



Abstract To date, descriptions of culturally sensitive therapies have insufficiently acknowledged the heterogeneity of perspectives on the role of culture in therapy. The generally homogeneous manner in which advocates of culturally sensitive therapies have described this work has likely contributed to the mainstream's slow acceptance of the importance of culture. In this article, I propose an organizing framework that may help recognize the diversity of viewpoints regarding what constitutes culturally sensitive therapy. It is my hope that this framework, along with critical self-evaluation of the strengths and weaknesses of the various perspectives, will lead to more rapid incorporation of culture across treatments.

Key Words cultural competence, culturally sensitive treatments, culture, empirically supported treatments

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Culturally Sensitive Treatments: Need for an Organizing Framework

In their article, La Roche and Christopher (2008) nicely highlight various ways in which many of the assumptions underlying empirically supported treatments (ESTs) are at odds with current conceptions of culture and the efforts to create culturally sensitive treatments (CSTs) that are well positioned to work with an increasing diverse population of clients. Their article is a complement to the increasing attention that scholars have begun to devote to these issues (e.g., Atkinson, Bui, & Mori, 2001; Bernal & Scharrón-del-Río, 2001; Hall, 2001; Miranda et al., 2005; Whaley & Davis, 2007). By reminding readers of the historical context of the development of the EST movement, namely reactions to the twin pressures of the biomedical/pharmacological field and the managed care/insurance arenas, La Roche and Christopher undermine the commonly held belief that ESTs developed purely out of a desire to improve the quality of public health care through the application of 'objective scientific criteria'. The authors then provide an excellent summary of the ways in which the EST perspective overvalues the importance of specific treatment factors and the methodology of randomized

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controlled trials while ignoring the importance of patient and therapist relationship variables that influence outcome, and the ways in which 'treatment' could lead to contextual change.

That said, as other notable criticisms of the EST movement have done, La Roche and Christopher have limited their description of the CST perspective by placing it in response to the limitations of the EST movement. This positioning, while understandable, has resulted in a limited and incomplete description of CST that is more reactive than proactive and creative. One consequence of the emerging CST movement generally failing to define itself in the affirmative has been the confusing and occasionally contradictory views on exactly what constitutes 'culturally sensitive therapy'. Many clinical, counseling, and cultural scholars have discussed their visions of how best to integrate culture into therapy; what remains lacking, however, is a framework that organizes this diversity of perspectives. Moreover, such a framework should be introspective and self-critical, acknowledging both the strengths and limitations of each perspective.

In this commentary, I will expand on La Roche and Christopher's paper by proposing an initial framework that I believe organizes much of the heterogeneity in perspectives among CSTs. My review of the literature has led me to identify at least three different emphases posited by scholars who support the explicit consideration of culture in psychotherapy: (1) culturally sensitive therapy is primarily or solely the product of culturally sensitive therapists; (2) empirically supported therapies can be adapted into culturally sensitive therapies; and (3) culturally sensitive therapies are only those that make culture the central focus. Each of these perspectives has intuitive appeal and some empirical support, and each has its strengths and limitations. It is my hope that this organizing framework may help the field more clearly articulate the various ways in which treatments could incorporate issues of culture.

Perspective I: Culturally Sensitive Therapy is the Product of Culturally Sensitive Therapists

The first set of perspectives focus less on the treatment itself and more on the cultural sensitivity displayed and practiced by the *therapist*. Advocates of this perspective tend to use the term 'cultural sensitivity,' or oftentimes 'cultural competence,' to describe particular therapist attitudes and behaviors when working with culturally diverse populations (e.g., Helms & Cook, 1999; S. Sue, 1998; Whaley & Davis, 2007). Different definitions of cultural competence exist, but the essential

elements triangulate around the ability to understand and develop a strong therapeutic relationship with individuals from different ethnic or cultural backgrounds. Generally, this ability includes knowledge about specific cultures, as well as a more general awareness and understanding of issues of difference, power, and marginalization (Hays, 2008; S. Sue, 1998). For example, there exist a number of articles and chapters that discuss counseling approaches with specific racial/ethnic groups in the United States (e.g., Arredondo & Perez, 2003; Hines & Boyd-Franklin, 1996), as well as some recent attention to addressing non-specific aspects of difference in therapeutic encounters (e.g., Cardemil & Battle, 2003; La Roche & Maxie, 2003).

