

THE COMPLEXITY OF CULTURE: DO WE EMBRACE THE CHALLENGE OR AVOID IT?

Esteban V. Cardemil

Clark University

This article responds to the comments of La Roche and Lustig (2010), O'Donohue and Benuto (2010), Ollendick, Lewis, and Fraire (2010), Sue (2010), and Stuart (2010) on the author's original article (Cardemil, 2010) that examined several issues related to the development and evaluation of cultural adaptations of empirically supported treatments. Although the comments were varied in their reactions to the author's original article, there were several common themes that emerged. In this response, I address the different themes by elaborating on my definition of culture, the need for cultural adaptations, what exactly constitutes a cultural adaptation, and the importance of also attending to therapist and client factors. I also continue to encourage the EST movement to acknowledge the limits of the existing research regarding the generalizability of its treatments and to therefore prioritize research that addresses this gap in our knowledge.

In my original article (Cardemil, 2010), my aim was to challenge clinical psychology to embrace the complexity of culture in its efforts to develop, evaluate, and disseminate empirically supported treatments (ESTs). The particular focus of this article was on cultural adaptations to interventions that have already been deemed empirically supported, with the emphasis on helping understand whether and when to adapt an existing intervention, how such adaptations should be made, and how these adaptations should be evaluated. I further challenged the field to acknowledge the limits of extant data regarding the generalizability of many of the ESTs and recommended that the generalizability of particular ESTs should be empirically evaluated before claims be made regarding its efficacy.

I was very pleased to receive the five responses to my original article, as they covered a wide range of reactions to both the overarching ideas and the specific details contained within. Three of the comments were

generally supportive of my premises, although they encouraged me to push further in efforts to incorporate attention to culture into empirically supported treatments. Two of the comments were more critical, expressing a variety of concerns commonly expressed about integrating cultural considerations into psychotherapy. Across the different perspectives offered by the commenters, I identified four broad themes that were present in some form or another across the comments. I present them here and provide some thoughts on them.

CONCERN #1: HOW DO WE DEFINE CULTURE?

Several of the commenters expressed some version of the concern that culture is a very difficult concept to accurately define and operationalize. Ollendick, Lewis, and Fraire (2010) rightly note that many within-group differences exist that create heterogeneity in cultural groups, which complicates the effort to develop an adaptation for a particular cultural group. They suggest that some of this variability can be found at the level of national origin as well as level of acculturation. O'Donohue and Benuto (2010) criticize my definition of culture, complaining that it could be at once overly

Preparation of this article was supported by NIMH grant R34 MH082043. Correspondence concerning this article should be addressed to Esteban Cardemil, Ph.D. at Clark University, 950 Main St., Worcester, MA 01610, Phone: 508-793-7738, Fax: 508-793-7265, E-mail: ECardemil@clarku.edu.

restrictive and overly inclusive and so does not provide any guidance to interested researchers. They make the additional point that there are so many potential cultural groupings as to make the adaptation and evaluation process infinite and not feasible. Stuart (2010) also commented on the multidimensionality of culture, with his concern being that no cultural adaptation could capture this complexity and so could in fact lead to cultural insensitivity on the part of researchers and clinicians.

All of these concerns have some measure of validity and need to be taken seriously, given my recommendation that developers of novel interventions assume the burden of proof regarding the generalizability of their interventions. However, despite the fact that culture is of course multidimensional and complex, researchers do not need to endlessly divide people into different cultural groups without any theoretical rationale. For example, as I noted in my original article, there is considerable evidence that individuals from low-income and racial and ethnic minority backgrounds are less likely than individuals from middle to upper-income and Caucasian backgrounds to seek out and remain engaged with mental health services (e.g., Alegría et al., 2002; Snowden & Yamada, 2005; U.S. Department of Health and Human Services, 2001). Thus, it is theoretically coherent, as well as functionally pragmatic, to develop cultural adaptations in response to these well-documented differences. In a similar vein, there is no reason that adaptations could not be developed for other sociocultural groups for whom the literature suggests that unique life experiences, norms, or psychological processes might exist that could be theoretically related to either differences in acceptability, engagement, or efficacy of the intervention.

