

*Annual Review of Clinical Psychology*  
**Culturally Responsive  
Cognitive Behavioral  
Therapy for Ethnically  
Diverse Populations**

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**Keywords**

CBT, clinician training, cognitive behavior therapy, cultural adaptation, cultural competence, mental health disparities, minority mental health

**Abstract**

Cognitive behavioral therapy (CBT) is often referred to as the “gold standard” treatment for mental health problems, given the large body of evidence supporting its efficacy. However, there are persistent questions about the generalizability of CBTs to culturally diverse populations and whether culturally sensitive approaches are warranted. In this review, we synthesize the literature on CBT for ethnic minorities, with an emphasis on randomized trials that address cultural sensitivity within the context of CBT. In general, we find that CBT is effective for ethnic minorities with diverse mental health problems, although nonsignificant trends suggest that CBT effects may be somewhat weaker for ethnic minorities compared to Whites. We find mixed support for the cultural adaptation of CBTs, but evidence for cultural sensitivity training of CBT clinicians is lacking, given a dearth of relevant trials. Based on the limited evidence thus far, we summarize three broad models for addressing cultural issues when providing CBT to diverse populations.

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## INTRODUCTION

Cognitive behavioral therapy (CBT) is well-supported for a wide array of mental health problems in children and adults, and may be the “gold standard” of the psychotherapy field (David et al. 2018). CBTs are widely disseminated in training and clinical settings, with CBTs taught in the majority of US training programs for psychologists, psychiatrists, and social workers (Ludgate 2015, Weissman et al. 2006). CBTs dominate international guidelines for psychosocial treatments, and many organizations in the United States and United Kingdom now routinely offer some form of CBT to patients who present with mental health problems (NPTMC 2017).

Yet there are persistent concerns about the appropriate application of CBTs to ethnic minority and non-Western clients, and whether tailoring is needed to optimize treatment for culturally diverse populations. Because cognitive behavioral theories and practices are typically grounded in dominant Western cultural models (e.g., focus on independence versus interdependence or primary versus secondary control), many argue that conventional CBTs may not “fit” as well with the worldviews and practices of many ethnic and cultural minority group members (Hall et al. 2021, Hays 2009). The biggest question for many involves the role of cultural tailoring and how best to train CBT clinicians to work with ethnic minorities.

In this review, we summarize the state of the evidence concerning CBTs for culturally diverse populations. We assess the effects of CBTs with ethnic minorities and whether culturally sensitive approaches improve CBT outcomes. In addition, we summarize different models for providing culturally competent care and supporting evidence, particularly as they relate to clinician training and CBT. Given the enormous gaps in the literature, we also discuss clinical implications and areas for future research.

## DEFINING CULTURAL COMPETENCE

The general consensus among experts is that cultural sensitivity embodies cultural awareness and application of this knowledge to diverse populations (Betancourt et al. 2003, Whaley & Davis 2007). Beyond this, however, there is no uniformity in terms of definition, terminology, and conceptual models concerning cultural competence. Indeed, as others have noted (Fuertes & Gretchen 2001, O'Donohue & Benuto 2010, Ridley et al. 2021), the biggest challenges in this field include (a) the definitional ambiguity with regard to cultural sensitivity and (b) the sheer number of models developed by experts over the years.

In an earlier review (Huey et al. 2014), we argued for differentiating between three broad models of cultural competence: skills-based models, adaptation models, and process-oriented models. Skills-based models emphasize the provider's ability to develop cultural knowledge of the self and others and to apply this knowledge to clinical contexts (e.g., Pedersen 1978). Adaptation models emphasize the use of systematic modifications to make conventional treatments more congruent with cultural beliefs and practices (e.g., Bernal et al. 2009). Process models emphasize the dynamic processes underlying therapy, particularly as they relate to client-therapist interactions and cultural meanings ascribed to behaviors (Lopez 1997). In short, skills-based models prioritize therapist characteristics, adaptation models prioritize treatment characteristics, and process models prioritize therapeutic processes.

Several key patterns are evident with regard to these models (Huey et al. 2014). First, skills- and process-based models dominate the conceptual literature on cultural competence, but they are rarely tested in clinical trials. In contrast, adaptation models dominate on the empirical front, with most randomized trials of culturally sensitive CBTs reflecting systematic adaptations to the core treatment. Second, rigorous testing to assess model specificity is rare, although, below, we showcase the few trials that try to assess the added value of culturally sensitive care in the CBT context. Finally, beyond any specific model, we know very little about how to effectively train evidence-based multicultural competencies in providers.

### Clinician Definitions

To our knowledge, only two investigations have surveyed clinicians to assess their conceptualizations of cultural sensitivity, which is surprising given the central role they play in executing mental health interventions. Zayas et al. (1996) surveyed 150 White doctoral- and masters-level clinicians, asking them to “define culture-sensitive or ethnic-sensitive treatment.” Roughly 25 years later, Benuto et al. (2021) used a mixed methods approach with 151 psychologists (79% White) to assess cultural sensitivity perspectives. First, they asked psychologists to describe “What is cultural sensitivity?,” and next they asked additional psychologists to complete a related cultural sensitivity survey. **Table 1** summarizes the themes emerging from both studies.

**Table 1** Comparison of two surveys assessing clinician definitions of cultural sensitivity

| Zayas et al. 1996                                       | Benuto et al. 2021   |
|---|--|
| Awareness of existence of differences                   | Awareness of cultural factors (including how cultural factors impact therapy relationships and clinician's own biases) |
| Knowledge of client's culture                           |  |
| Distinguish between culture and pathology in assessment | Consideration of cultural factors with case conceptualization  |
| Taking culture into account in therapy                  | —  |
| —   | Ideographic sensitivity—considering client's unique, individual circumstances  |

Despite different methodologies and the 25-year gap between studies, there was considerable overlap in emerging themes. Awareness of cultural factors was one of the common themes, with emphasis on understanding client–clinician differences and how this might affect the therapy process. The second common theme related to use of cultural knowledge in the assessment and case conceptualization process. This evidence suggests some convergence between dominant models of cultural sensitivity and clinician views.

### **Cognitive Behavioral Therapy Conceptualizations**

Recent years have seen the emergence of numerous models for addressing culture within the context of CBT (e.g., Bernal et al. 1995, Hays 1996, Hwang et al. 2008, McCabe et al. 2020, Pina et al. 2019), and they all conceptualize cultural competence in different ways. Perhaps the most prominent of these models with regard to scope and impact is Pamela Hays’s ADDRESSING model (Hays 1996, 2008).

Hays (2009) argues that CBT and multicultural therapy models share numerous features that make them ideal for integration. These features include (a) an emphasis on tailoring to unique client needs, (b) an emphasis on empowerment, (c) a focus on conscious processes that can be easily articulated and accessed, (d) attention to ongoing outcome and process assessment from the client’s perspective, which demonstrates respect for the client’s viewpoint, and (e) attention to naturally occurring strengths and supports that can be leveraged to facilitate change. Yet, according to Hays, there are gaps as well that limit the broad applicability of unadapted CBT. For example, standard CBT emphasizes assertiveness, personal independence, verbal ability, and rationality, which might be contraindicated if the client’s cultural mores emphasize subtle/indirect communication, interdependence, listening and observing, and spirituality. Thus, Hays developed the ADDRESSING framework, which is a comprehensive approach to working with multicultural populations within the CBT paradigm (Hays 1996, 2008). Each letter of this acronym stands for a different aspect of a person’s cultural identity: Age, Developmental and acquired Disabilities, Religion, Ethnicity, Socioeconomic status, Sexual orientation, Indigenous heritage, Native origin, and Gender. The framework is designed to help clinicians attend to the diverse worldviews and experiences of their clients while being mindful of their own backgrounds and identities. It also offers specific strategies to facilitate multicultural competency, such as validating clients’ self-reported experiences of oppression and avoiding challenging core cultural beliefs.