From this perspective, cultural competency (and, by extension, culturally sensitive therapy) is conceptualized as a therapist skill, much like other therapist skills. In support of this perspective, researchers have begun to develop scales that can measure cultural competence (e.g., Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002; Sheu & Lent, 2007). However, the generally unstated assumption is that therapists who skillfully practice cultural competence will have better outcomes with their diverse clients than will therapists who do not. And with regard to this assumption, there is a notable absence of empirical support.

Nevertheless, this perspective has several strengths. First, because cultural competence is a therapist skill, it can be taught and learned through participation in coursework, conference workshops and seminars, independent reading, and introspection. A second strength is its flexibility. Cultural competence can be achieved by therapists from different theoretical orientations, in different mental health settings, and with clients of different racial, ethnic, and cultural backgrounds. Taken together, these two strengths raise considerable hope that the numbers of culturally competent therapists, and by extension the practice of CST, will increase. That is, insofar as CST is defined solely as the product of culturally competent therapists, then any existing therapeutic approach could be deemed culturally sensitive if conducted by a culturally competent therapist. From this perspective, the various traditional therapeutic approaches could easily incorporate cultural competency, much as has already happened with the incorporation of humanistic principles (i.e., therapy alliance) by the cognitive, behavioral, and psychodynamic schools.

There are several important limitations to this perspective, however, that go beyond the general lack of empirical support for the relationship between cultural competence and treatment outcome. Most critical is the dearth of consideration of the congruence, or theoretical

fit, between those therapist behaviors that are encouraged by considerations of cultural competence and those therapist behaviors that are prescribed, or proscribed, by the particular therapeutic orientation (see Helms & Cook, 1999, as one exception to this lack of attention). While the fit between these two sets of behaviors is likely to be high for some therapy orientations (e.g., humanistic therapy, cognitive-behavioral therapies), there are other therapies that proscribe the very behaviors that are recommended by some advocates of cultural competency (e.g., informality between therapist and patient, increased self-disclosure on the part of the therapist). Thus, before considerations of culture can be effectively integrated into all therapy orientations, the field must stop to consider and resolve some of the inconsistent recommendations that can emerge.

In sum, then, while there is much to value in a perspective that places the location of cultural sensitivity in the therapist, the ways in which this perspective is limited have led some scholars to push for a different approach, which I describe next.

Perspective 2: Empirically Supported Therapies Can Be Adapted into Culturally Sensitive Therapies

The second perspective on culture and therapy argues that existing ESTs can be adapted in ways that make them more culturally relevant and attractive to individuals from different cultures (e.g., Muñoz & Mendelsohn, 2005; Otto & Hinton, 2006). Contained under the broad category of *cultural adaptations*, these include both efforts to take established manual-based treatments and adapt them for particular cultural groups, as well as novel treatments that have been developed for specific cultural groups, but that adhere to theoretical principles of change that have been developed in Western cultures. For example, in their recent article discussing adapting cognitive-behavioral therapy for Native Americans with anxiety disorders, De Coteau, Anderson, and Hope (2006) describe the importance of attending to the worldview of the clients, the use of culture-specific assessment instruments and rituals, and the consideration of socioeconomic contextual factors, all while working within a cognitive-behavioral framework. Thus, cultural sensitivity includes both cultural competence on the part of the therapist and explicit attention in the intervention to culturally relevant issues, such as discussion of immigration-related stress (see Cardemil, Kim, Pinedo, & Miller, 2005).

