clinical presentation, including the legacy of oppression and discrimination (Adames et al., 2020; Comas-Díaz & Torres Rivera, 2020).

Assessment

In beginning any intervention, a culturally responsive assessment is integral to laying the foundation for culturally appropriate and integrated work. A culturally informed interview can provide essential information for selecting or developing a culturally adapted intervention.

Culturally Informed Interview Methods

It is important to utilize interview methods that recognize the complexity of Latinx clients' cultural backgrounds, including their experience as immigrants or native-born U.S. citizens. From a practical standpoint, a tool that can be used to gain a better understanding of the significance of culture and the intersecting forces that can impact upon a client's clinical presentation is the Cultural Formulation Interview (CFI; American Psychiatric Association, 2013). This personalized 16-question semi-structured interview protocol provides a guide for clinicians to engage in an individualized assessment that relies on the person's (and family's if desired) own understanding of their cultural experience, thereby avoiding preconceptions or stereotypic notions about their race/ethnicity or country of origin (Lewis-Fernández et al., 2016). The core components of a cultural formulation approach are: (a) cultural identity of the individual; (b) cultural conceptualizations of distress; (c) psychosocial stressors and cultural features of vulnerability and resilience; (d) cultural features of the relationship between the individual and the clinician; and (e) overall cultural assessment (American Psychiatric Association, 2013). The CFI is often useful during the initial evaluation of a client or family, but it can be conducted at any point in care.

Another psychosocial interview that can help shed light on factors that play a significant role in the lives of Latinx immigrants follows the acronym CAMINO (Silva et al., 2017), which denotes a path or journey in Spanish. This interview offers practical guidelines for assessing aspects of the immigrant experience that may not be readily elicited in a standard clinical interview. Specifically, CAMINO prompts the clinician to ask recommended questions on community and family supports (C), acculturative stress (A), migration history (M), idioms of distress and resilience (I), native language and preferences (N), and origin (O). This assessment is not meant to be diagnostic but to complement and enhance information gathered as part of the clinical intake process.

Once a holistic assessment has been conducted with particular attention to the aspects that help place Carlos, María de los Angeles, and their children in an appropriate cultural context, the next step is to select a psychotherapeutic intervention that takes into account not only the psychosocial, clinical, sociodemographic, structural, and attitudinal elements that constitute the lived experiences of the client(s) but also culture-related aspects of all these elements. Most providers are trained in one or two EBTs and they must always ask themselves whether that approach can be helpful to the clients and their situation. A second important question is whether the adaptations made to that specific EBT sufficiently address the client's needs in the context of their culture. This, coupled with clinician awareness of the presence, attributed meaning, and expression of culturally patterned values and beliefs the client may possess, has the potential to positively influence engagement and eventual outcomes (Añez et al., 2008; Falgas-Bague et al., 2019).

Clinical Interventions to Consider

There are potentially many different therapeutic approaches that a clinician can use to help the Ramírez family. The framework and approach that is selected will depend on several factors, including the provider's previous training, philosophy of change, the fit of the treatment to the presenting problems, and client preferences. It will also depend on which individual, couple's, or family issues/processes are deemed to be most proximal to the presenting complaints and the best place in which to intervene to help the family. In selecting a treatment, the provider must understand how the culture-related beliefs, worldview, and lived experiences impact each process and consider how different treatment options can address the cultural aspects.

After the assessment, a clinician might consider the following questions when selecting a treatment, finding out whether there are culturally adapted versions of that treatment, and considering whether it is necessary to further culturally adapt the treatment for Carlos, María de los Angeles, and their two children:

1) What role do early experiences, migration history, family dynamics, cultural patterns of expressing distress, and adherence to specific values play in the presenting symptoms (e.g., exacerbating or buffering the stressors and reactions)?
2) Given the long-standing mental health and substance use issues that have emerged from the assessment, what psychotherapeutic modalities would be clinically indicated for Carlos and the rest of the family?
3) What short and long-term interventions would best serve the family?
4) How will progress in the treatment goals be measured?
5) What criteria (e.g., need for community-based supports) will be used to assess readiness to conclude the treatment?

The following sections will highlight the rationale for a variety of psychotherapeutic modalities that may be of benefit to the Ramírez family. These include: (a) individual; (b) pharmacological; (c) couple's and family; and (d) parenting and child development.

Individual Interventions

Based on the information gathered during the assessment, it appears that Carlos may benefit from engaging in individual therapy with a culturally responsive provider. Given the history of excessive drinking, anger, and hostility towards others, and symptoms that may be consistent with a diagnosis of Posttraumatic Stress Disorder (PTSD), there are multiple individual psychotherapeutic interventions that may be clinically indicated for Carlos. Additionally, Carlos is experiencing a variety of psychosocial stressors that may be linked to his status as an undocumented immigrant. A provider's ability to link these complex issues into a cohesive narrative is paramount in helping Carlos achieve a renewed sense of balance in his life and begin to improve the quality of his interpersonal relationships. What follows is a rationale as to the reasons for considering Motivational Interviewing and Cognitive-Behavioral Therapy as key individual interventions. Some of the other therapies that may be useful in Carlos' situation and are amenable to cultural adaptation include Interpersonal Psychotherapy, Solution-Focused Therapy, and Problem-Solving Therapy. See Appendix B for these resources.