### **THE RATIONALE FOR CULTURALLY COMPETENT CARE**

Beyond the conceptual arguments, there are pragmatic concerns that culturally sensitive practice should help address. In this section, we briefly outline some key reasons for considering culturally competent mental health care.

#### **Mental Health Disparities**

Racial and ethnic disparities in access to and utilization of mental health services have been well documented, with evidence suggesting that these disparities have increased over time (Cook et al. 2017, Rodgers et al. 2022). Specifically, people of color are less likely to seek out and receive psychotherapy compared to White people (Cummings et al. 2019, Marrast et al. 2016, Rodgers et al. 2022, Yang et al. 2020), and these disparities persist even after controlling for socioeconomic status. Furthermore, when they do receive mental health services, people of color often receive a lower quality of care than White people (Mallinger et al. 2006, Primm et al. 2010). For instance, Black and Latino/a individuals are less likely to be offered evidence-based treatment (EBT) (Wang

et al. 2000), less likely to receive guideline-concordant care (Cummings et al. 2019, Primm et al. 2010), and more likely to be misdiagnosed (Bell et al. 2015) compared to White clients.

Drivers of disparities in mental health access and service quality are multifaceted (Cook et al. 2019) and can be categorized broadly into client-, clinician-, and institutional-level factors. Compared to White people, people of color are less likely to believe that mental health treatment will be helpful and, instead, rely more on their natural support systems such as family, friends, and spiritual/religious leaders (Gone & Trimble 2012, Jimenez et al. 2012, Turner et al. 2016). Higher rates of mental health stigma in communities of color, including perceptions of mental illness as a sign of personal weakness, have also been identified as barriers to help-seeking (Clement et al. 2015, Eylem et al. 2020, Harris et al. 2020, Misra et al. 2021). Turning to clinician- and institutional-level factors, the shortage of racially and ethnically diverse clinicians and lack of culturally competent clinicians (Santiago & Miranda 2014) may also fuel mental health disparities. Although people of color comprise 40% of the US population (US Census Bureau 2020), 84% of psychologists are White (APA 2019). Thus, the mental health workforce does not reflect the racial and ethnic demographics of this country, which may decrease clients' willingness to seek and engage in services, especially for clients of color who may prefer to be matched with a clinician of the same race (Cabral & Smith 2011, Thompson et al. 2004).

### **Provider Bias**

Racial biases among mental health providers are also prevalent and may contribute to disparities in mental health access and service quality. These biases appear to affect service delivery at various stages of the treatment process, including the initial psychodiagnostic assessment. Clinician racial biases can lead to errors in clinician decision making, resulting in the overdiagnosis or underdiagnosis of certain disorders in clients of color. For instance, clients of color, especially Black individuals, are more likely to be diagnosed with schizophrenia and less likely to be screened or diagnosed with mood disorders than White clients (Fearon et al. 2006, Gara et al. 2012, Hahm et al. 2015). Furthermore, even when showing comparable behaviors, youth of color are more likely to be diagnosed with conduct disorder and oppositional defiant disorder, whereas White youth are more likely to be diagnosed with mood, anxiety, or developmental disorders (Baglivio et al. 2017, Fadus et al. 2020, Mizock & Harkins 2011). These findings suggest that some therapists may harbor stereotypes of youth of color as more aggressive, violent, and disruptive, leading to biases and errors in diagnostic decision making.

In addition to affecting psychodiagnostic assessments, clinician bias may also manifest as racial microaggressions—defined as verbal and nonverbal messages that communicate hostility, insensitivity, or degradation based on their race (Pierce et al. 1978, Sue et al. 2007)—toward clients of color (Constantine 2007; Hook et al. 2016; Owen et al. 2011, 2014). For example, in a study of more than 2,000 people of color with experience in counseling (30% Black, 31% Hispanic, 12% Asian, 6% American Indian/Alaska Native), 82% of participants reported experiencing at least one racial microaggression in that setting (Hook et al. 2016). The most commonly reported experiences of racial microaggressions included clinicians' avoidance of cultural issues and denial or lack of awareness of their own biases. Not surprisingly, racial microaggressions in clinical contexts have been linked with worse client and therapeutic outcomes, including poorer psychological well-being (Owen et al. 2014), decreased working alliance (Davis et al. 2016), lower perceived cultural humility of the clinician (Davis et al. 2016; Hook et al. 2013, 2016), and decreased willingness to seek future care (Crawford 2011). Thus, experiences of racial microaggressions not only appear to negatively affect the specific therapeutic context in which these experiences occur, but they also alter clients' perceptions of therapy and mental health services more broadly, including

greater mistrust of mental health providers (Dovidio & Casados 2019). These findings underscore the downstream effects that clinicians' biases and lack of cultural competency might have on the maintenance of racial inequities in mental health outcomes.

Studies of racial microaggressions in therapy, along with well-documented disparities in diagnostic assessment and service delivery quality, suggest that clinician biases may be at play. However, surprisingly, few studies have directly linked clinicians' biases with their treatment of clients. In contrast, there is a growing body of research in the medical field demonstrating associations between healthcare providers' implicit biases and provider-patient interaction quality (for a review, see Maina et al. 2018). Specifically, healthcare providers with higher implicit racial biases have been shown to demonstrate lower empathy, more negative affect, and more verbal dominance when interacting with clients of color (Haider et al. 2014, 2015; Maina et al. 2018). More research is needed that examines these associations between provider bias and patient care specifically among mental health providers.

### **Student and Professional Concerns**

Despite requirements by the American Psychological Association (APA 2012) and the Psychological Clinical Science Accreditation System (PCSAS 2022) regarding training and education in multiculturalism, the shortage of clinicians trained in culturally competent care suggests that graduate programs in health service psychology may not be providing students with adequate training. Indeed, a recent study of current graduate students in clinical psychology PhD and PsyD programs in the United States found that while the majority of trainees (91.3%) have worked with clients of color, many have done so without adequate training in cultural humility and attending to the unique racial stressors that clients of color face (Galán et al. 2023). These findings underscore significant gaps between trainee needs and what they may actually receive from their respective programs. As a result, many students emerge from graduate programs feeling they are not prepared with the knowledge, awareness, and skills to provide culturally sensitive care. Underrepresentation of ethnic minorities in the mental health workforce may be disproportionately affected by this gap, with ethnic minority graduate students reporting less satisfaction with their training in multiculturalism than their White peers (Gregus et al. 2020). This means that many emerging clinicians, even when well-intended, may unintentionally contribute to the maintenance and widening of racial inequities in mental health access and service quality.

Experienced clinicians express concerns as well. The inherent structure of CBTs and other manualized treatments has led clinicians to voice concerns about the cultural compatibility of EBTs (Addis et al. 1999, Palinkas et al. 2013). In addition, although quantitative and qualitative studies find that clinicians are generally satisfied with the cultural competency training that they received, specifically related to the topics of race and ethnicity, many believe that there were significant gaps with regard to their graduate training (Benuto et al. 2019, Green et al. 2009, Park et al. 2020b). To strengthen their cultural competence, psychology trainees have expressed a desire for more concrete and technical training, as well as training that is integrated across their coursework, clinical work, and research (Benuto et al. 2019, Gregus et al. 2020). Aligned with findings from reviews on cultural competency trainings, psychology trainees have reported that training increased their knowledge and awareness (Benuto et al. 2019).