From this perspective, cultural sensitivity plays a critical role in making the intervention more attractive to participants and making it

more likely that participants stay engaged throughout the course of therapy. Importantly, however, cultural sensitivity is not generally viewed as an active ingredient that will directly contribute to improvement in the functioning of the client. Although the literature is limited, the emerging evidence suggests that these approaches can be efficacious in treating some mental disorders (Miranda et al., 2005). An excellent example of this approach can be found in Roselló and Bernal's (1999) randomized controlled study examining cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT) with Puerto Rican adolescents. The authors adapted both therapies in a variety of ways to make them culturally sensitive, including the delivery of the intervention in the native language (Spanish), attention to the similarities and differences between client and therapist, and the use of culturally relevant metaphors and concepts, like traditional cultural values of *familismo* and *respeto* (Bernal & Saéz-Sanchez, 2006; Rosselló & Bernal, 1996). Results were positive: adolescents in both the IPT and the CBT conditions reported significantly fewer depressive symptoms than those adolescents randomized to the wait-list condition. Other researchers have begun to find support for the efficacy of cultural adaptations of EST across a variety of disorders, including anxiety, substance use, and disruptive disorders in children (Miranda et al., 2005).

A strength of this approach has been the explicit attention to quantitative empirical evaluation of both outcome and process variables. While La Roche and Christopher and others have cogently argued for the importance of qualitative methods for evaluating the efficacy of treatments, it remains true that the majority of the field of clinical psychology and psychiatry value traditional quantitative methods. As such, approaches that work within this framework have the potential to effect more change within the field. Moreover, as with the first perspective discussed, aspects of cultural sensitivity are theoretically teachable, increasing the likelihood of broad dissemination.

However, an important limitation is the fact that none of the existing cultural adaptations has adequately assessed culture sensitivity, either on the part of the therapist or in the ways in which the adaptation incorporates cultural elements into the treatment. Instead of actually measuring cultural sensitivity, the most common approach has been to rhetorically describe the ways in which the adaptation is culturally sensitive. This neglect of empirical assessment is puzzling, given the explicit valuation of quantitative assessment of outcome championed by the advocates of this perspective.

A second important limitation has been the absence of empirical evidence demonstrating that the provision of adapted ESTs produces

better outcomes than the standard versions of the ESTs with individuals from the targeted cultural groups (Lakes, López, & Garro, 2006). The state of the literature is still very much in its infancy, however, and so the careful comparisons have not yet been conducted. It is plausible that the adapted ESTs will demonstrate their benefit in the domains of treatment acceptability, retention, and adherence, rather than in alleviation of symptoms, but the field needs to attend more closely to this issue.

Perspective 3: Culturally Sensitive Therapies Are Those That Make Culture the Central Focus

The third perspective regarding the integration of cultural considerations into therapy is by far the most comprehensive, and has been termed *culturally-centered therapies* by some scholars (Bernal & Saéz-Santiago, 2006; Pedersen, 1997). According to this perspective, any attempt to impose a Western-based therapy upon individuals from non-Western cultures is built upon the faulty assumptions of universality and essentialism (Atkinson et al., 2001; Bernal & Scharrón-del-Río, 2001). Moreover, because Western-based therapies are part and parcel of the societal status quo, they are inherently limited in the ways in which they can empower individuals to overcome the societal structural obstacles that exist for racial and ethnic minorities. Thus, while ESTs can produce positive results with racial and ethnic minorities, it is likely that therapies that are not constrained by Western perspectives will produce better results. For these reasons, adherents of this perspective suggest that clinical psychology would do better to expend its resources in the support and development of novel therapy approaches that centralize culture in the treatment process, by working from particular cultural conceptions and idioms of distress, utilizing culture-specific traditions of pathways to health and sickness, and explicitly addressing societal structure issues in treatment (e.g., race, gender, class, sexual orientation).

From this perspective, cultural sensitivity is not simply a means to increase the attractiveness of therapy, nor is it limited to specific therapist behaviors, as in the previous two perspectives. Rather, cultural sensitivity is the central guiding principle underlying the development of an entire new therapeutic approach. La Roche and Christopher cite the example of *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). *Cuento* therapy, then, uses

culturally salient techniques (i.e., folktales) in the service of a culturally salient goal (i.e., increased connection to family and culture). Other examples of this perspective can be found in the counseling psychology tradition, which has historically focused less on resolving pathology and more on promoting developmental well-being. The scholars who have developed therapies that centralize multiculturalism in both mental health and treatment have tended to give attention to the relationship between the client and therapist, as well as a variety of sociocultural developmental issues, including racial and ethnic identity, spirituality and religion, and social class struggles (e.g., Atkinson, Morton, & Sue, 1998; D.W. Sue, Ivey, & Pedersen, 1996).

