

CULTURALLY CENTERED PSYCHOSOCIAL INTERVENTIONS

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Over the last few decades, psychologists and other health professionals have called attention to the importance of considering cultural and ethnic-minority aspects in any psychosocial interventions. Although, at present, there are published guidelines on the practice of culturally competent psychology, there is still a lack of practical information about how to carry out appropriate interventions with specific populations of different cultural and ethnic backgrounds. In this article, the authors review relevant literature concerning the consideration of cultural issues in psychosocial interventions. They present arguments in favor of culturally centering interventions. In addition, they discuss a culturally sensitive framework that has shown to be effective for working with Latinos and Latinas. This framework may also be applicable to other cultural and ethnic groups. © 2006 Wiley Periodicals, Inc.

The thesis that cultural and social processes must be considered in treatment, prevention, and mental health service delivery has been advanced over the last several decades (Bernal, Trimble, Burlew, & Leong, 2003; Marín & Marín, 1991; Rogler, 1989, Sue & Zane, 1987). A growing number of authors are emphasizing the need to consider cultural and contextual aspects in psychosocial interventions (Bernal, Bonilla, & Bellido, 1995; Bernal & Scharron-del-Rio, 2001; Nagayama-Hall, 2001; Rogler, Malgady, Costantino, & Blumenthal, 1987; Sue & Sue, 2003; Sue & Zane, 1987). The field is progressively moving toward recognition of multiculturalism in nearly all aspects of psychology, as evidenced by the adoption of documents, such as the multicultural guidelines on education, research, training, practice, and organizational change (American Psychological Association [APA], 2003). Nevertheless, there are very few guiding frameworks available to investigators who are interested in tailoring treatment or preventive interventions to work with specific populations of various cultures and languages. The challenge is to develop evidence-based, culturally sensitive interventions.

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Culturally sensitive interventions has been described as a continuum of the following dimensions: (a) awareness of culture, (b) acquisition of knowledge about cultural aspects (such as norms, customs, language, lifestyle, etc.), (c) capacity to distinguish between culture and pathology, and (d) capacity to integrate the previous three dimensions in the intervention (Zayas, Torres, Malcolm, & DesRosiers, 1996). It is important to note that cultural sensitivity is a dynamic process that changes across time and in different contexts, in which the cultural hypothesis should be constantly tested against the alternative ones (López et al., 1989).

Various terms have been used over the years to refer to the consideration of culture, including “culturally sensitive,” “culture centered,” “culturally competent,” “multicultural competence,” or “culturally responsive.” All of these terms, while perhaps varying in degree of intensity, have in common the consideration of culture and language-related issues in any psychosocial intervention. In this article, we primarily use the term “culture-centered” first described by Pederson (1997) and subsequently adopted in the *Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists* (APA, 2003).

In this article, we discuss the need for culturally specific psychosocial interventions and present an evolving framework for the adaptation of empirically based, culturally sensitive treatment and interventions for ethnic minority populations. While our work has focused primarily on adapting interventions for Latino populations, the guiding framework presented here is applicable to other populations as well. We will begin with an overview of information pertinent to the circumstances of ethnic minorities (and specifically the Latino population) in the United States, which will clearly illustrate the need for culturally sensitive interventions.

ETHNIC MINORITIES IN THE UNITED STATES

Ethnic minority populations represent a considerable proportion of the entire population in the United States. According to the 2002 American Community Survey, 24.2% of the U.S. population identified as something other than White (U.S. Census Bureau, 2002). Of these, 13.5% identified as Hispanics/Latinos, 12.0% as African American, 4.1% as Asian/Pacific Islander, 0.7% as Native American or Alaskan Native, and the remaining 1.2% reported other ethnicities.