By focusing on particular cultural groups about which the psychological or health disparities literature suggests that an adaptation might be beneficial, researchers are therefore able to focus their efforts so as to lead to maximum benefit. La Roche and Lustig (2010) provide an excellent guide for helping researchers determine when and how to adapt a particular intervention. Their approach involves taking the time to consider and understand the cultural characteristics and assumptions of the intervention itself, the cultural characteristics of the target population of interest, and the match or lack thereof between the intervention and the target population. Finally, La Roche and Lustig recommend careful assessment of the relevant cultural variables at the level of the individual in order to help determine for whom the adapted intervention was most efficacious. These recommendations should be taken seriously because they allow researchers to identify

those cultural variables that are most relevant to their particular location and the population for whom they see the most need to develop an adapted intervention. Importantly, this determination could expand the traditional (and limited) definition of culture to include conceptions of gender, class, and minority status as suggested by several of the commenters.

CONCERN #2: LITTLE TO NO EVIDENCE SUPPORTS THE NEED FOR CULTURAL ADAPTATIONS

O'Donohue and Benuto (2010) directly attack the premise of my original article by questioning whether any evidence in fact exists that supports the need for cultural adaptations. They state that my article assumed that the ESTs lack external validity and then suggest that no research has examined this question in an empirical manner. Further, they dismiss the healthcare disparities research as irrelevant to the question of the need for cultural adaptations because the need to address access issues should not be confused with the need to develop cultural adaptations.

While important to consider these points, there exists a substantial body of research that undermines each of O'Donohue and Benuto's claims. First, contrary to O'Donohue and Benuto's belief that politics and unexamined assumptions are the driving forces behind my article, there indeed does exist quite good empirical evidence demonstrating the demographic homogeneity of the clinical trials that underlie the establishment of empirically supported treatments. As one concrete example, in 2001, the Surgeon General put out a report on mental health and culture (U.S. Department of Health and Human Services, 2001). The authors of this report presented an analysis of over 9,000 individuals who had participated in the efficacy studies for bipolar disorder, schizophrenia, depression, and ADHD that underlie the major treatment guidelines for these disorders. The data are striking in their homogeneity: fewer than 7% of participants are identified as African American, Latino, Asian American, or American Indian. More recently, Mak, Law, Alvidrez, & Pérez-Stable (2007) examined the samples from 379 NIMH-funded clinical trials that were published in five major mental health journals (*Archives of General Psychiatry*, *American Journal of Psychiatry*, *Journal of American Academy of Child and Adolescent Psychiatry*, *International Journal of Geriatric Psychiatry*, and *Journal of Consulting and Clinical Psychology*). The authors of this study found that all racial/ethnic groups except Caucasians and African Americans

were underrepresented. Further, only 29% of the studies were sufficiently powered so as to allow researchers to examine whether there were any efficacy differences across racial/ethnic groups. A third example was conveniently provided to me by Ollendick and colleagues (2010), who describe the sample from a large treatment trial for childhood anxiety (Walkup, Albano, Piacentini, Birmhaer, Compton, Sherrill, et al., 2008) that is consistent with this general trend. That is, in this study, the percentage of participants in the sample from racial/ethnic minority groups was below the demographic representations of the cities in which the studies took place. In addition, the low numbers precluded the possibility of sufficiently powered moderation analyses that could investigate the relative efficacy of the different interventions. Given these data, and the plethora of other extant data, it seems fairly safe to note that few empirically supported treatments have been evaluated with samples that are culturally diverse in their make-up.