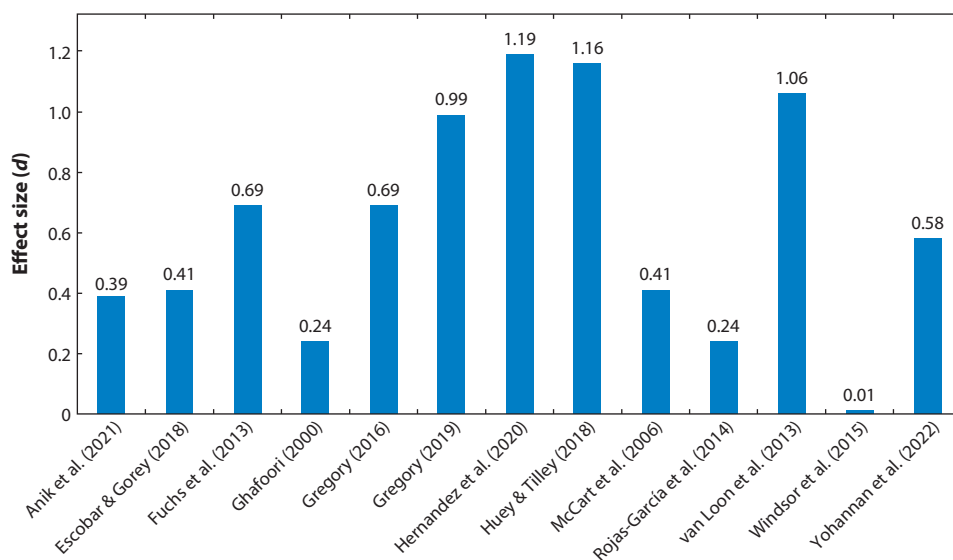
### **DO COGNITIVE BEHAVIORAL THERAPIES WORK WITH ETHNIC MINORITIES?**

In other reviews, we show that EBTs are generally effective for ethnic minorities with various mental health problems, with effect sizes ranging from small to large depending on the target

problem and cultural group (Huey & Polo 2008, Huey et al. 2014, Huey & Tilley 2018, Pina et al. 2019). Although CBTs often predominate among EBTs, this is not the case for all mental health problems. In this section, we focus specifically on whether CBTs are effective for ethnic minorities. We briefly synthesize results from reviews of CBTs with ethnic minority populations, while supplementing with data from our own database of randomized trials of mental health treatments. We highlight several key findings.

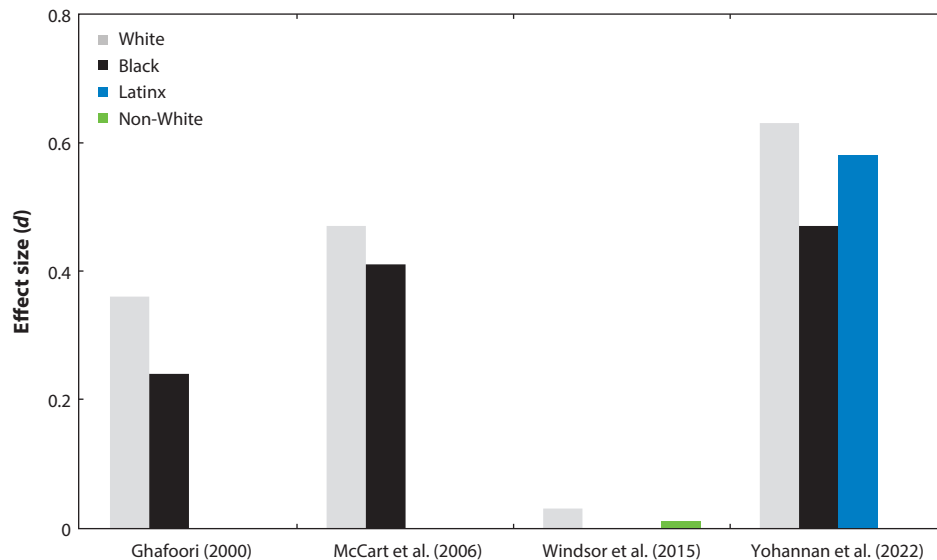
First, CBTs are generally effective for ethnic minorities with a broad array of mental health problems, including anxiety disorders (Gregory 2019, van Loon et al. 2013), antisocial behavior and conduct problems (Ghafoori 2000, Gillespie & Huey 2015, McCart et al. 2006, Usher & Stewart 2014), depressive disorders (Anik et al. 2021, Escobar & Gorey 2018, Gregory 2016, van Loon et al. 2013), posttraumatic stress disorder and other trauma-related symptoms (Yohannan et al. 2022), psychosis (Turner et al. 2020), and substance use problems (Huey & Tilley 2018, Stoner 2018). Notably, the majority (58%) of mental health treatments identified by Pina et al. (2019) as well-established, probably efficacious, or possibly efficacious for ethnic minority youth were CBTs.

Second, CBT effects are fairly robust. **Figure 1** shows effect sizes reflecting CBT effects for ethnic minorities across 13 meta-analytic studies. Although one CBT meta-analysis showed a null effect for substance use problems ( $d = 0.01$ ) (Windsor et al. 2015), the others all reported significant small-to-large CBT effects for ethnic minorities ( $d = 0.24$  to  $1.19$ ). That said, there are significant gaps in the literature, particularly with regard to treatment of autism spectrum disorders



**Figure 1**

Cognitive behavioral therapy (CBT) effects for ethnic minorities across 13 treatment outcome meta-analyses. Effect sizes represent CBT effects for antisocial and disruptive behaviors in African American youth (Ghafoori 2000, McCart et al. 2006); anxiety in African Americans (Gregory 2019); depression in African Americans (Gregory 2016), Latinos (Escobar & Gorey 2018), and ethnic minorities (Anik et al. 2021, Rojas-García et al. 2014); anxiety and depressive disorders in ethnic minorities (van Loon et al. 2013); substance use problems in ethnic minorities (Windsor et al. 2015); trauma-related symptoms in ethnic minority youth (Yohannan et al. 2022); and diverse mental health problems in Asian Americans (Huey & Tilley 2018), Latinos (Hernandez et al. 2020), and clients from nondominant cultural or marginalized backgrounds (Fuchs et al. 2013).



**Figure 2**

Results from four cognitive behavioral therapy (CBT) outcome meta-analyses testing ethnicity as a moderator of treatment effects. Meta-analyses by Ghafoori (2000), McCart et al. (2006), Windsor et al. (2015), and Yohannan et al. (2022) all indicate that ethnicity (White vs. Black, Latinx, or non-White) does not moderate CBT effects.

(Safer-Lichtenstein et al. 2017), bipolar disorders (Miklowitz et al. 2021), eating disorders (Hilbert et al. 2020), and obsessive-compulsive disorders (Thompson-Hollands et al. 2014, Williams et al. 2010) with ethnic minorities.