There is evidence suggesting that ethnic minorities in the United States are currently experiencing major mental health problems. Ethnic minorities often have less access to health care, and the care that is available is frequently of poorer quality than that available to the White population (U.S. Department of Health and Human Services, 2000). Ethnic minorities experience disproportionately higher poverty and social stressors associated with psychological and psychiatric conditions than do Whites (Mays & Albee, 1992; U.S. Department of Health and Human Services, 2000). In fact, after controlling for variables such as socioeconomic status, educational level, health and mental health history, and attitudes toward health-related issues, there are significant disparities in the use and quality of mental health services among and across different ethnic, cultural, and racial communities (National Institute of Mental Health [NIMH], 1999). These disparities in mental health services represent a major challenge to the field (U.S. Department of Health and Human Services, 2000). The goal of decreasing disparities between ethnic minority groups and the majority populations is currently a national effort, spearheaded by the National Institute of Mental Health (NIMH, 1999).

Latinos and Latinas Living in United States

In the United States, Latinos and Latinas are currently the largest ethnic minority group. In 2002, the number of Latinos and Latinas living in the United States was estimated at approximately 37.9 million, comprising 13.5% of the entire population (U.S. Census Bureau, 2002). Of these, 63.3% were Mexican Americans, 9.5% were Puerto Ricans, 3.4% were Cubans, and 23.8% were from some other Hispanic/Latin American country. The census projections indicate that by 2050, the Latino population will increase to 102.6 million, which will comprise approximately one-fourth of the total U.S. population.

It is important to note that the Latino population in the United States is diverse and heterogeneous. However, statistics show that all of the various Latino ethnic groups share certain similarities, among which are: (a) poverty, (b) inadequate housing, (c) high proportion of single-parent families, (d) alcohol/drug addiction, (e) acculturative stress, (f) discrimination (Dana, 1998), (g) relatively low educational and economic status (U.S. Department of Health and Human Services, 2000), and (h) a history of conquest, oppression, defeat, and struggle for liberation (Garcia-Prieto, 1982), particularly for the Mexican Americans and Puerto Ricans. Also, literature reviews reveal a set of characteristics shared by most Latinos and Latinas, such as the Spanish language and cultural ideals such as *personalismo* (personal contact), *simpatía* (social engagement, charm), and *familismo* (familialism) (Bernal & Enchautegui-de-Jesús, 1994; Dana, 1998).

Certainly, the family system contributes to the development and maintenance of both health-promoting and health-damaging behaviors (Bagley, Angel, Dilworth-Anderson, Liu, & Schinke, 1995). Thus, familialism could be considered as either a protective factor or a risk factor for the mental health status of Latinos as living in the United States. One disadvantage faced by many minority groups is the loss of their traditional cultural orientation, which may lead to family disruption (Bagley et al., 1995). Such disruption is common in Latino families who migrate from their native countries to the United States. Given the loss of the extended family resources and the difficulties of keeping in touch across national boundaries, many family ties are broken.

As are other ethnic minority populations, Latinos and Latinas are in need of mental health services. Epidemiological studies (The Epidemiologic Catchment Area Study and The National Comorbidity Study) have found that Latinos and Latinas—mostly Mexican Americans—have similar rates of mental disorders as Whites, and that the Latino population is considered to be at high risk for mental health complications. Despite this need for mental health services, Latinos and Latinas and those belonging to other ethnic minority groups have less access to mental health services than do Whites, and all too frequently, these services are inadequate or of poor quality (U.S. Department of Health and Human Services, 2000).

There are a number of factors that impede access to mental health services (Echeverry, 1997). These factors can be grouped into the following broad categories: (a) client variables, (b) client–therapist variables, and (c) organizational and structural variables. *Client variables* include demographic characteristics (age, gender, educational level, and legal status in the United States), cultural factors (religious beliefs, degree of acculturation, national origin, English proficiency level, resource preference, and beliefs about mental illness and treatment), and individual factors (presenting problem and personality variables). *Client–therapist variables* refer to confidentiality concerns and socialization with clients. Finally, *organizational and structural variables* consider the geographic location of mental health services, the cost of evaluation and treatment, the scheduling

of services, the type of services offered, and the availability of Spanish-speaking or bilingual personnel. It is essential that all these variables be taken into consideration when developing and implementing any mental health services for the Latino population. Nevertheless, the majority of the mental health services provided overlook these important aspects, causing the disparities in access and acceptance of such services.