Second, O'Donohue and Benuto prematurely dismiss the relevance of healthcare disparities research. As many researchers in this field have noted, healthcare disparities are multifaceted and are caused by many different factors, including community-level and systems-level issues like those noted by O'Donohue and Benuto (i.e., poverty and lack of available professionals). However, researchers have also documented additional barriers to receiving and engaging in healthcare, including barriers at the provider-level (i.e., bias and error in diagnoses; Alegria & McGuire, 2003), patient-level (e.g., attitudes toward mental health services; Whaley, 2001) and provider-patient interaction level (i.e., bias and discrimination, communication difficulties; Betancourt & Maina, 2007). Some evidence that contradicts O'Donohue and Benuto's contention that healthcare disparities research is irrelevant include the fact that not only are racial and ethnic minorities less likely than Caucasians to utilize mental health services, but they are more likely to prematurely drop out of services than Caucasians (Organista, Muñoz, & Gonzalez, 1994; Sánchez-Lacay et al., 2001). These disparities are also found even when controlling for sociodemographic and clinical characteristics (Lagomasino et al., 2005; Padgett, Patrick, Burns, & Schlesinger, 1994) as well as insurance status (Miranda & Cooper, 2004), telling us that much more than community and systems-level issues are contributing to the healthcare disparities in the U.S.

The absence of data investigating the generalizability of ESTs coupled with the (indeed, quite) relevant healthcare disparities research make it difficult to understand O'Donohue and Benuto's desire to hold fast to

assumptions of universality of ESTs because the goal of science is to find "universal regularities." It seems strange to defend a scientific enterprise that conducts its research with a small and unrepresentative segment of society, ignores data suggesting that there exist important differences with coherent societal subgroups, and then makes unsupported claims about generalizability to these different subgroups. My perspective is rather different: good science follows the extant data and seeks it out when it does not exist. Thus, when evidence exists for generalizability, then there is no need to develop an adaptation. When no such evidence exists, then researchers should investigate this question and proceed accordingly.

CONCERN #3:

WHAT EXACTLY CONSTITUTES AN ADAPTATION?

Both Ollendick and colleagues (2010) and O'Donohue and Benuto (2010) note that there is not compelling evidence to support adaptations that make substantive changes to the purported active ingredients of the different interventions. Ollendick and colleagues note that "all ESTs should rest on a sound theoretical rationale that addresses not only the determinants of the condition or the disorder to be changed, but also the purported mechanisms for bringing about the desired changes in those disorders." O'Donohue and Benuto provide the example of urine alarm therapy for functional enuresis as a treatment that may be more "culturally neutral" than marital therapy, implying that the underlying mechanism for this treatment may be generalizable across populations.

The positions presented in these two comments are in fact consistent with the arguments I laid out in my original article, since I defined cultural adaptations as those adaptations that do not alter the core, active ingredients that are purported to lead to symptom and functional improvement. Other scholars who have written about cultural adaptations have made this same point (e.g., Castro et al., 2004; Lau, 2006). In fact, as Castro and colleagues (2004) eloquently note, the development of cultural adaptations requires navigating the tension between fidelity and fit. Adaptations that do not sufficiently consider the fit with the target population are hardly adaptations, and adaptations that lose track of the core theoretical approach become different interventions altogether. And so, when I described the different types of adaptations that could be made (i.e., at the level of program structure, program content, delivery of the intervention, and therapist behavior), I was referring to

adaptations that would leave intact the core theoretical approach of the original, standard intervention.

It is quite plausible, of course, that basic research identifies psychological experiences, processes, or outcomes that are unique or uniquely enacted in particular cultural groups. And so, it would be reasonable to develop an intervention that attempts to address these experiences, processes, or outcomes in culturally appropriate ways. Others have termed these interventions “culturally-centered interventions” (Bernal and Saéz-Santiago, 2006), and elsewhere, I distinguished them from cultural adaptations (Cardemil, 2008; Cardemil & Sarmiento, 2009). Two commonly cited examples of culturally-centered interventions are *Cuento Therapy*, an approach that uses cultural folktales to increase children’s connection both with their parents and with their Puerto Rican culture and heritage (Costantino, Malgady, & Rogler, 1986; Malgady, Rogler, & Costantino, 1990), and Bicultural Effectiveness Training (BET; Szapocznik, et al., 1986), an intervention developed to improve family functioning through the explicit consideration and working through of cultural conflict that arises between family members as a result of differences in acculturation level. Neither of these examples should be conceptualized as a cultural adaptation, however, because they focus on psychological experiences, processes, and outcomes that are particular to the populations for whom the intervention was developed.