Cultural Adaptation of Motivational Interviewing

A foundational aspect of any psychotherapeutic intervention essential to treatment outcome is the therapeutic alliance (Bernal et al., 1998). In establishing a strong alliance, the clinician should consider what strategies are necessary to effectively engage the client, being cognizant that individual preferences and subjective experiences play a role in the development of culturally congruent services. One therapeutic intervention that can offer support in working with clients who, like Carlos, are ambivalent about participating in treatment is Motivational Interviewing (MI), a collaborative conversation style for strengthening a person's own motivation and commitment to change (Miller & Rollnick, 2013). Specifically, culturally adapted MI has been found efficacious in reducing drinking behavior among men of Latinx descent (Lee at al., 2013; Valdez et al., 2018) and in enhancing adherence and retention in antidepressant therapy among depressed Latinx outpatients (Interian et al., 2013; Lewis-Fernández et al., 2013).

In thinking about how to culturally adapt MI to best serve Carlos, conceptualizing his case through a social-contextual lens can provide a good starting point. According to Lee at al. (2011) "social contextual factors [can] include: historical and political experiences around immigration, contexts of migration, receptivity of the host community, the language barrier, and discrimination" (p. 318). As such, areas to consider and explore with Carlos are the social-contextual influences that may play a prominent role in his life and how these are interconnected with the struggles he is experiencing in his relationship with his wife and children, his unemployment, loss of social support, and drinking behavior (Singer, 1992). In an effort to enhance and foster engagement, it is equally important to "gain awareness into the presence, attributed meaning, and expression of culture-specific values and beliefs" (Añez et al., 2008, p. 154) that may also be important to Carlos. Motivational Interviewing is uniquely designed to value and elicit a client's own values and motivations to change.

Carlos expressed intense ambivalence about engaging in the therapeutic process. From an MI perspective, assessing for adherence to culturally patterned values and views can enhance the therapeutic alliance and the person's intrinsic motivation to change. As such, the appropriate use of the relational (MI spirit) and technical elements (open questions, affirmations, reflections, and summary statements) of MI can go a long way in developing the necessary therapeutic relationship

that will allow for a deeper exploration into the concerns that have been articulated at intake (Paris & Martino, 2018). From a relational standpoint, the MI spirit consists of four interconnected elements:

- Collaboration (two individuals working together towards a common goal);
- Acceptance (viewing the client's situation non-judgmentally and empathically);
- Compassion (working in the best interest of the client); and
- Evocation (strengthening motivation for change) (Atkinson & Earnshaw, 2020).

These interconnected elements can provide a relational foundation during the cultural adaptation process to address Carlos's acculturative conflicts that have led to role reversal, feelings of isolation, and difficulty in communicating effectively with family members.

Cultural Adaptation of Cognitive-Behavioral Therapy

There is evidence to suggest that Carlos may be experiencing a co-occurring Alcohol Use Disorder (AUD) and PTSD. Cognitive-Behavioral Therapy (CBT) is an intervention that has demonstrated success in the treatment of both PTSD and AUD (Beck, 2013). In terms of its affinity to cultural adaptation, Rathod et al. (2018) conducted a review of meta-analyses and concluded that CBT was the psychotherapy that had been most frequently culturally adapted. Other recent meta-analyses and systematic reviews have found culturally adapted CBT interventions to be more effective than non-adapted interventions for Latinx communities (Escobar & Gorey, 2018; Nelson et al., 2020; Pineros-Leano et al., 2017). This treatment approach is time limited, evidence-based, cost-effective, tailored to the individual's needs, and focused (Naeem et al., 2019). These same authors provided guidance on how CBT can be culturally adapted by attending to: (a) awareness of cultural knowledge (e.g., culture, religion, spirituality, language); (b) assessment of the client's beliefs (e.g., interpretation of cognitive errors and dysfunctional views); (c) effective engagement strategies (e.g., use of MI); and (d) adjustment to the therapy process (e.g., use of stories and sayings (dichos), therapy style, use of homework, explanation of the cognitive model, selection of therapy techniques) (Naeem et al., 2019).

Organista (2019) provides additional guidance on how to adapt CBT for Latinx communities, including: (a) use a traditional Latinx relationship protocol to engage clients; (b) engage in pretherapy orientation; and (c) recognize and address the values underlying CBT as well as traditional Latinx culture. In the case of Carlos, the primary focus is to help identify, evaluate, and reframe some of the core beliefs and automatic thoughts that may be interfering with his ability to lead a self-actualized life. As CBT is culturally adapted to support Carlos in processing his thoughts, it is important to frame these in the context of the cultural values he may adhere to and his unique lived experiences (e.g., migration history, acculturative stressors). For additional CBT resources, see Appendix C.

Benefits of Individual Therapy

- Allows for exploration of the client's cultural beliefs and values (norms, practices, worldview)
- Allows for an understanding of emotions and response style (behavior and methods of coping)
- Confidentiality can be easily maintained
- The 1:1 nature of the clinical encounter allows the clinician to focus exclusively on the client's concerns and the client receives specific feedback in return
- Ease of assessment of the client's presenting concerns
- May ease establishing a working alliance
- The pace of treatment can be adjusted based on the level of engagement and needs of the client
- Helps the client establish healthy boundaries
- Helps to empower the client
- Helps the client work on a variety of coping skills that can positively impact relationships, including communication skills, problem-solving skills, and anger management
- Skills can be tailored to the specific presenting concerns of the client
- Provides space for vulnerability from the beginning
- Provides a space for the client to quickly become comfortable with treatment
- Accessibility to the provider
- Client-centered experience and treatment goals target self-growth
- Client has the power to decide who can join the treatment
- Client expands their support network
- Easy to schedule

Disadvantages of Individual Therapy

- Can be expensive
- It may be difficult to move forward if a therapeutic alliance is not established – might mean having to see various clinicians before finding someone
- It may not lend itself well to addressing dysfunctional family/relationship dynamics
- Can limit the client's ability to practice establishing healthy relationships and boundaries with others
- Might prompt the client to feel pressured to have an agenda in order to benefit from treatment
- The client may feel uncomfortable being the focal point of the conversation
- May not work well if the client is not committed to the therapeutic process
- Client may feel uncomfortable sharing their experience for a variety of reasons, including fear of deportation, privacy concerns, and distrust resulting from a history of xenophobia in the U.S.