Barona and Santos de Barona (2003) summarized the status of mental health services for the Latino population by indicating the following needs: (a) to increase the number of bilingual and bicultural mental health professionals who are competent in the carrying out of evaluations, diagnosis, and treatments, (b) to better train primary care service providers and mental health professional so that they can recognize symptoms of emotional distress, and (c) to develop effective and affordable models of mental health services.

THE CASE FOR CULTURALLY CENTERED PSYCHOSOCIAL INTERVENTIONS

The need for mental health providers to attend to cultural aspects when working with members of diverse ethnic minority communities is well documented (APA, 2003; Bernal, Bonilla, & Bellido, 1995; Lopez et al., 1989; McGoldrick, Pearce, & Giordano, 1982; Sue, 2003; Sue & Zane, 1987; Tharp, 1991; U.S. Department of Health and Human Services, 2000). The National Institute of Mental Health Strategic Plan for Reducing Health Disparities (1999) pointed out several findings from the literature on ethnicity and mental health. This report highlighted the following observations: (a) one's cultural beliefs about the nature of mental illness influence one's view of the course and treatment of any condition; (b) there are differences in how individuals from different cultural backgrounds experience and manifest symptoms of mental illness; and (c) diagnoses of mental disorders vary across cultures. In a later supplement on culture, race, and ethnicity (U.S. Department of Health and Human Services, 2001) to the Surgeon General's report on mental health (U.S. Department of Health and Human Services, 1999), the U.S. Surgeon General concludes that culture influences many aspects of mental illness, such as manifestation of symptoms, coping styles, family and community support, and willingness to seek treatment, as well as diagnosis, treatment, and service delivery. Subsequently, the American Psychological Association approved guidelines for multicultural counseling (APA, 2003). This document, based on the available literature, provides guidelines for clinical practice, research, organizational change, education, and training in psychology. In general, these guidelines encourage psychologists to increase their awareness of the influence of culture on themselves, as well as on their patients, clients, and trainees. In accordance with this premise, Pedersen (2003) points out that all behavior is learned and displayed within a cultural context, and, therefore, an effective intervention requires attention to the cultural context in which the client/patient is immersed.

Bernal and Scharron-del-Rio (2001) note that because psychotherapy is a cultural phenomenon, culture plays an important role in treatment. Evidence from several research studies supports this idea. For example, studies on service utilization (Arroyo, Westerberg, & Tonigan, 1998; Cheung & Snowden, 1990; Flaskerud & Liu, 1991; McMiller & Weisz, 1996; Schacht, Tafoya, & Mirabla, 1989), treatment preferences (Aldous, 1994; Constantino, Malgady, & Rogler, 1994; Flaskerud & Hu, 1994; Flaskerud & Liu, 1991; Penn, Kar, Kramer, Skinner, & Zambrana, 1995; Schacht, Tafoya, & Mirabla, 1989), and health beliefs (McMiller & Weisz, 1996; Penn et al., 1995) have reported that members of ethnic minority communities tend to respond differently to treatment than do nonminorities. These differences are most likely due to cultural differences.

Nagayama-Hall (2001) points out that there may be conflicts between the cultural values of ethnic minorities and the more mainstream values often used in conventional psychotherapies. For example, conventional treatment approaches tend to promote individualistic value systems (i.e., differentiation, individuation, etc.) rather than the interdependent value systems (i.e., familism) within which minority communities are often socialized. The role of spirituality in healing processes, which is being increasingly acknowledged in the realm of mental health care, has not traditionally been part of formal treatment approaches, and this, too, may have an important intra- and interpersonal role among ethnic minorities. Certainly, the degree of discrimination one experiences has important implications for treatment. Poverty and lack of access to resources are often part of the ethnic minority experience, and it is essential to understand how ethnicity, culture, cultural values, discrimination, community resources, and SES may impact a particular client or family. These dimensions can be considered in intervention protocols to work more effectively with ethnic minority groups.