The distinction between a cultural adaptation and a culturally-centered adaptation is not merely semantic because of the implications for generalizability and the dissemination of ESTs. Cultural adaptations of ESTs that keep intact the active mechanisms of the interventions can speak to the generalizability of the intervention. Culturally-centered interventions, or adaptations that change the active mechanisms, cannot and instead should be evaluated independently as *de novo* interventions.

CONCERN #4:

WHAT ABOUT THERAPIST AND CLIENT FACTORS?

Both Sue (2010) and Stuart (2010) noted the relative lack of attention in my original article to therapist behavior. Sue (2010) reminds us that while attention to interventions and treatment tactics is important, it is also important to consider therapist factors. He rightly points out the distinction between therapist techniques (i.e., particular behaviors) and therapist characteristics (i.e., self-awareness), noting that disentangling the relative contributions of each would likely prove fruitful.

Stuart expressed concern that cultural adaptations made at the level of the intervention could promote stereotypical thinking and behavior because they encourage clinicians to assume homogeneity within particular cultural groups. He provided a thought experiment in which a clinician anticipates a first session with three different clients whose names incorrectly suggest particular cultural backgrounds, and noted that a cultural adaptation for Latinos would provide very little useful information for how to navigate each of the individual’s life circumstances and particular cultural backgrounds.

Said another way, the issues raised by Sue and Stuart entail the application of the nomothetic to the idiographic, or the general to the particular. This concern should be very familiar to supporters of ESTs, since the implementation of an EST with a particular client involves the same challenge. Indeed, critics of the EST movement have suggested that the use of manualized, modular interventions ignores both the idiographic life circumstances of particular clients and the valuable role of therapists in determining appropriate course of treatment (Duncan & Miller, 2006; Beutler, 2009). Just like the implementation of ESTs that use treatment manuals involves the flexible application of techniques in a client-responsive manner (e.g., Addis & Cardemil, 2006; Gibbons, Crits-Christoph, Levinson, & Barber, 2003), so too does the application of a cultural adaptation to an EST. That is, a cultural adaptation of an EST should be done in a thoughtful manner which allows therapists to consider possible cultural issues and address them or not, depending on the particular presenting client.

Thus, Sue and Stuart are absolutely correct when they state that my focus on cultural adaptation at the level of the intervention cannot be the end of the story. There exists a considerable body of research on therapist cultural competence, as well as increasing attention to therapist-client interactions when cultural differences exist between the therapist and client. Very little of this research has been conducted within the EST framework, however, and so Sue and Stuart’s comments are excellent calls for additional research on the implementation and the enactment of cultural adaptations with individual clients. Ollendick and colleagues (2010) described the traditional function of mediation analyses to test the theorized mechanisms of change of the intervention; this same approach can be nicely applied to therapist factors and the therapist-client relationship. Others have begun to integrate attention to therapist-client relationship within ESTs (e.g., Constantino, Arnow, Blasey, & Agrad, 2005), and so this approach would simply bring this theoretical and analytic perspective to cultural adaptations.

How therapists respond to client factors can increasingly be done empirically, since there is increasing evidence supporting the application of an individual differences framework to issues of culture. Considerable research has documented individual variability in a number of cultural constructs, including acculturation level, ethnic identity, and adherence to specific cultural values (Chun, Organista, & Marín, 2002; Gloria, Ruiz, & Castillo, 2004; Phinney & Ong, 2007). As La Roche and Lustig (2010) point out, by measuring individual client adherence to specific cultural variables, researchers and clinicians avoid the problem of stereotyping and assuming homogeneity in very heterogeneous samples. Moreover, some recent work in the area of health promotion messages has had intriguing success with tailoring programs and messages to very specific client cultural characteristics (e.g., Kreuter et al., 2005).

WHERE DO WE GO FROM HERE?