Combining Motivational Interviewing and Cognitive-Behavioral Therapy

Based on Carlos' initial presentation, a combination of MI and CBT may work well in his case. Since Carlos is presenting with substantial ambivalence, MI can be a useful strategy to facilitate engagement. The clinician should engage Carlos in a culturally responsive manner, considering the social determinants and aspects of his cultural background that have ultimately brought him to the clinic. CBT may prove effective in navigating the way Carlos's cognitions contribute to his emotional and behavioral reactions (Naar & Safren, 2017).

Cultural Adaptation of Individual Therapy Elements

The cultural adaptation of individual psychotherapy that is implemented with this client should incorporate attention to values that are often present in culturally traditional men (Añez et al., 2005; Bridges & Dueweke, 2020; Nuñez et al., 2016; Organista, 2019), such as:

- gender roles that value the function of the man as provider and head of household, which often come into conflict with contemporary United States mainstream society ideas of gender equality;
- notions of respeto (respect) that emphasize the inherent deference due to individuals in social contexts, including appropriate use of the formal pronoun when speaking in Spanish, and the transition to the familiar pronoun to signal a deepening of intimacy. Respect may be breached (falta de respeto) by interpersonal exchanges that are considered inappropriate or offensive by the aggrieved party, including unintentional slights, leading to a deep sense of umbrage and possible relational ruptures;
- the importance of personalismo (priority given to personal over institutional connections, even in professional relationships) that often depends on expressions of warmth and caring from providers; and
- the function of familismo (family orientation emphasizing the well-being of the collective over that of the individual) given Carlos' commitment to providing financial support to his elderly parents.

Pharmacological Interventions

In addition to individual psychotherapy, pharmacological intervention may be helpful in helping to improve Carlos' symptoms. He might benefit from pharmacological treatment, in particular for his symptoms of PTSD. If medications are being considered as a supplement to CBT or Interpersonal Psychotherapy for PTSD to reduce symptom burden and augment the effect of psychosocial treatments, selective serotonin reuptake inhibitors are the usual first choice.

Benefits of Psychopharmacology	Disadvantages of Psychopharmacology
• Enhancing the symptom-reducing effects of psychotherapy • Emphasizing the serious nature of the condition, as represented by the need for medications	• May increase the perceived stigma attached to treatment • Risk of disempowering patients from attempting the psychosocial changes that emerge in psychotherapy due to hopes for a “magic cure” from medications • May heighten the client’s ambivalence about clinical care • Possible adverse effects from medications

Cultural Adaptation of Pharmacotherapy Elements

The limited literature on the systematic cultural adaptations of pharmacotherapy with Latinx individuals (Vargas et al. 2015) suggests the following elements are important:

- Addressing the typically strong ambivalence about taking psychiatric medications among Latinx individuals and families given concerns about stigma, side effects, and dependence/addiction. If unaddressed, these may lead to intermittent use, reduced dosing, and/or premature discontinuation.
- Framing the patient’s desire to “poner de mi parte” (putting forth effort) as a reason forparticipating actively in pharmacotherapy, including by monitoring adherence and positiveand adverse effects.
- Managing the treatment to enlist the patient’s participation in decision-making aroundfrequency and dosing of medications.
- Distinguishing between Latinxs’ concerns about dependence and addiction to medications. Dependence refers to the need to rely on the medication in order to carry out daily tasks,which if overused may lead to atrophy of internal volition or ability. Addiction, on theother hand, refers to physical cravings for the medication, which are considered moreintrinsic to the compound and less amenable to personal control. Both types of concernshould be monitored and addressed to avoid escalation leading to disengagement.

Couple and Family Interventions

There are a number of symptoms, life experiences, and stressors that are specific to Carlos and that can be treated by individual treatments and/or pharmacology as shown above. There are also significant relational issues that have emerged in the couple and in the larger family that include the children. It is always difficult to know whether relationship issues existed before the individual symptoms and contributed to their emergence and maintenance, or whether the relational issues are simply a consequence of Carlos’ symptoms and difficulties. Regardless of the timeline, some providers may choose a circular explanation for the difficulties and a more systemic approach to positively impacting the presenting complaints.

A provider may consider that a therapy approach focusing on the couple is most appropriate or impactful given what we know about the presenting situation and the provider’s desire to work directly on the couple’s relationship and not only through Carlos. The family reports:

- Conflict regarding María de los Angeles’ employment, new friends, and extra-family activities;
- Controlling behavior and aggression by Carlos that intimidates María de los Angeles and that may be precursors to domestic violence; and
- That a separation or divorce may be looming.