Toward Culturally Centered Intervention With Specific Ethnic Minority Groups

To decrease the disparity in mental health services and to be able to provide effective psychosocial treatments, we must work to develop new studies. These studies should directly address disparities in access and in the knowledge base by using state-of-the-art research methods and the best practice treatment protocols that focus on mental health issues in the low income, ethnic minority communities that are often overlooked by NIMH-funded research. In the absence of reliable information on the efficacy and effectiveness of mental health treatments for ethnic minorities, there is a need for research that can contribute to the knowledge base of what works and how it works. Thus, we must develop studies on the efficacy and effectiveness of treatments that are culturally sensitive or that use manuals that have been adapted to include important cultural considerations. There is a great need to produce or adapt treatment manuals and instruments, and to test these manuals and instruments in preparation for efficacy trials with ethnic minority communities. In this manner, it may be possible to adequately respond to the NIMH's call for investigators to move toward more generalizable studies (National Advisory Mental Health Council's Clinical Treatment and Services Research Workgroup, 2000). Particularly necessary are studies that target underserved and underresearched populations that approximate the types of cases seen in community mental health centers. If we conduct clinical trials that consider cultural and language issues as being integral to the treatment itself, we may be able to move more quickly from efficacy to effectiveness. Studies that consider ecological validity serve to bridge knowledge gaps and move the field toward translational and dissemination studies (National Advisory Mental Health Council's Clinical Treatment and Services Research Workgroup, 1999).

Sue (2003) discusses several positions that have emerged concerning research issues about cultural competence. These positions are that:

- ... a) more resources are needed in order to meaningfully address cultural competency; b) the emphasis on randomized clinical trials and efficacy research has, in fact, hindered understanding; c) theoretically driven research is needed because of the impossibility of studying each significant minority group; d) cultural competency cannot be easily defined operationally and subjected to testing; and e) despite the lack of definitive research, guidelines for policies and practices must be established (p. 966).

Debate on Culturally Centered Treatments and Ecological Validity

A careful examination of the so-called empirically supported therapies (EST) list reveals that most of these studies include little formal consideration of the cultural, interpretative, population, ecological, and construct validity of the intervention. *Cultural validity* means the identification of specific “rules” that influence the behaviors of individuals, groups, and larger systems. *Interpretative validity* refers to how the subject’s motivations, backgrounds, goals, and methods of goal achievement affect his or her actions. *Population validity* is defined as the degree to which one can generalize from a specific sample to the population and/or to other populations. *Ecological validity* may be defined as the degree of agreement between the subject’s and the investigator’s respective perceptions of environment. *Construct validity* integrates the ecological, population, interpretative, and cultural validities. Washington and McLoyd (1982) proposed that all of these dimensions need to be considered to ensure external validity in research involving minorities. While, at the time, these authors were referring to the developmental psychology literature, we believe that these are issues of relevance to psychosocial treatment research today.

To contribute to models that consider diversity, intervention research with ethnic minorities is needed not only to address the problem of external validity but also because ethnic research is good science (Sue & Sue, 2003). The external validity of most evidenced-based psychosocial treatments is simply not known. Most efficacy studies do not include minorities in their sample. The problem of generalization is central to this debate, and may be addressed by culturally adapting treatments within a set of clinical trials on specific ethnic minority populations or by testing innovative, culturally centered treatments with ethnic minority groups. Thus, the development and testing of culturally sensitive therapies is critical to the field.

Lloyd Rogler called attention to issues of cultural sensitivity (1989) and, recently, to cultural insensitivity (1999) in research. He notes that cultural insensitivity is prevalent in research, as manifested in the expert rational analysis model of content validity, the unilateral elimination of the decentering process in translations, and the uncritical transfer of concepts cross-culturally. Rogler proposed that research be made culturally sensitive through careful attention to methodological issues that include the kind of adaptations that consider culture. All aspects of the research process need to be considered (from the planning and design to instrumentation, analysis, and results) in light of changing cultural contexts.

A Culturally Sensitive Framework for Interventions

There is a growing movement toward the consideration of culture in intervention and treatment research. A number of authors have argued in favor of treatments in which culture becomes the basis for understanding social interactions, behavior, and the meaning of actions (Casas, 1995; Echeverry, 1997; Lopez et al., 1989; McGoldrick, Pearce, & Giordano, 1982; Ramírez, Valdez, & Perez, 2003; Rogler, 1989; Sue, 1998).