Third, ethnic minorities and Whites may benefit equally from CBTs, although variation across studies complicates this point. To address this issue in a systematic fashion, we briefly summarize results from five meta-analyses that test whether ethnicity moderates CBT effects. Four of these meta-analyses reported separate effect sizes for White versus non-White participants (see **Figure 2**). These meta-analyses focused on CBT for treatment of conduct problems in youth (Ghafoori 2000, McCart et al. 2006), psychosis (Turner et al. 2020), substance use problems (Windsor et al. 2015), and trauma-related symptoms in youth (Yohannan et al. 2022). All showed that ethnicity did not significantly affect CBT outcomes, which the authors mostly interpreted to mean that there were no ethnic differences in CBT effects. For example, Yohannan et al. (2022) argued that their nonsignificant ethnicity effect “implies that children and adolescents from Black or African American, Hispanic or Latino/a, and White or European American backgrounds made similar gains after engaging in CBT” (p. 715).

We also approached the issue of treatment moderation in a different way. To assess whether White and ethnic minority participants benefitted differentially when receiving identical treatment, we identified 13 randomized controlled trials (RCTs) of various CBTs in our database that (a) compared CBT to a no treatment, placebo, or treatment-as-usual (TAU) control group, (b) tested ethnicity as a moderator of treatment effect, and (c) reported sufficient data to allow us to calculate posttreatment effect sizes separately for White and non-White participants. These were diverse CBTs focused on a range of mental health problems for youth and adult samples. When combined, the mean effect sizes for both ethnic minority ( $d = 0.40$ ,  $SE = 0.10$ ,  $p = 0.000$ ,  $I^2 = 37\%$ )



and White ( $d = 0.39$ ,  $SE = 0.10$ ,  $p = 0.000$ ,  $I^2 = 16\%$ ) participants were significant, with the small difference between groups not significant,  $Q(1) = 0.00$ ,  $p = 0.99$ .

On the surface, these findings suggest that CBTs are equally effective for White and non-White participants. However, when we consider nonsignificant trends across several data sources, a more concerning pattern emerges. **Figure 2**, for example, shows that CBT effect sizes for White participants are always higher than those for ethnic minority participants, although the difference is never statistically significant. A recent review of EBTs for ethnic minority youth provides further support for this trend (Pina et al. 2019). When focusing only on well-established and probably efficacious interventions for ethnic minority youth, 13 studies showed that ethnicity did not moderate treatment effects. However, of the eight studies that found significant ethnicity-as-moderator effects, all but one showed greater treatment benefits (mostly CBTs) for European American youth compared to ethnic minorities (Pina et al. 2019).

In summary, CBTs are generally effective for ethnic minorities with diverse mental health problems, and effect sizes are fairly robust. Although moderator analyses mostly show that ethnicity does not moderate CBT effects, nonsignificant trends suggest that CBT benefit may not be as strong for ethnic minorities. One possibility is that the lack of cultural tailoring partly explains this latter finding. We examine research on cultural tailoring effects in the next section.

## DOES CULTURAL TAILORING ENHANCE COGNITIVE BEHAVIORAL THERAPY OUTCOMES?

Assessing whether cultural tailoring improves the efficacy of CBT is complicated for several reasons. First, there are many diverse models of culturally competent practice, and replication of model effects in clinical trials is rare. Second, the majority of clinicians say they are at least modestly culturally competent and report that they tailor interventions when working with culturally diverse populations (Huey et al. 2014). This is true for CBT clinicians and trainees as well (e.g., Maxie et al. 2006, Sehgal et al. 2011). Thus, even “generic” or “standard” CBTs may ultimately include cultural content, because clinicians naturally tailor to address cultural difference. Third, nearly all meta-analytic reviews of culturally tailored treatments (see Huey et al. 2014) focus broadly on cultural tailoring, rather than tailoring specifically in the context of CBT. Finally, there is very little rigorous research that attempts to isolate cultural tailoring effects (Huey & Polo 2008, Huey et al. 2014).

In our 2014 review, we summarized 10 meta-analyses that tested the effects of culturally tailored treatments, with all finding that they are generally efficacious with ethnic minorities (Huey et al. 2014). Since then, at least a dozen additional reviews have been published (e.g., Hall et al. 2016) that all reach the same conclusion. Here, we briefly summarize findings from four recent meta-analyses that speak to the effects of culturally adapted cognitive behavioral therapies (CA-CBTs) specifically rather than treatment more broadly.

We start with several meta-analyses assessing the effects of culturally tailored CBT for ethnic minority populations. van Loon et al. (2013) found that culturally adapted treatments were highly effective in treating ethnic minorities with anxiety and depressive disorders, with an overall effect size of 1.03—a large effect. Similarly, Anik et al. (2021) found that culturally adapted therapies that were predominantly cognitively or behaviorally oriented (69%) were effective at reducing depression for depressed adults, with an overall effect in the medium-to-large range ( $d = 0.63$ ).

Two additional meta-analyses provide evidence suggesting that cultural tailoring quality or specificity may matter as well, although both are based on fairly small samples. Escobar & Gorey (2018) used meta-analysis to assess the relative effects of CBTs with deep structure cultural adaptations (i.e., incorporating Hispanic-specific cultural, social, or historical content) versus surface

structure adaptations (i.e., matching intervention materials/messages to observable cultural characteristics or preferences) on Latina/o adults with depression. Overall, they found that CBT yielded small-to-medium effects for Latinas/os with depression at posttreatment ( $d = 0.41$ ) and follow-up ( $d = 0.44$ ). Importantly, they found that including deep structure adaptations to CBTs was associated with significant increases in treatment success at posttreatment and follow-up compared with using surface structure adaptations or no adaptations at all (Escobar & Gorey 2018). Similarly, Huey & Tilley (2018) used meta-analysis to test the effects of interventions for Asian Americans with diverse mental health problems, and 52% of studies included CBTs. They found that CBTs (89% culturally tailored) were highly effective for Asian Americans, yielding a substantially larger effect ( $d = 1.16$ ) than non-CBTs ( $d = 0.37$ ). Notably, when all treatments were combined, they found that specificity of cultural tailoring was associated with better outcomes; treatments tailored for specific Asian subgroups (e.g., Chinese Americans) showed the largest effects ( $d = 1.10$ ), followed by treatments tailored for Asians broadly ( $d = 0.58$ ), and finally those tailored broadly for ethnic minorities or with no adaptations ( $d = 0.25$ ).

A major limitation is that the above meta-analyses focused primarily on trials comparing CA-CBT to no treatment, placebo, or TAU control conditions. While informative, the trial designs do not allow us to determine whether cultural tailoring is responsible for improved outcomes. The ideal design involves randomly assigning participants to standard CBT or culturally tailored CBT, with the two treatments similar in terms of core content and length/intensity (Huey et al. 2014). In our current database, we found nine randomized trials that included these design features, all focused on treating ethnic minority participants with preexisting mental health problems. **Table 2** gives a brief summary of these trials, cultural tailoring elements, whether cultural competence training was a primary focus, and other study features.