Evidence-based Couple’s Therapy

To select couple’s therapy in this case does not imply that the couple’s relationship is more important or salient than the symptoms Carlos is displaying such as aggression, controlling behavior, avoidance, substance use, and low mood. Couple’s therapy works under the assumption that the stress in the couple’s relationship (and the protective factors that are being weakened by the conflict) are contributing significantly to both partners’ emotional suffering and specifically to Carlos’ behaviors and symptoms. Carlos’ controlling and aggressive behaviors are potential precursors to domestic violence and may emerge in the relationship with María de los Angeles. For this reason, the couple’s relationship and the way Carlos attempts to control it, can become a possible target of intervention. Couple’s therapy can also help María de los Angeles to express her distress in response to these behaviors. By addressing the stress and emotional injuries, and by mobilizing the positive factors in the couple, the symptoms may be significantly improved. Strictly speaking, the “client” becomes the couple and not Carlos as an individual.

Behavioral Couple’s Therapy is perhaps the couple’s therapy with the most empirical support (Snyder & Halford, 2012) and a more recent version called Integrative Behavioral Couple’s Therapy (IBCT) has worked on enhancing the traditional approach (Christenson & Doss, 2017).
IBCT uses the acronym DEEP to represent work on: (a) Differences between partners in personality, interests, and goals; (b) Emotional sensitivities or vulnerabilities; (c) External circumstances such as that may highlight or exacerbate existing issues in the couple, and (d) Pattern of Interaction that may be maladaptive and rigid when couples are distressed.

Consideration of a More Inclusive Therapy Involving the Family System

A clinician may further consider that a family systems approach that brings to treatment more family members than just the partner/couple is beneficial because they can see how different family members are impacted by the situation. The provider may value the ability to work directly on all family relationship issues (e.g., ruptured relationships, loss of hope, disrupted parenting) and not only through Carlos or the couple. The difficulties reported at school and the involvement of the school counselor suggest that the family difficulties may be contributing to the adolescents’ behavior problems. It is possible that the adolescents are negatively impacted by the father’s symptoms and the couple’s conflicts to an extent that they cannot be put aside or that they themselves contribute in some way to maintaining the maladaptive family processes. By addressing the interactions between all the family members simultaneously, the problem dynamics may be modified more completely and efficiently. A decision that must continue to be made is whether the family system changes that are made are impacting the major symptoms or whether a major presenting problem (e.g., Carlos’

drinking) requires a more focused treatment approach (e.g., specific to a drinking problem in an adult). When working with families, the entire family system becomes the "client". This is a broader perspective than one that focuses on either Carlos or the couple as the clients. The family in our vignette reports that:

- The adolescents are feeling conflicted about loyalty commitments and are taking opposite sides in the argument (one defending the father and one defending the mother);
- Antonio is feeling pressure to jump in to defend his mother, which would be a dangerous development, especially when alcohol is involved;
- At least one of the adolescents is feeling a sense of loss and a desire to return to their home country;
- Both adolescents are coping with the worry that the parents may separate or divorce, also raising a lot of anxiety; and
- Difficulties have emerged at school, prompting a counselor to contact the parents.

Evidence-based Family Therapy

Multidimensional Family Therapy (MDFT) is one of the best-known and empirically established interventions that include adults and adolescent clients (Liddle, 2016). Although the focus is often primarily on adolescent symptoms, MDFT addresses symptoms in all family members and, most importantly, on the underlying family interactions that impact multiple symptoms.

MDFT is a multicomponent therapy that provides individual work with adolescents and adults (e.g., establishing goals, improving parenting, strengthening self-esteem) and family work (e.g., improving communication, repairing ruptured relationships). The focus is on changing family processes that can either trigger and maintain symptoms or on enhancing family processes that promote well-being.

Benefits of Systemic (Couple's and Family) Therapy

- Facilitates the detection of systemic/ contextual triggers (e.g.,discrimination, racism) for the presenting symptoms
- Allows enhancement of contextual protective and resiliency factors (e.g.,familism, religiosity) that can buffer individuals from stressors
- Can help identify family-level values and worldviews that impact distress in one member
- Can enhance family member acceptance and validation of the struggling individual client
- Having family in the therapy room facilitates a more complete evaluation of the conflict and negativity at home
- Provider can work DIRECTLY and "in-vivo" on communication, conflict, relationships, and boundaries
- Having multiple members in treatment makes it easier to see distortions by one family member
- Can assess negative impact of one person's behavior on children and other family members and mitigate the impact

Disadvantages of Systemic (Couple's and Family) Therapy

- It takes considerable training to effectively handle negativity and conflictthat emerge in the therapy room
- It is difficult to juggle therapeutic alliances with multiple family members
- It is more difficult to give 1:1 time to focus on an individual family member's concerns
- Some very sensitive feelings or thoughts might not be expressed in front of other family members
- Engagement and scheduling of multiple family members, some of whom may be reluctant to attend, is a complex task
- Confidentiality can be more difficult to maintain
- It may be more difficult to select a client agenda that will guide treatment
- It may be more challenging to explain why couple's or family therapy is optimal for a problem presented as an individual's problem

If the clinician decides that a couple's or family approach would be most appropriate, it is important to assess the fit between this model and the expectations and preferences of the clients. It is always important for clients to "buy into" the assumptions regarding how the therapy process will have a beneficial impact. This is a key aspect of developing a strong therapeutic alliance.

The provider will have the challenge of presenting the case for why couple's therapy or family therapy might be most beneficial, validating any concerns the family members have about letting an outsider "intrude" into an intimate couple or family relationship issues.