One of the early pioneering efforts to develop culturally informed treatment studies with Latinos was presented by José Szapocznik and collaborators (Szapocznik et al., 1984, 1986, 1989). They proposed a contextual view in which the individual is embedded within a family context, which, in turn, is embedded within cultural contexts. This view is based on the concept of contextualism, which emphasizes that an individual must be

understood within the context of his or her family, and at the same time, this family needs to be understood within the context of the culture in which it is immersed. This work is a result of a productive research program that focused on developing and testing treatments with Latino youth and their families living in the United States. Szapocznik has found that when working with these Latino families, it is essential to pay attention to the increasingly multicultural and pluralistic context in which they are embedded.

Our work is also based on a contextualist view. In 1995, we developed a framework for culturally sensitive interventions with ethnic minorities (Bernal et al., 1995), particularly Latinos and Latinas, which we have used as a methodological tool to carry out adaptations of psychosocial interventions when working with Puerto Ricans. The framework serves to “culturally center” a given intervention (Pedersen, 2003), and it includes eight elements or dimensions that must be incorporated into treatment to augment both the ecological validity and the overall external validity of a treatment study. These centering elements are: (a) language, (b) persons, (c) metaphors, (d) content, (e) concepts, (f) goals, (g) methods, and (h) context. In addition, this model emphasizes the consideration of developmental, technical, and theoretical issues.

The first dimension, *language*, is often a carrier of culture; thus, treatments delivered in the native language of the target population assume an integration of culture. Regarding this idea, Sue and Zane (1987) have pointed out that knowledge of language often goes hand in hand with greater cultural knowledge. Furthermore, language is not only related to culture but also to the expression of emotional experiences. If a mental health care provider is unfamiliar with cultural norms insofar as emotional expression, mannerisms, and verbal style, he or she may misinterpret such expressions, which could affect the course of the treatment (Barona & Santos de Barona, 2003). Moreover, Echeverry (1997) points out that even those Latinos and Latinas living in the United States who have enough English proficiency to enable them to function in their work and daily lives, confront difficulties when trying to communicate about intimate personal matters that may be laden with emotion and with subtle cultural nuances. Thus, it is important to note that language-appropriate interventions require more than the mere mechanical translation of a particular intervention. In contrast to a decentered translation, a common practice in cross-cultural research, the objective is to use culturally centered language as part of the intervention or treatment with the given ethnic group. The language used in an intervention must be culturally appropriate and syntonic, taking into consideration differences in inner city, regional, or subcultural groups. In light of such considerations, several authors have argued in favor of bilingual clinicians instead of interpreters when providing services to Latinos and Latinas in the United States.

The dimension of *persons* refers to the client–therapist relationship during the intervention. A culturally centered intervention must consider the role of ethnic and racial similarities and differences in the client–therapist dyad. This dimension brings into focus the consideration of ethnic and race matching in the client–therapist dyad, as it may be important to acknowledge ethnic, racial, or cultural similarities and differences. To achieve this goal, these issues must be discussed and acknowledged during the treatment process. Echeverry (1997) highlights the importance of clarifying the client’s expectations about the therapist in the very beginning of the therapeutic process. To exemplify the importance of this clarification, Echeverry mentions that Latino clients have been known to discontinue therapy early because their therapist would not accept their invitations to socialize with them and their family. This situation is closely related to *personalismo*, as this cultural value may foster the expectation that the provider will interact in a caring manner and provide a more constant presence of support and assistance (Barona

& Santos de Barona, 2003). Given that a culturally centered therapist working with Latinos should be familiar with this cultural aspect, he or she should let the client know early on exactly what the limitations of his or her role as therapist are, to avoid unfulfilled expectations or misunderstandings that could lead the client to abandon therapy.

The next dimension presented in the framework is the use of *metaphors* in interventions. This dimension refers to the symbols and concepts that are shared by a particular cultural group. Muñoz (1982) has recommended the incorporation of objects and symbols of the client's culture in the office where the client will be received; this may make the client feel more comfortable and understood. Similarly, Zuñiga (1992) points out that the use of *dichos*—sayings or idioms—is a good way to incorporate metaphors into therapy, particularly with Latinos.