Three of the nine studies showed positive cultural tailoring effects on symptom reduction, with two focused on Asian Americans and one on Black Americans. Pan and colleagues (Huey & Pan 2006, Pan et al. 2011) compared the effects of culturally adapted one-session treatment (OST), standard OST, and manualized self-help for phobic Asian Americans. The seven adaptations were mostly implicit accommodations to East Asian cultural values and norms (e.g., exploiting the vertical nature of the therapeutic relationship by using directives rather than queries or requests) and were derived from psychological research with Asian Americans. Although both OST conditions were more effective than self-help, culturally adapted OST also led to greater phobia remediation (on two of six measures) than standard OST (Pan et al. 2011). In addition, several cultural process factors (e.g., facilitating emotional control, exploiting the vertical clinician-client relationship) were predictive of positive treatment response. Hwang et al. (2015) investigated the effects of CA-CBT versus standard CBT for Chinese American adults who met DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders*, fourth edition) criteria for major depression. In the CA-CBT condition, the adaptations provided comprehensive psychoeducation on treatment and depression, while also incorporating cultural values and salient cultural references. Although decreases in depression rates were greater for CA-CBT than for CBT, the actual severity rates were similar between groups at the end of treatment. Webb Hooper et al. (2017) randomly assigned Black smokers to eight sessions of either standard or culturally specific group-based CBT. Adaptations included interventionist-participant race-matching and discussions about unique struggles of the African American community, such as historical medical and research distrust, health disparities, cultural values, experiences of racism, and African American mental health. Culturally specific CBT led to greater smoking cessation than standard CBT at the end of treatment and 3-month follow-up, but not at 6- and 12-month follow-up.

Three trials showed that cultural tailoring had no significant effect on symptom change for ethnic minorities, with all focused on externalizing Latino/a youth. Grodnitzky (1993) recruited

**Table 2 Summary of randomized trials comparing standard and culturally tailored versions of CBT**

| Study  | Identity group and target problem  | Tailoring model   | Core treatment                        | Brief tailoring summary  | Cultural competence training as primary focus?  | Outcome summary   |
|--|--|---|---------------------------------------|--|---|---|
| Burrow-Sanchez & Wrona 2012                            | Latino/a (~88% Mexican heritage) youth with drug abuse or dependence disorders | Burrow-Sanchez's cultural accommodation model   | Group CBT                             | Adaptations included incorporating culturally relevant examples and role-play, developing a new ethnic identity and adjustment module, and increasing therapist-parent contact.  | No. Therapists trained on cultural elements of Latino/a families, although no content was described. The same therapists delivered treatment for both conditions. | No treatment effects on retention or symptoms   |
| Burrow-Sanchez et al. 2015, Burrow-Sanchez & Hops 2019 | Latino/a (~81% Mexican heritage) youth with drug abuse or dependence disorders | Burrow-Sanchez's cultural accommodation model   | Group CBT                             | Same as that for Burrow-Sanchez & Wrona 2012.  | No. Content of therapist training was not described. The same therapists delivered both treatments.   | No treatment effects on retention or symptoms post treatment or at 3-month follow-up. However, at 12-month follow-up, A-CBT > S-CBT for substance use days. |
| Gerdes et al. 2021                                     | Latino/a (~85% Mexican heritage) youth with ADHD diagnosis                     | Unclear, but ecological validity model and Bernal's cultural adaptation framework mentioned | PMT                                   | Adaptations for Latino/a families involved providing culturally congruent examples and explanations, additional course materials, two new culturally appropriate classes with subsequent home visits, and increasing engagement with parents and other family members. | No. Clinicians for both conditions participated in a cultural competence workshop, but content was not described.   | CA-PMT > S-PMT for homework completion; no treatment effect on symptoms   |
| Groditzky 1993   | Puerto Rican adolescents with maladaptive behavior                             | Cuento therapy approach   | Modeling-based narrative intervention | Hero modeling for male Puerto Rican adolescents involved biographies of seven Puerto Rican historical male role models, followed by discussion and role-play in a group format.  | No. Content of facilitator training was not described.  | No treatment effects on symptoms  |
| Hwang et al. 2015                                      | Chinese American adults with major depression                                  | Hwang's PMAF model  | CBT                                   | CBT adapted for Chinese Americans by providing a comprehensive therapy orientation, reducing stigma, placing greater focus on goal setting and problem solving, and discussing somatic aspects of depression.  | No. Content of therapist training was not described.  | CA-CBT > CBT for depressive symptoms over the course of treatment (but groups showed similar posttreatment depression rates).                               |

(Continued)

Table 2 (Continued)

| Study                                 | Identity group and target problem                        | Tailoring model         | Core treatment                                   | Brief tailoring summary   | Cultural competence training as primary focus?  | Outcome summary   |
|---------------------------------------|--|-------------------------|--|---|---|---|
| McCabe & Yeh 2009, McCabe et al. 2012 | Mexican American youth with disruptive behavior problems | No explicit model noted | PCIT   | Adaptations involved tailoring based on cultural assessment, referencing cultural concepts in treatment, framing treatment as education/skills-building, greater rapport-building, Mexican American representations, and engagement protocol. | No. However, some cultural sensitivity training content was described. Therapists trained for their condition only. | No GANA versus PCIT effects on dropout or disruptive behavior   |
| Pan et al. 2011                       | Asian American college students with phobias             | No explicit model noted | OST  | Cultural adaptations based on Asian American research included assessing the explanatory model, normalizing the target problem, facilitating emotional control, exploiting vertical nature of therapy, and psychoeducation.                   | No. Content of therapist training was not described. A single therapist delivered both treatments.                  | OST-CA > OST-S for general fear and catastrophic thinking   |
| Perez 2006                            | Mexican American college students                        | No explicit model noted | Two-session speech exposures plus video feedback | The four conditions differed in terms of (a) whether exposure speeches were given in English only versus both English and Spanish and (b) whether the speech was conducted in front of a perceived White versus Latino/a audience.            | No. Content of provider training was not described.   | Standard exposure (i.e., White audience + English speech) > the three culturally adapted exposure conditions for public speaking and social anxiety |
| Webb Hooper et al. 2017               | African American adults who smoke daily                  | No explicit model noted | Group CBT  | Adaptations included discussion about disparities, historical medical and research distrust within the African American community, and concerns about pharmacotherapy. Race-matched group facilitators were also included.                    | No. Content of therapist training was not described. Therapists trained to lead groups for their condition only.    | CS-CBT > CBT for smoking abstinence   |

Abbreviations: A-CBT, culturally accommodated group cognitive behavioral therapy; ADHD, attention-deficit/hyperactivity disorder; CA-CBT, culturally adapted cognitive behavioral therapy; CA-PMT, culturally adapted parent management training; CBT, cognitive behavioral therapy; CS-CBT, culturally specific cognitive behavioral therapy; GANA, Guiando a Niños Activos; OST, one-session treatment; OST-CA, culturally adapted one-session treatment; OST-S, standard one-session treatment; PCIT, parent-child interaction therapy; PMAF, psychotherapy adaptation and modification framework; PMT, parent management training; S-CBT, standard group cognitive behavioral therapy; S-PMT, standard parent management training.

Puerto Rican and Anglo youth showing “maladaptive behavior” and assigned them to hero modeling (focused on biographies of Puerto Rican historical figures), non-hero modeling (Puerto Rican role models were excluded), or no treatment control. No treatment effects were found on externalizing symptoms for either ethnic group. McCabe & Yeh (2009) assigned disruptive, Mexican American youth and their parents to parent-child interaction therapy (PCIT), *guiando a niños activos* (GANA) (a culturally modified version of PCIT), or TAU. Although both GANA and PCIT led to greater reductions in externalizing behavior than TAU, no significant differences were found between GANA and PCIT at posttreatment or 2-year follow-up (McCabe & Yeh 2009, McCabe et al. 2012). Gerdes et al. (2021) piloted a culturally adapted parent management training (CA-PMT) versus standard parent management training (S-PMT) for Latino/a children with ADHD. CA-PMT included culturally relevant communication, terminology, and role-plays and increased engagement with family members in treatment. There were no significant condition effects for ADHD symptoms or overall child and parent functioning. However, treatment engagement (i.e., homework completion) was significantly higher in CA-PMT compared to S-PMT.