Cultural Adaptation of Systemic Therapy Elements

Latinx families typically have a strong tradition of familism. Familism is a reliance on and support for family members, including extended family, and a commitment to family goals over individual goals. For families such as the Ramírez, there are also "transnational" issues with family left behind in their country of origin. For these and other reasons, couple's or family therapy may be relevant, acceptable, and a good fit with their expectations and worldviews.

In order to work effectively with a Latinx couple or family, the provider should have the basic skills enabling them to do the following (Celano & Kaslow, 2000):

- Recognize the effects of the clinician's own culture;
- Acknowledge that family therapies and techniques reflect the culture within which theywere developed;
- Attend to the dynamic interplay of the cultural influences that affect the individual's andfamily's functioning; and
- Devise and implement problem-resolution strategies that are culturally acceptable.

In addition, a couple's or family psychotherapy approach can consider research on the following cultural constructs:

- Traditional gender roles (often glossed as machismo and marianismo) and how these can continue to exert a strong influence on relational dynamics even among couples acculturated to U.S. society (Skogrand et al, 2008; Miville & Constantine 2006);
- Power differentials in the family that emerge when Latina women acquire more job opportunities (Maciel et al., 2009), especially when Latino men have more difficulty inserting themselves in a post-industrial service economy (Singer, 1992);
- How non-egalitarian relationships that may create a blueprint for the couple's relationship and struggles in a new society may challenge the clinician's own values (Orengo-Aguayo, 2015); and
- Issues of cultural diversity and social justice that impact Latinx families: Falicov's Latino Families in Therapy (2014) and her Multidimensional Ecological Comparative Approach offer extraordinary insights into both the cultural diversity and the social justice aspects of Latinx families.

In couple's work with the Ramírez family, a provider might choose to focus on culture-related views, assumptions, and patterns of behaviors that include:

- Men's and women's roles in the family, in the employment world, and in activities outside the family's environment;
- Egalitarian versus traditional/non egalitarian couple's relationships;
- The role of alcohol in couple's relationships
- The role of intimidation in couples;
- The role of religion; and
- Decisions regarding having children and family/work balance.

When working with the larger family using a systemic family therapy approach, the provider can link culture-related views and behaviors to specific family processes (Santisteban et al., 2013). These may include:

- The impact of immigration-related stress and/or parent-child separations on relationship quality;
- Changes in the cultural blueprint of what constitutes desirable parenting roles and couple's relationship practices; a family's ability to buffer youth from racism, marginalization, and anti-immigrant messages; and
- Immigrants' views about their roles as advocates for their children in the school system.

Additional resources and information on couple's and family therapies can be found in Appendix D.

Parenting and Child Development Interventions

The Ramírez children are experiencing behavioral disturbances as a result of their parents' conflict at home. Some of these conflicts are fueled by external stressors such as loss of employment and financial difficulties, but others are internal (e.g., father's emotional dysregulation secondary to trauma and substance use). Carlos is reluctant to engage in treatment. He only participated in an intake evaluation because María de los Angeles threatened to leave and take the children. A Parent Training intervention would give the family the opportunity to address the children's behavioral disturbances while focusing on building upon strengths and promoting resilience.

Many scholars have pointed to the urgent need for a strengths-based perspective in interventions with Latinx families. Parent training is an excellent vehicle for addressing and building strengths. Evidence-based parent training programs have many core components in common that address strengthening family relationships by building positive exchanges, promoting effective family communication, and providing important boundaries for child behavior. Some programs explicitly incorporate emotional regulation in the parents, which is a helpful skill for Carlos and María de los Angeles during such stressful times.

Latinx parents are typically motivated to participate in parenting interventions if they are relevant to their context (Parra-Cardona et al., 2009). This relevance is embedded in practices already present in evidence-based parenting programs. Historically, men have been excluded from parenting research, yet recent evidence has pointed to the importance of the father role for Latinx men (Parra-Cardona et al., 2006, 2008) and their engagement in evidence-based Parent Training (Parra-Cardona et al., 2017).

Benefits of Parent Training	Disadvantages of Parent Training
• Takes into account the whole family, supporting changes in parents and children alike • Consistent with traditional Latinx values of hierarchy within the family • Group format provides social support from other parents • Group format may feel more like "a class" than like "psychotherapy" and be more acceptable to parents • Structure allows for family to develop skills in a timely manner, thus addressing "now" problems now • Can be easily used with other treatments to amplify benefits to the family	• No time to address individual issues that may be the cause of parenting challenges; may be supplemented by individual treatment as needed • Group format may be difficult if the family feels like they are "airing dirty laundry"; clinician can point to the parents' choice in calibrating their participation to share in a way that is congruent with their values • In learning new ways of parenting, parents may feel like they are betraying their own parents and/or ignoring their cultural worldviews (e.g., los niños hablan cuando las gallinas mean [children speak when chickens pee]). It is critical to address this over the course of treatment

Cultural Adaptation of Parent and Child Development Intervention Elements

Some important cultural adaptations that have been made to parenting training programs include transformative and additive adaptations (Domenech Rodríguez & Bernal, 2012). Transformative adaptations revise existing materials to make them more accessible and relevant for families whereas, as the name suggests, additive adaptations provide additional content to improve relevance. Adaptations relevant to this family are:

- Transformative: offering the intervention in Spanish; ensuring the intervention is implemented by providers with knowledge and experience working with Latinx immigrant families; using culturally relevant "dichos" (sayings) and other forms of cultural knowledge (e.g., "árbol que crece torcido jamás su tronco endereza" [a tree that grows crooked never straightens out its trunk]); explicitly discussing cultural values; confirming with the family a shared goal of raising children who are "bien educados" (well educated) and "respetuosos" (respectful) (Baumann et al., 2014; Domenech Rodríguez et al., 2011)
- Additive: considering additional content specific to biculturalism and immigration challenges (Parra-Cardona et al., 2017)

Providers may consider either a group or individual format for delivery depending on whether the social aspect of the group therapy format is experienced as positive (e.g., apoyo [validation of similar struggles]) or negative (e.g., vergonzoso [shameful]).