The most apparent strength of this perspective is the coherence between the conceptualization of the problem, which is located in society or in the disconnection with one's culture, and the resultant treatment approach. There are fewer inconsistencies than exist in the other two perspectives, as cultural sensitivity is not being added as a separate component onto existing treatment paradigms. Moreover, the central attention given to culture allows these treatment approaches to be well positioned to work within an ever-changing global community.

Despite this strength, this perspective has several notable weaknesses beyond the general lack of evidence demonstrating its effectiveness. From a pragmatic point of view, this perspective is the most difficult to disseminate. Because treatments are developed for particular groups, their development is necessarily slow. Moreover, the education and training of practitioners are likely more labor-intensive than the other perspectives, which will also contribute to the slow growth of this paradigm. A second limitation is the general lack of attention to heterogeneity within cultural groups, despite the centrality that culture is given in all of these models. For instance, it is plausible that culturally centered therapies would work less well with more assimilated individuals, who may not resonate with approaches that utilize traditional healing pathways. Very little guidance is given to help with these determinations. Similarly, although the multicultural counseling perspectives tend to explicitly prioritize assessment of the client's sociocultural location, there has been less attention given to providing guidance for working with clients who may prefer standard therapeutic approaches.

Where Should the Field Go from Here?

Advocates of the CST movement have correctly critiqued the EST movement for its disregard of culture and its role in therapy. These

critiques have appeared rather steadily over the past ten years, by a variety of different authors, and in a variety of publication outlets. And there has been some evidence that the larger clinical psychology field has taken notice of these critiques. For example, as La Roche and Christopher note, the National Institutes of Mental Health now require all funded investigators to document the expected numbers of research participants from different racial and ethnic backgrounds. And yet, the overall change could best be described as incremental. Why is the inclusion of culture not being more readily embraced by advocates of the EST movement?

There are many reasons for the slow pace of change, and La Roche and Christopher highlight a number of them. However, I believe that one of the impediments to more rapid change has been the generally muddled state of the field with regard to cultural sensitivity and the development of CSTs. Concretely, EST scholars who agree with the importance of incorporating culture into their research programs might receive contradictory information from the literature regarding how to proceed. For example, if an EST researcher were to approach me for recommendations, I might encourage the consideration of cultural adaptation research. However, in their article, LaRoche and Christopher devalue the cultural adaptation approach, and instead argue for more culturally centered approaches. Both of these approaches have merit, but because the CST perspective lacks an organizing framework, it is likely unclear to EST advocates where to begin when attempting to incorporate cultural considerations into their research.

Let me be clear: I believe that the variability in perspectives regarding how to incorporate culture into therapy is a *strength* of the CST movement, as each of the perspectives that I described in this commentary has its strengths that merit attention. At the same time, however, I recognize that without some clarity and organization, this variability can be an impediment to increasing the number of scholars and clinicians who attempt to expand their research programs to include culture. Moreover, without an honest appraisal of the weaknesses of the various perspectives, we risk the possibility that scholars who attempt to incorporate culture will encounter unanticipated difficulties and complications which may lead them to be less likely to embrace the CST movement.

Perhaps the organizing framework that I propose can provide some clarity and promote some critical self-reflection on the heterogeneity that exists in perspectives on culture and therapy. It is my hope that by refining our thinking around culture and the therapy process, we can then position ourselves to make affirmative judgments and

recommendations about the efforts that ESTs and other standard approaches have taken and can take to consider culture. This affirmative position may help us step out of a reactionary mode of self-description, so that we may create models of action that have concrete guidelines like the ones articulated by La Roche and Christopher, and, it is to be hoped, lead to more tangible change than is evident to date.

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