The dimension of *content* refers to cultural knowledge about values, customs, and traditions shared by ethnic and minority groups. Cultural and ethnic uniqueness should be integrated into all phases of a treatment process, including assessment and treatment planning. Thus, when working with ethnic minority communities, cultural content is an essential starting point for sharing experiences in a therapeutic context.

Concepts refer to the constructs of the theoretical model to be used in treatment. The way in which the presenting problem of a client is conceptualized and communicated to him or her is very important. In this process, the consonance between culture and context is critical for treatment efficacy. If this congruence is absent, the therapist's credibility will be reduced and consequently the treatment efficacy may be threatened.

The sixth dimension, *goals*, implies the establishment of an agreement between the therapist and client as to the goals of treatment. The goals of treatment should reflect a cultural knowledge, because these goals must be created taking into consideration the specific values, customs, and tradition of the client's culture.

The dimension of *methods* refers to the procedures to follow for the achievement of the treatment goals. As can be expected, the development of a culturally centered treatment should incorporate procedures that are congruent with the client's culture. An important methodological tool in treatment is the use of language.

Finally, the dimension of *context* refers to the consideration of the client's broader social, economic, and political contexts. Additionally, it is important to consider cultural processes, such as acculturative stress, phases of migration, developmental stages, availability of social support, and the one's relationship to his or her country or culture of origin.

GUIDELINES FOR MULTICULTURAL PRACTICE IN COMMUNITY PSYCHOLOGY INTERVENTION RESEARCH

For years, community psychologists have been at the forefront of contextualized research that considers cultures and language. The framework of a culturally sensitive treatment described above is consistent with the multicultural guidelines recently adopted by the American Psychological Association (2003). The general guidelines of this document state that "psychologists are encouraged to recognize that, as cultural beings, they may have attitudes and beliefs that can detrimentally influence their perceptions of, and interactions with, individuals who are ethnically and racially different from themselves" (p. 19), and to "recognize the importance of multicultural sensitivity/responsiveness, knowledge, and understanding about ethnically and racially different individuals" (p. 27). These guidelines for clinical practice emphasize that psychologists should focus the client within his or her cultural context. In so doing the psychologist

seeks to understand how some experiences, such as socialization, discrimination, and oppression, may relate to the client's presenting problem. The guidelines bring attention to the importance of sociopolitical factors in the client's history (e.g., generational history, history of migration, citizenship or residency status, fluency in English and/or other languages, extent of family support, levels of community resources, level of stress related to acculturation). These are issues that, within the proposed framework, are considered contextual or may be handled within specific cultural knowledge or unique aspects of a particular ethnic and minority group.

As we discussed above, in the presentation of the dimension of *metaphors*, multicultural guidelines encourage psychologists to be aware of the environment in which the client will be received. Another recommendation for psychologists in clinical practice is to have a broad repertoire of interventions. These interventions should reflect the different worldviews and cultural backgrounds of clients, incorporating clients' ethnic, linguistic, racial, and cultural background into therapy. In addition, the guidelines encourage therapists to examine the interventions used in traditional psychotherapies to determine their cultural appropriateness. Therapists are urged to expand these interventions to include multicultural awareness and culturally specific strategies.

CONCLUSIONS

Clearly, there is a need for ethnic minority participation in intervention research. On the one hand, population estimates point toward an accelerated increase in ethnic minorities in the United States, which sets the stage for an increasingly multicultural society. On the other hand, little evidence is available on the validity of empirically supported interventions with ethnic minorities and other multicultural groups because minorities have not been part of most clinical trials. At the very least, the inclusion of ethnic minorities in intervention research must be a priority. In addition, it is imperative that studies that focus on specific ethnic minority groups be supported. Over the years, many investigators and clinicians have called for incorporating culture in interventions and treatments. There are, however, still very few resources that offer a systematic approach to the consideration of culture and context. The culturally sensitive framework described here serves to culturally anchor interventions used with Latinos and Latinas and may be of use to investigators interested in working with other groups as well. Our hope is that such a framework may serve as a resource to investigators in planning and conducting intervention studies with ethnic minorities.

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