Given their history, Carlos and María de los Angeles are likely to agree that caring for their children is important. The children's behavioral issues at home (Antonio ignores Carlos; Ramón sasses María de los Angeles) can be easily understood as "faltas de respeto" (breaches of respect) that need to be addressed by both parents in their united efforts to raise children who are "bien educados" (polite and thoughtful, literally "well educated"). Through parent training, María de los Angeles and Carlos can work on:

- Developing clarity about their expectations for their children's behavior that are consistent with their cultural values (e.g., showing respeto by responding when spoken to, using a calm voice, showing good manners by saying "please," "thank you," "excuse me"), making space for and validating culturally patterned expectations for parent-child exchanges;
- Conveying those expectations effectively (e.g., active communication strategies, emotional regulation, family meetings) in culturally acceptable ways;
- Monitoring the children's growth in learning these expectations, for example by connecting concepts like respeto with specific behavioral manifestations that can be monitored for compliance; and
- Shaping learning through the use of positive reinforcements (from social to tangible rewards depending on the behavior and the difficulty in establishing it) when expectations are met, and mild sanctions (e.g., time out, privilege loss, work chores) when expectations are not met.

Applying the Culturally Adapted Intervention

After identifying a treatment model or approach and the pertinent cultural adaptation(s) that will best serve the client(s), the provider striving for cultural competence must continue to ensure fidelity to the treatment approach and address challenges and changes in the family's status as the treatment progresses. One of the challenges that a culturally adapted intervention must address is that each family member may acculturate at a different rate. Some adaptation may fit some family members more than others and the tension caused by worldviews that are moving in different directions are part of the challenge in helping the Latinx family.

Best Practices in Cultural Adaptation

Treatments that are culturally adapted for Latinxs address assumptions and reflect world views that are consistent with that population. Some treatments combine transformative adaptations (those that change existing content) with additive adaptations in order to address specific factors such as experiences of discrimination, immigration challenges, and acculturative stress. An excellent example is Parra-Cardona's randomized controlled trial comparing culturally adapted parent training with an "enhanced" version that utilized the culturally adapted treatment and added two sessions, one on immigration and one on biculturalism (Parra-Cardona et al., 2017). Both treatments showed effectiveness, but there were important benefits to the enhanced intervention over time.

Culturally adapted treatments may better articulate the unique life experiences that help pattern symptoms and may contribute to improvement. For example, a therapy that is used with Latinxs should be prepared to focus on important experiences in this community like the stressors related to immigration, acculturation, discrimination and context, which have been linked to various symptoms (Abraido-Lanza et al., 2016; Lewis-Fernández et al., 2016). It should also take these experiences as a starting point for how symptoms and healthy functioning are conceptualized. Logically, treatments that address the powerful everyday stressors experienced by many Latinx clients (e.g., discrimination, immigration, acculturative stress) will be perceived as more relevant and attractive by the client.

It is important to note that good outcomes may be observed with informal cultural adaptations. Across six case studies presented in a special issue on cultural adaptations (Koslofsky & Domenech Rodríguez, 2017), clinicians working with ethnically and culturally diverse clients used many of the cultural adaptations outlined in various models even without following a formal cultural adaptation model or framework. This suggests that clinicians' general cultural competence may enable them to implement specific adaptation techniques with specific clients. The compilation of case studies also reflected the dynamic nature of cultural adaptations, since even when specific models were followed, clinicians made additional adaptations to refine their approach to improve their clients' outcomes.

Challenges in Cultural Adaptation

There are some important challenges to implementing culturally adapted evidence-based treatments:

Access to manuals and training. EBTs are rigorously developed and tested by researchers based on lengthy and costly clinical trials. These treatments are then packaged for use by organizations that hold copyrights. The use of EBTs often requires specific training and ongoing supervision of service providers and/or administrators, adherence to detailed program manuals, and data collection

to track program delivery and impact. Implementing EBTs within community-based organizations is costly (Kerns et al., 2016). Some organizations may struggle to find the resources to use EBTs.

Transportability. EBTs are typically developed within a university setting by investigators with adequate resources, such as research funding and staff time. Not enough consideration has been given to how existing EBTs may be used in community settings by service providers with limited resources. Organizations are often confronted with challenges to readily customize treatments for the diverse goals, priorities, infrastructures, resources, and staff of community-based organizational settings (Cabassa & Baumann, 2013). A systematic cultural adaptation of an EBT introduces additional demands on organizations. These include the need for staff with expertise in developing an in-depth familiarity with the scientific literature, forming partnerships with community members, systematically adapting treatment manuals, and conducting extensive pilot work to test whether changes appear feasible and effective.