One of the 10 studies suggested that cultural tailoring can sometimes diminish the effects of conventional practice. In an analog study with undergraduates as interventionists, Perez (2006) randomly assigned bilingual, speech-phobic Mexican American college students to one of four video feedback conditions that differed in terms of (*a*) whether exposure speeches were given in English only versus both English and Spanish and (*b*) whether the speech was conducted in front of a perceived White versus Latino/a audience. Unexpectedly, phobics in the standard condition (i.e., English feedback—White audience) generally showed more clinical improvement than those in the three conditions that were adapted for language, audience ethnicity, or both. However, rather than arguing against the need for cultural tailoring, these results might instead suggest the need to modify CBTs in ways that “reflect the cultural reality of minority students attending predominantly White institutions” (Perez 2006, p. 59).

A final pair of studies yielded somewhat complicated findings suggesting the possibility of sleeper effects with regard to cultural tailoring. Burrow-Sanchez and colleagues completed two randomized trials evaluating the effects of standard group cognitive behavioral therapy (S-CBT) compared to culturally accommodated group cognitive behavioral therapy (A-CBT) for Latino/a youth with substance use disorders. Cultural adaptations included adding a module on ethnic identity and adjustment, revising treatment content for cultural congruence, and integrating regular phone contacts with parents (Burrow-Sanchez & Wrona 2012). Across both trials, no condition effects were found at posttreatment or 3-month follow-up (Burrow-Sanchez & Wrona 2012, Burrow-Sanchez et al. 2015). At 12-month follow-up, however, A-CBT led to significantly greater reductions in substance use than S-CBT (Burrow-Sanchez & Hops 2019), suggesting that cultural tailoring effects may take a while to materialize.

Notably, eight of the nine direct comparison trials had sample sizes that were quite small by clinical trial standards, with most being pilot studies with fewer than 100 participants. Indeed, the only trial with more than 30 participants per condition was Webb Hooper et al.’s (2017), which included approximately 170 participants per condition and was an outlier among these studies. Thus, most of these trials may have been underpowered to detect significant cultural tailoring effects (Huey et al. 2014). To partly address this concern, we conducted a random-effects meta-analysis by aggregating across all nine CBT trials; we calculated an effect size reflecting the overall effect of culturally tailored CBT compared to standard CBT on both engagement (e.g., alliance, sessions attended, treatment retention) and symptom outcomes. Results showed that the combined effect of cultural tailoring on measures of engagement ( $d = 0.14$ ,  $SE = 0.09$ ,  $p = 0.12$ ) and symptom reduction ( $d = 0.00$ ,  $SE = 0.21$ ,  $p = 0.99$ ) was small and nonsignificant.

Overall, several suggestive trends emerge from these findings. First, although aggregate effects were nonsignificant, there is some evidence that cultural tailoring can significantly enhance CBT effects for African Americans (Webb Hooper et al. 2017), Asian Americans (Hwang et al. 2015, Pan et al. 2011), and Latinos (Burrow-Sanchez & Hops 2019) with mental health challenges. However, these findings are tentative and no positive effects have yet been replicated. Second, three of the nine trials show preliminary evidence that CA-CBT is most effective for ethnic minorities who are highly identified with their culture of origin, whereas standard CBT is most effective for those with the lowest levels of identification (Burrow-Sanchez & Wrona 2012, Burrow-Sanchez et al. 2015, Pan et al. 2011). Similarly, Perez (2006) unexpectedly found that her highly acculturated sample of Latina women with speech phobias benefitted most when engaging in the standard exposure task (i.e., English language speech given to White audience). Thus, evidence supports the argument that assessment of appropriate cultural fit might be critical when considering whether and how to tailor CBTs for any particular client (Huey et al. 2014). Third, one study showed that cultural adaptation effects were significant at long-term follow-up but not at earlier assessment periods, which suggests that longer follow-up periods are sometimes needed for cultural tailoring uptake (Burrow-Sanchez & Hops 2019). This argues for the possibility that sleeper effects for tailored treatments might occur months or even years later when clients actually have the opportunity to use, in real-life settings, the knowledge or skills they acquired during treatment (Huey 2013).

A final note, and a point of some concern, is this: Nearly all studies focused on cultural adaptation of existing CBTs—that is, making significant adaptations to the treatment manual, adding or altering content/modules, increasing contact with parents or family members, or making other modifications to the core CBT intervention. However, none focused primarily, if at all, on training clinicians to be more culturally competent and then applying those skills when using conventional CBTs. In their meta-analysis of culturally responsive treatments for anxiety and depression, van Loon et al. (2013) made a similar observation. Thus, although experts frequently state the imperative to train clinicians to be culturally competent, the most rigorous trials focus primarily on cultural adaptation and thus offer little empirical justification for cultural competence training.

In summary, these trials provide some tentative support for promoting cultural adaptation of CBTs but say little about how best to optimize training of clinicians to be culturally competent. So where does this leave us in terms of recommendations for training clinicians to apply CBT with diverse populations? We address this issue in the next section.

## CULTURAL COMPETENCY TRAINING OUTCOMES

Over the past decade, the number of studies investigating the effects of cultural competency trainings has nearly doubled (Chu et al. 2022). Reviews find that cultural competency trainings employ a variety of methods to cover a wide range of topics (see **Table 3**; see also Benuto et al. 2018, Chu et al. 2022, Lie et al. 2011, Smith et al. 2006). Most commonly, they are didactic (i.e., using lectures and group discussions) and cover general cultural concepts and sociocultural information. Although some trainings are based in cultural competence models, such as Pedersen's triad training model that focuses on training clinicians to consider the verbal exchange between the client and the clinician, the client's internal dialogue, and the clinician's internal dialogue (Wade & Bernstein 1991), many trainings do not report the theory behind their curriculum (Lie et al. 2011).

Recent evaluations of cultural competency trainings suggest some measure of success, at least on the surface. Chu et al. (2022) found that cultural competence trainings generally improved clinicians' cultural knowledge, attitudes, and skills. Similarly, Benuto et al. (2018) found that cultural competency trainings improved clinicians' cultural knowledge but found mixed results with regard to clinician attitudes, awareness, and self-reported and objective skills. The consistent finding that