As I noted at the outset of this response to the comments, my aim in writing my original article (Cardemil, 2010) was to push the field of clinical psychology to proactively attend to culture within the EST paradigm. The variability in perspectives contained in the comments to my original article nicely captures the diversity of opinion that currently exists in clinical psychology with regard to culture. Some researchers and clinicians are enthusiastic regarding the integration of cultural considerations, while others remain skeptical of its utility. Importantly, all of the comments recognized both the importance and complexity of culture, a recognition that I believe is shared by the field of clinical psychology as a whole.

Where the comments diverged, however, was in how to (and if) to address this complexity. Although in this response to comments I addressed many of the concerns, I readily acknowledge that addressing culture through the development of cultural adaptations is a complicated and messy process. As much as we might yearn for elegant and simplistic conceptualizations of culture, the reality of the world in which we live precludes this from occurring. Cultural considerations are inevitably and inextricably interwoven with additional sociocultural considerations like gender and social class. Culture is a dynamic process that changes over time and is elicited differently depending on the context in which it is assessed. And so, when viewed from within a traditional experimental framework that valorizes the identification and control of discrete, well-defined variables, the whole endeavor to capture the complexity of culture can appear overwhelming.

However, this sense of overwhelming complexity has already been navigated quite successfully by supporters of the EST movement in a different realm altogether: namely, the development, evaluation, and dissemination of treatments for discrete psychological disorders themselves! In particular, developers of a novel treatment for a disorder must navigate a myriad of unclear and fuzzy concepts when deciding whether to develop a novel treatment for a particular disorder. For example, the fact that the DSM series is continually expanding (leading to an ever-growing and unmanageable list of treatments for clinicians to master) means that our understanding of psychological distress is not fixed in time, but rather dynamic and influenced by a variety of factors. Similarly, the high rates of comorbidity across disorders, and especially the personality disorders, has led some to question the utility of a discrete nosological approach to psychological distress and instead advocate for a unified approach to treating emotional disorders that ignores diagnoses (Moses & Barlow, 2006). And, as I noted earlier, although the field recognizes that individual therapists cannot simply deliver a manualized intervention without taking into consideration individual client characteristics, our ability to research and understand this process is limited. Notwithstanding the claims made by critics of the EST movement (e.g., Westen, Novotny, & Thompson-Brenner, 2004), the navigation of these complexities to produce a list of treatments with good empirical support is a benefit to the public at large and a testament to the scientific enterprise within clinical psychology.

I believe that this scientific enterprise is up to the challenge of scrutinizing itself more carefully. By acknowledging the limits of the existing research, prioritizing the generalizability and social validity of our interventions, and expanding our notion of research to include attention to both therapist and client factors, we can conduct research that identifies those interventions that are indeed generalizable across multiple cultural groups, those that require adaptations, and perhaps those that require entirely new approaches. However, this work is neither simple nor easy, and it will require some reexamination of both personal and professional assumptions. In particular, I encourage those critics who see politics as the driving force behind the development of cultural adaptations to consider the role of politics in maintaining the status quo. I also encourage them to examine their own desires to hold fast to assumptions of universality when the evidence does not support these assumptions.

In the end, though, I continue to believe that because clinical psychology in general, and supporters of the

EST movement in particular value the scientific method, the field will move beyond political motivations and ultimately turn to the empirical evidence when deciding whether and how to develop cultural adaptations. And given the creative energy underlying the explosion of innovative interventions for the ever-growing number of psychological disorders, I have little doubt that this energy will ultimately lead to a new generation of cultural adaptations that addresses the complexity of culture and the psychotherapeutic process.