Fidelity. Some scholars have advanced the concern that cultural adaptations could produce effects such as poor outcomes by compromising program fidelity. These effects occur when the treatment itself is responsible for negative rather than positive outcomes. Fidelity refers to the retention of the active or curative factors in treatment that lead to meaningful change. Indeed, one program courageously reported on the negative impacts of cultural adaptation (Kumpfer et al., 2002) where the attention to cultural fit resulted in the loss of important intervention content that was needed to produce changes in outcomes. This Toolkit has intended to show that cultural adaptations can be systematic, rigorous, and based on scientific findings regarding health and well-being among ethnic groups (Domenech Rodríguez & Bernal, 2012a). Cultural adaptation scholars point to the importance of maintaining the integrity of the original treatment while the validity of the EBT for the target group is enhanced with cultural adaptations. One way to attend to fidelity during the process of adaptation is to work closely with the treatment developer (see Cultural Adaptation Process Model; Domenech Rodríguez & Wieling, 1995). In fact, it may be that cultural adaptations can strengthen the fidelity of an evidence-based program (Domenech Rodríguez & Bernal, 2012a). Language adaptations provide a good example. When an intervention is delivered in the clients' preferred language, they are more likely to understand the material and put it to good use. Similarly, when treatment goals are aligned with the client's goals, treatments are more effective. In the context of a parenting training program, for example, the goal of increasing a child's "respeto" toward a Latinx parent not only does not threaten fidelity to the intervention but might actually enhance fidelity by making the concepts of the intervention more meaningful to the parents. The lack of cultural adaptation may unintentionally create a gap between the family's views and needs and what an evidence-based intervention can offer. The process of cultural adaptation should be transparent and well documented to make it replicable and testable for effectiveness (Domenech Rodríguez & Bernal, 2012a).

Summary

This Toolkit has attempted to make accessible the process of cultural adaptation by providing a specific case that illuminates a family's cultural context from the outset of evaluation and treatment. The consideration of culture and context begins at the moment of initial referral and is deepened during the assessment process. A deep understanding of who the client(s) is/are, what the problem(s) is/are, and what approaches will be acceptable, accessible, and effective to meet the client's goal(s) helps inform the course of treatment. We presented various intervention approaches with specific considerations for cultural adaptations. Some treatments will have already undergone a formal cultural adaptation process and resources may be available for providers. In other cases, providers may want to engage an informal cultural adaptation process. We would recommend that the process be informed by one of the many models of cultural adaptation available in the literature. We also recommend that clinicians become familiar with published research to inform the content of their cultural adaptations. For example, Falicov's (2014) presentation of Latinx families' contextual stressors and strengths can help inform the kinds of adaptations that a clinician might make for each of Bernal et al.'s (1995) eight dimensions of cultural adaptation. When formal adaptations are not feasible, informal adaptations hold promise. Although this Toolkit covered a lot of ground, it did not provide guidance for the important task of tracking treatment progress and outcomes. Providers who engage in evidence-based practices are encouraged to consider how culture and context might inform the treatment progress (e.g., How are outcomes measures? What outcomes are measured? How often?) as well as the suitability of the cultural adaptations deployed, keeping in mind the critical importance of acceptability, accessibility, and effectiveness in reducing mental health disparities.

Appendix A – Culturally Adapted Meta-Analyses

Culturally adapted meta-analyses include:

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, 58(3)*, 279-289. https://doi.org/10.1037/a0023626

Escobar, K. M., & Gorey, K. M. (2018). Cognitive behavioral interventions for depression among Hispanic people: Promising meta-analytic evidence for deep cultural adaptations. *Social Work in Mental Health, 16(6)*, 746-758. https://doi.org/10.1080/15332985.2018.1476284

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

Hernández Robles, E., Maynard, B. R., Salas-Wright, C. P., & Todic, J. (2018). Culturally adapted substance use interventions for Latino adolescents: A systematic review and meta-analysis. *Research on Social Work Practice, 28(7)*, 789-801. https://doi.org/10.1177/1049731516676601

Leijten, P., Meléndez-Torres, G. J., Knerr, W., & Gardner, F. (2016). Transported versus homegrown parenting interventions for reducing disruptive child behavior: A multilevel meta-regression study. *Journal of the American Academy of Child & Adolescent Psychiatry, 55(7)*, 610-617. https://doi.org/10.1016/j.jaac.2016.05.003

Rathod, S., Gega, L., Degnan, A., Pikard, J., Khan, T., Husain, N., Munshi, T., & Naeem, F. (2018). The current status of culturally adapted mental health interventions: A practice-focused review of meta-analyses. *Neuropsychiatric Disease and Treatment, Volume 14*, 165-178. https://doi.org/10.2147/NDT.S138430

Soto, A., Smith, T. B., Griner, D., Domenech Rodríguez, M. M., & Bernal, G. (2018). Cultural adaptations and therapist multicultural competence: Two meta-analytic reviews. *Journal of Clinical Psychology, 74*, 1907-1923. https://doi.org/10.1002/jclp.22679

van Mourik, K., Crone, M. R., de Wolff, M. S., & Reis, R. (2017). Parent training programs for ethnic minorities: A meta-analysis of adaptations and effect. *Prevention Science, 18(1)*, 95-105. https://doi.org/10.1007/s11121-016-0733-5

Appendix B - Other Therapies to Consider When Selecting Cultural Adaptations of Individual Therapies

Interpersonal Psychotherapy

Interpersonal Psychotherapy (IPT; Weismann et al., 2000) is based on the premise that a particular mental health issue can be connected to one of four interpersonal problem areas: (a) grief (e.g., loss of social support); (b) role dispute (e.g., reversal of traditional roles); (c) role transition (e.g., migration to host country); or (d) interpersonal deficits (e.g., dysfunctional family dynamics). In examining the interpersonal dynamics at play in an individual's life, a culturally responsive clinician working with Latinx clients will assess the stressors, values, and coping strategies best suited to assist the person (Markowitz et al., 2009).