**Table 3** Summary of meta-analytic and narrative reviews of cultural competency training

| Meta-analysis        | Included studies  | Curricular methods <sup>a</sup>  | Curricular topics <sup>a</sup>   | Outcomes   |
|----------------------|---|--|--|--|
| Smith et al. 2006    | 37 studies on multicultural education reporting outcomes: 6 experimental designs, 12 quasi-experimental designs, 19 pre-post studies                                      | Skill-building experiential activities (e.g., counseling role-plays, cultural immersion experiences, supervision of counseling), didactic instruction (e.g., readings/films, lectures/discussions, written reports/journaling)                               | Trainings were based on the multicultural competency literature (9), Pedersen's triad model (8), mainstream psychological theories (3), Helm's racial identity development model (2), and Ivey's microskills training (1); 14 trainings provided no information about the theoretical basis. | Large positive effect on multicultural competence  |
| Lie et al. 2011      | 7 studies on cultural competency training for health professionals reporting patient outcomes: 2 RCTs, 2 quasi-experimental designs, 3 pre-post studies                   | Lecture, group discussion, community engagement activity, role-play, performance feedback, immersion and cultural workshops, interactive and experiential curricular methods   | Based on various theories, including Pedersen's triad model and the LEARN model  | No to moderate positive effect on patient-report outcomes  |
| Renzaho et al. 2013  | 13 studies on patient-centered care that incorporates a cultural competence perspective: 3 RCTs, 8 pre-post studies, 2 qualitative studies                                | Not reported   | Not reported   | Positive outcomes for knowledge, self-reported practice, and patient satisfaction; null patient health outcomes  |
| Smith & Trimble 2016 | 47 studies on multicultural education reporting outcomes: 23 experimental or quasi-experimental designs, 24 pre-post studies  | Not reported   | Not reported   | Large positive effect on multicultural competency, with inconsistent results across studies                      |
| Benuto et al. 2018   | 17 studies on cultural competency trainings for psychologists: 2 RCTs, 5 trials without random assignment, 5 pre-post studies, 2 post-only studies, 3 qualitative studies | Lecture (8), discussion (7), case scenario (2), cultural immersion (2), role-play (4), contact with diverse individuals (5), service learning (2), self-reflections (3), journaling (3), supervision (2), and other curricular methods (3)                   | General cultural concepts (7), clinician-client interaction (7), cultural identity (5), specific cultures (5), personal attitudes (4), racism and discrimination (2), worldviews (2), and biases (2)   | Positive outcomes for knowledge; mixed outcomes for attitudes, awareness, and self-reported and objective skills |
| Chu et al. 2022      | 42 studies on cultural competency trainings for mental health professionals: 3 RCTs, 13 quasi-experimental designs, 15 pre-post studies, 11 post-only studies             | Lecture (33), discussion (32), multimedia (27), reading (26), assignment (22), exercise (22), reflection (19), direct contact (19), role-play (16), case scenario (15), experiential immersion (10), feedback (9), clinical experience (6), and modeling (5) | Sociocultural information (33), identity (29), client interaction (28), stereotype (26), mental health (23), heritage (23), theory (22), discrimination and prejudice (20)   | Positive outcomes for cultural attitudes, knowledge, and skills  |

Abbreviations: LEARN, Listen, Engage, Acknowledge, Respect, Negotiate; RCTs, randomized controlled trials.

<sup>a</sup>Numbers in parentheses represent the number of associated trainings.

cultural competency trainings improve clinicians' knowledge may be related to the didactic format of many trainings, which tends to improve knowledge but not skills (in the absence of active learning, such as role-playing or modeling) (Frank et al. 2020). Multiple reviews from the broader health services literature find that trainings improve healthcare providers' self-reported multicultural competence (Renzaho et al. 2013, Smith et al. 2006, Smith & Trimble 2016); however, few studies have investigated how training providers to be more culturally competent influences client and system outcomes. The few studies that have reported client outcomes have found null results (Renzaho et al. 2013). To our knowledge, no studies to date have examined the effect of cultural competency trainings on service outcomes (e.g., treatment effectiveness, equity, efficiency) or implementation outcomes (e.g., treatment fidelity, feasibility, sustainability).

Although the cultural competency literature has grown substantively in recent years, there remain notable gaps that obscure concrete recommendations for training culturally competent CBT clinicians. For instance, the cultural competency literature has included predominantly healthcare providers, with only a small set of studies focused on mental health providers and even fewer focused on CBT clinicians (Benuto et al. 2018, Lie et al. 2011). Additionally, the overwhelming majority of cultural competency evaluations in the mental health and counseling literatures have employed pre-post evaluation designs, with only a few RCTs testing cultural competency training. For example, of the cultural competency training studies reviewed by Benuto et al. (2018) and Chu et al. (2022), only 12% and 8%, respectively, involved random assignment to conditions; moreover, those few randomized trials are of limited utility because they are mostly older, analog studies involving nonclinical "clients" receiving one to three intervention sessions (Christensen 1984, Wade & Bernstein 1991). In addition to more rigorous testing of the effects of cultural competency training for CBT clinicians, further research is needed to elucidate which methods and content of cultural competency training are most helpful for improving CBT clinicians' cultural sensitivity, as well as client, service, and implementation outcomes.

## EVIDENCE-INFORMED MODELS OF CULTURAL SENSITIVITY

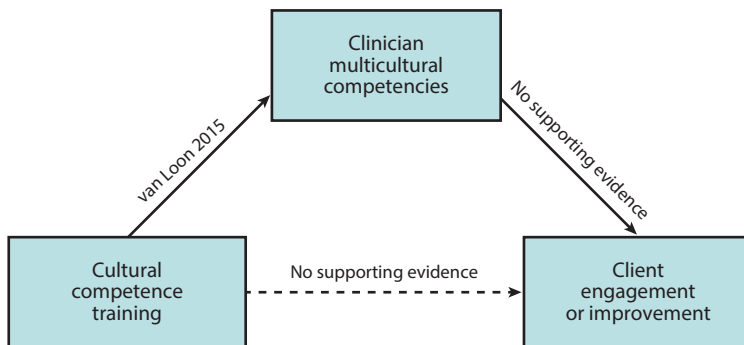
Despite growing consensus regarding the importance of incorporating culture into psychotherapy, empirically supported models for delivering culturally sensitive CBT remain elusive. Moreover, the evidence base for effective cultural sensitivity training of CBT clinicians is lacking. In the absence of evidence-based guidance on how to incorporate culture into CBT implementation, there is an increased risk that clinicians may ignore cultural considerations or may make cultural modifications that unintentionally impede treatment progress (Huey et al. 2014). In this section, we briefly summarize three broad models for addressing culture in clinical contexts, and in doing so we focus on implications for training CBT clinicians to optimize treatment engagement and outcomes with culturally diverse populations.

### Adopt a Skills-Oriented Training Model

The first approach emphasizes adopting a skills-based model of cultural sensitivity, which primarily involves training clinicians to be more culturally competent when working with diverse clients. The argument made by many theorists (sometimes explicitly but often implicitly) is that cultural sensitivity training increases clinician multicultural competencies, which in turn facilitates client engagement and clinical progress. **Figure 3** shows this implicit causal sequence.

Suggestive evidence for the Training → Client Improvement path is evident in numerous CBT-focused RCTs. For example, Miranda et al. (2003) randomized primary care practices to one of two quality improvement conditions or to usual care control. One condition was quality improvement therapy, which involved training clinicians in CBT and orienting them to "cultural





**Figure 3**

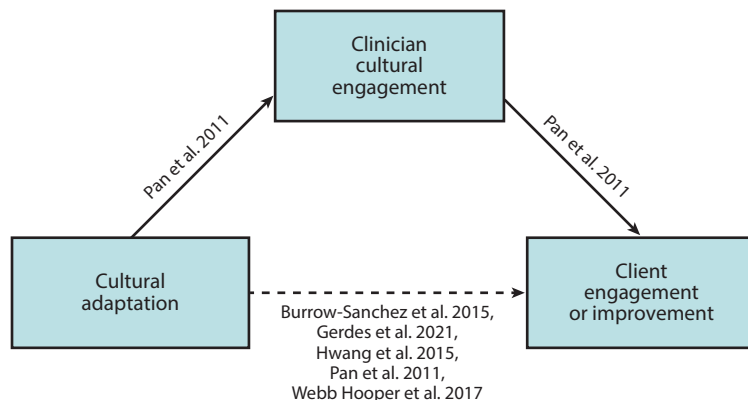
Conceptual model of cultural competence training in mental health treatment and validation evidence. van Loon's (2015) study supports the Cultural Competence Training → Clinician Multicultural Competencies path. No support was found for the other paths.