REFERENCES

- Addis, M.E., & Cardemil, E.V. (2006). Psychotherapy manuals can improve outcomes. In J.C. Norcross, L.E. Beutler, & R.F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 131–140). Washington, DC: American Psychological Association.
- Alegria, M.A., Canino, G., Ríos, R., Vera, M., Calderón, J., Rusch, D., & Ortega, A.N. (2002). Inequalities in use of specialty mental health services among Latinos, African Americans, and non-Latino Whites. *Psychiatric Services*, *52*, 1547–1555.
- Alegria, M.A., & McGuire, T. (2003). Rethinking a universalist framework in the psychiatric symptom–disorder relationship. *Journal of Health and Social Behavior*, *44*, 257–274.
- Bernal, G., & Saéz-Santiago, E. (2006). Culturally centered psychosocial interventions. *Journal of Community Psychology*, *34*, 121–132.
- Betancourt, J.R., & Maina, A. (2007). Barriers to eliminating disparities in clinical practice: Lessons from the IOM report “Unequal Treatment.” In R.A. Williams (Ed.), *Eliminating healthcare disparities in America: Beyond the IOM report* (pp. 83–97). Totowa, NJ: Humana Press.
- Beutler, L.E. (2009). Making science matter in clinical practice: Redefining psychotherapy. *Clinical Psychology: Science and Practice*, *16*, 301–317.
- Cardemil, E.V. (2010). Cultural adaptations to empirically supported treatments: A research agenda. *The Scientific Review of Mental Health Practice*, *7*(2), 8–21.
- Cardemil, E.V. (2008). Culturally sensitive treatments: Need for an organizing framework. *Culture and Psychology*, *14*, 357–367.
- Cardemil, E.V., & Sarmiento, I. (2009). Clinical approaches to working with Latino adults. In F.A. Villarruel, G. Carlo, J. M. Grau, M. Azmitia, N. Cabrera, & T.J. Chahin (Eds.), *Handbook of Latino Psychology* (pp. 329–345). Thousand Oaks, CA: Sage Publications.
- Castro, F.G., Barrera, M., & Martinez, C.R. (2004). The cultural adaptation of prevention interventions: Resolving tensions between fidelity and fit. *Prevention Science*, *5*, 41–45.
- Chun, K.M., Organista, P.B., & Marín, G. (2002). *Acculturation: Advances in theory, measurement, and applied research*. Washington, DC: American Psychological Association.
- Constantino, M.J., Arnow, B.A., Blasey, C., & Agras, W.S. (2005). The association between patient characteristics and the therapeutic alliance in cognitive-behavioral and interpersonal therapy for bulimia nervosa. *Journal of Consulting and Clinical Psychology*, *73*, 203–211.
- Costantino, G., Malgady, R.G., & Rogler, L.H. (1986). Cuento therapy: A culturally sensitive modality for Puerto Rican children. *Journal of Consulting and Clinical Psychology*, *54*, 639–645.
- Duncan, B.L., & Miller, S. D. (2006). Treatment manuals do not improve outcomes. In J. C. Norcross, L.E. Beutler, & R.F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 140–149). Washington, DC: American Psychological Association.
- Gibbons, M.B.C., Crits-Christoph, P., Levinson, J., & Barber, J. (2003). Flexibility in manual-based psychotherapies: Predictors of therapist interventions in interpersonal and cognitive-behavioral therapy. *Psychotherapy Research*, *13*, 169–185.
- Gloria, A.M., Ruiz, E.L., & Castillo, E.M. (2004). Counseling and psychotherapy with Latino and Latina clients. In T.B. Smith (Ed.), *Practicing multiculturalism: Affirming diversity in counseling and psychology* (pp. 167–189). Boston: Allyn and Bacon.
- Kreuter, M., Skinner, C., Holt, C., Clark, E., Haire-Joshu, D., Fu, Q., et al. (2005). Cultural tailoring for mammography and fruit and vegetable intake among low-income African American women in urban public health centers. *Preventive Medicine*, *41*(1), 53–62.
- Lagomasino, I.T., Dwight-Johnson, M., Miranda, J., Zhang, L., Liao, D., Duan, N., et al. (2005). Disparities in depression treatment for Latinos and site of care. *Psychiatric Services*, *56*, 1517–1523.
- La Roche, M.J., & Lustig, K. (2010). Cultural adaptations: Unpacking the meaning of culture. *The Scientific Review of Mental Health Practice*, *7*(2), 26–30.
- Lau, A.S. (2006). Making the case for selective and directed cultural adaptations of evidence-based treatments: Examples from parent training. *Clinical Psychology: Science and Practice*, *13*, 295–310.
- Mak, W.W.S., Law, R.W., Alvidrez, J., & Pérez-Stable, E.J. (2007). Gender and ethnic diversity in NIMH-funded clinical trials: Review of a decade of published research. *Administration and Policy in Mental Health and Mental Health Services Research*, *34*, 497–503.
- Malgady, R.G., Rogler, L.H., Costantino, G. (1990). Culturally sensitive psychotherapy for Puerto Rican children and adolescents: A program of treatment outcome research. *Journal of Consulting and Clinical Psychology*, *58*, 704–712.