Solution-Focused Therapy

Solution-focused therapy (de Shazer et al., 2007) is a short-term and goal-driven strengths-based intervention that is future-focused in its attempt to help the client solve presenting problems. The ultimate goal is to construct sustainable solutions that will maintain long-term behavior change. There is literature to suggest the potential benefit of utilizing solution-focused therapy with individuals of Latinx descent experiencing a multitude of psychosocial stressors. For example, it has been suggested that the focus on the interpersonal context, emphasis on behavior change rather than feelings, cooperation, goals that resonate for the client, future orientation, and alignment with culture specific values all lend credence to its consideration as an effective intervention (González Suitt et al., 2016).

Problem-Solving Therapy

Problem-solving therapy (PST; D'Zurilla & Nezu, 2007) has its underpinning in CBT and is focused on helping individuals develop adaptive coping strategies to effectively deal with stressful events (e.g., death of a loved one, illness, divorce, ongoing interpersonal difficulties). In essence, PST espouses a strengths-based approach to coping and utilizes a number of strategies, including psychoeducation, problem-solving training exercises, and homework in an effort to build self-efficacy. There is a growing body of evidence to suggest the PST is amenable to cultural adaptation for individuals of Latinx descent (Collado et al., 2016; Vega et al., 2020).

Appendix C – Additional Resources for Individual Therapy Interventions

The following are additional resources and information available to help clinicians implement Cognitive-Behavioral Therapy:

Topics that can be introduced in treatment and that can be culturally adapted include:

- psychoeducation on the antecedents, associated beliefs, and consequences of the client's behaviors
- the relationship between substance use and PTSD symptoms
- enhancing coping skills
- managing negative emotions
- exploring the impact of trauma symptoms
- cognitive reframing
- behavioral activation
- anger management
- assertiveness training
- relapse prevention
- prolonged exposure

Within the realm of CBT, there are several integrated protocols with varying degrees of empirical support to treat PTSD and alcohol use disorder, including:

- Seeking Safety (Najavits, 2002)
- Cognitive Processing Therapy (Kaysen et al., 2014; Resick et al., 2016)
- Trauma Exposure and Empowerment Model (TREM) (Fallot & Harris, 2002)
- Addictions and Trauma Recovery Integrated Model (ATRIUM) (Miller & Guidry, 2001)
- CBT for PTSD (McGovern et al., 2009)
- Transcend (Donovan et al., 2001)
- Substance Dependency Posttraumatic Stress Disorder Therapy (Triffleman et al., 1999)
- Trauma Affect Regulation: Guidelines for Education and Therapy (TARGET) (Ford & Russo, 2006)

Additionally, there are several CBT manuals that have been culturally adapted to varying degrees, including:

- Behavioral Activation for Latinos Treatment Manual (Kanter et al., 2014; Kanter et al., 2015)
- Gestión de la Ira: Un Manual de Terapia Conductual Cognitiva (Anger Management: A Cognitive-Behavioral Therapy Manual) and Libro de Actividades del Participante (Participant Activity Book) (Reilly & Shopshire, 2019; Reilly et al., 2019)
- Treatment Manual for Cognitive-Behavioral Therapy for Depression (Roselló & Bernal, 2007)
- Cognitive-Behavioural Therapy for People of Latin American Origin: A Manual for Enhancing the Effectiveness of CBT for People of Latin American Origin in Canada (Vidal et al., 2011)
- Saber es Poder: Modelo de Trauma y Recuperación para Mujeres Latinas (Knowledge is Power: Trauma and Recovery Model for Latina Women) cultural adaptation of the Trauma Exposure and Empowerment Model (Harris et al., 2006)

Appendix D – Additional Resources for Culturally Adapted Family Therapy

Commonly used evidence-based family therapies with adolescents include a strong focus on:

- Strengthening Parenting Practices: Includes focusing on developmentally appropriate parenting and monitoring.
- Repair of Ruptured Relationships: Works on in-family relationships that have become conflictual or distant to help shape them into more adaptive relationships.
- Subsystem Work: Focuses on the couple's, parental, and sibling subsystems to strengthen each component of the family.

Some of the work that has been done with family systems EBTs to create ***cultural adaptations*** are:

- Celia Falicov's *Latino Families in Therapy* (2014) and her Multidimensional Ecological Comparative Approach offer extraordinary insights into both the *cultural diversity* and the *social justice* aspects of Latinx families.
- Joan Koss-Chioino's and Luis Vargas' *"Working with Latino Youth"* (1999) provides excellent insights into Latinx youth and family issues.
- Jose Szapocznik's *Brief Strategic Family Therapy* (BSFT 2000, 2003) is an evidence-based intervention tested with Latinx families.
- Daniel Santisteban's *Culturally Informed and Flexible Family-Based Treatment for Adolescents* (CIFFTA; 2011, 2013, 2017) is a more recent evidence-based treatment that was developed for and tested with Latinx populations.

These treatments specifically focused on Latinx families may place special emphasis on elements like:

- Acculturation processes affecting individuals and differential acculturation between family members;
- The impact of acculturation on core family processes (e.g., parenting, couple's relationship, interactions with systems like schools and juvenile justice;
- Loss (country of origin and family left behind);
- Multinational families; and
- Trauma (e.g., Ramírez family father's loss and immigration).

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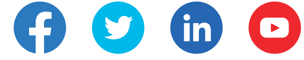

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