- Miranda, J., & Cooper, L.A. (2004). Disparities in care for depression among primary care patients. *Journal of General Internal Medicine, 19*, 120–126.
- Moses, E.B., & Barlow, D.H. (2006). A new unified treatment approach for emotional disorders based on emotion science. *Current Directions in Psychological Science, 15*, 146–150.
- O'Donohue, W., & Benuto, L. (2010). The many problems of cultural sensitivity. *The Scientific Review of Mental Health Practice, 7*(2), 34–37.
- Ollendick, T.H., Lewis, K.M., & Fraire, M.G. (2010). Cultural adaptations to empirically supported treatments: The challenge before us. *The Scientific Review of Mental Health Practice, 7*(2), 22–25.
- Organista, K.C., Muñoz, R.F., & Gonzalez, G. (1994). Cognitive-behavioral therapy for depression in low-income and minority medical outpatients: description of a program and exploratory analyses. *Cognitive Therapy and Research, 18*, 241–259.
- Padgett, D.K., Patrick, C., Burns, B.J., & Schlesinger, H. (1994). Ethnicity and the use of outpatient mental health services in a national insured population. *American Journal of Public Health, 84*, 222–226.
- Phinney, J.S., & Ong, A.D. (2007). Conceptualization and measurement of ethnic identity: Current status and future directions. *Journal of Counseling Psychology, 54*, 271–281.
- Sánchez-Lacay, J.A., Lewis-Fernández, R., Goetz, D., Blanco, C., Salmán, E., Davies, S., & Liebowitz, M. (2001). Open trial of nefazodone among Hispanics with major depression: Efficacy, tolerability, and adherence issues. *Depression and Anxiety, 13*, 118–124.
- Snowden, L., & Yamada, A.M. (2005). Cultural differences in access to care. *Annual Review of Clinical Psychology, 1*, 143–166.
- Stuart, R.B. (2010). Cultural insensitivity for clinicians? Choosing how to use cultural research. *The Scientific Review of Mental Health Practice, 7*(2), 38–40.
- Sue, S. (2010). Cultural adaptations in treatment. *The Scientific Review of Mental Health Practice, 7*(2), 31–33.
- Szapocznik, J., Rio, A., Perez-Vidal, A., Kurtines, W., Hervis, O., & Santisteban, D. (1986). Bicultural effectiveness training (BET): An experimental test of an intervention modality for families experiencing intergenerational/intercultural conflict. *Hispanic Journal of Behavioral Sciences, 8*, 303–330.
- U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—A Supplement to Mental Health: A report of the Surgeon General*. Rockville, MD: Author. Retrieved September 26, 2004, from: <http://media.shs.net/ken/pdf/SMA-01-3613/sma-01-3613>.
- Walkup, J.T., Albano, A.M., Piacentini, J., Birmaher, B., Compton, S.N., Sherrill, J.T. et al. (2008) Cognitive behavioral therapy, sertraline, or a combination in childhood anxiety. *The New England Journal of Medicine, 359*, 1–14.
- Westen, D., Novotny, C. M., & Thompson-Brenner, H. (2004). The empirical status of empirically supported psychotherapies: Assumptions, findings, and reporting in controlled clinical trials. *Psychological Bulletin, 130*, 631–663.
- Whaley, A.L. (2001). Cultural mistrust and mental health services for African Americans: a review and meta-analysis. *Counseling Psychologist, 29*, 513–531.