beliefs and ways of overcoming barriers to appropriate treatment for Latino/a and African American patients" (Miranda et al. 2003, p. 619). At 6- and 12-month follow-up, quality improvement led to significant improvement in depressive symptoms for Black and Latino/a patients (Miranda et al. 2003), and changes were maintained at 5-year follow-up (Wells et al. 2004). Similarly, Silverman et al. (1999) randomized phobic youth to group-based CBT or waitlist control, with CBT including clinicians with cultural sensitivity training. Specifically, clinicians were "sensitized. . .to issues specific to working with multicultural populations, such as cultural differences in modes of coping, definitions of anxiety-provoking objects or events, and particular parenting styles" (Silverman et al. 1999, p. 996). At posttreatment, group CBT led to greater reductions in anxiety symptoms, with treatment being equally effective for Latino/a and White youth. However, in these and other trials (e.g., Ngo et al. 2009), the design did not permit an assessment of whether cultural sensitivity training actually enhanced the impact of CBT on ethnic minority participants.

Indeed, as **Figure 3** shows, causal evidence for this model with clinical samples is almost completely lacking, and we found only one study that offered a rigorous evaluation of cultural sensitivity training with real-world clinicians and patients. In a Dutch outpatient care context, van Loon (2015) randomized Moroccan and Turkish immigrant outpatients with anxiety/depressive disorders to mental health clinicians trained in cultural competencies or to clinicians who were not trained. Cultural competence training was designed to increase clinician knowledge, awareness, and skills in diagnosing and treating Moroccan and Turkish patients. Clinicians were also trained to use the Cultural Formulation Interview, and they participated in monthly peer group meetings to fortify their cultural knowledge and skills. In terms of clinician fidelity, the intervention was implemented as planned: During the intake process, culture-related topics were discussed more often in the cultural competence group than in the comparison group. However, in terms of client engagement, there were no significant differences by condition for dropout or no-shows (van Loon 2015).

### **Train Clinicians in Evidence-Based Cultural Adaptation Strategies**

For better or worse, the empirical case for cultural adaptation is currently much stronger than that for cultural competence training. Indeed, above, we identified five CBT evaluations that showed some level of cultural adaptation impact on client engagement, symptoms, or both. For cultural adaptation theorists, the conceptual rationale (sometimes explicit but often implicit) is that



**Figure 4**

Conceptual model of cultural adaptation adoption in mental health treatment and validation evidence. The studies by Burrow-Sanchez et al. (2015), Gerdes et al. (2021), Hwang et al. (2015), and Webb Hooper et al. (2017) support the Cultural Adaptation → Client Engagement or Improvement path, and the study by Pan et al. (2011) supports all three paths shown.

appropriate cultural adaptation of an intervention results in greater cultural engagement by clinicians (i.e., employing adaptation-prescribed behaviors), which in turn facilitates client engagement and clinical progress. **Figure 4** shows this causal sequence and identifies which studies appear to support each causal pathway. Notably, only the trial by Pan and colleagues (Huey & Pan 2006, Pan et al. 2011) showed support for all three pathways, with a follow-up analysis showing that several facets of cultural engagement mediated the relationship between cultural adaptation (versus standard treatment) and clinical outcomes (S.J. Huey, C.W. Wang & D. Pan, unpublished data). However, this pilot study included only 30 participants and has not been replicated.

The adaptation approach has several potential advantages with regard to training clinicians to attend to culture (Huey et al. 2014). First, the “package” of modifications for some cultural adaptation models has been heavily scrutinized by investigators and appears to yield validated benefits in some clinical trials. In addition, cultural adaptations for some prominent models are well-specified in detailed protocols and treatment manuals (e.g., Bernal et al. 1995), although this is not always the case. However, there are significant disadvantages as well. A primary concern among critics is that cultural adaptation models are often impractical given the diverse identities that clients present with in real-world clinical contexts (O’Donohue & Benuto 2010). Relatedly, adaptation models are heavily skewed toward addressing ethnocultural diversity (Soto et al. 2018), and other critical aspects of client diversity (e.g., gender, religion, sexual orientation) are rarely the focus of adaptation trials, although there are exceptions (e.g., Razali et al. 1998). Thus, ironically, even though the adaptation model has a stronger evidence base than the skills training model, the latter approach may be more practical with regard to clinician training and effort.

### **Adopt a Personalized Model of Psychotherapy That Incorporates Culture**

Until a more robust literature on training culturally sensitive CBT clinicians exists, guidance may be gleaned from the growing literature on personalized psychotherapy. In response to cumulative findings indicating that EBTs are not one-size-fits-all, increasing attention has been placed on a precision medicine approach to psychotherapy (Bickman et al. 2016, DeRubeis 2019). These precision mental health approaches have ranged from identifying which treatment will be most effective for which client [e.g., which clients will benefit more from antidepressant medication

versus interpersonal psychotherapy, and vice versa? (Wallace et al. 2013)] to determining what to do in the next session to best meet the client's needs [e.g., when a client faces an unexpected life event, is it more beneficial to continue or adapt the original treatment plan? (Guan et al. 2018, 2019a,b)].

The basis that psychotherapy techniques have differential effects for different clients can be applied to inform when and how to incorporate culture into psychotherapy. For instance, Hall et al. (2021) recently proposed the personal relevance of psychotherapy (PROP) model for culturally adapting psychotherapy to reduce mental health disparities. The PROP model considers how universal, group, and individual characteristics may influence the relevance of treatment for a given client (i.e., personal relevance) and may thereby influence treatment effectiveness. As an example, conventional CBT is a well-established treatment for many mental health problems (Cuijpers et al. 2013, Magill et al. 2019, Mayo-Wilson et al. 2014), and these positive effects often extend to ethnic minorities as well (see above sections). However, the emphasis in CBT on the independent self, and the relative underemphasis on the self in relation to others, raises the potential for loss of face among people of East Asian ancestry (Zane & Ku 2014), for example. Accordingly, when considering group factors, conventional CBTs may have less personal relevance for many individuals of East Asian ancestry. That said, face concerns among Asian Americans have been found to be moderated by acculturation (Leong et al. 2018). As such, the personal relevance of CBT for an Asian American client may vary, such that CBT may be more relevant if the client identifies more with American culture and less relevant if the client identifies more with East Asian culture. Considering how universal, group, and individual characteristics influence the personal relevance of CBT can help facilitate the implementation of culturally competent services. One limitation is that PROP is not a model for training clinicians or adapting treatments but, rather, a framework for matching clients with forms of treatment to maximize effectiveness. Another limitation concerns the evidence base thus far. Although neuroimaging data show preliminary support for some model assumptions (Hall et al. 2021), there are no randomized trials directly validating the PROP approach. That said, some suggestive support is evident in a randomized trial of Internet-delivered cognitive-behavioral and dissonance-based treatment with ethnically diverse women at risk for eating disorders (Chithambo & Huey 2017). In moderator analyses, they found that Asian American women benefitted more than their European American counterparts (Chithambo & Huey 2017), perhaps because the treatments targeted cognitions that may be particularly salient for East Asian women (i.e., the thin ideal) (Yates et al. 2004).

Chorpita and colleagues have proposed another model for personalizing psychotherapy to meet the needs of diverse clients and contexts (Becker et al. 2019, Chorpita & Daleiden 2018, Park et al. 2020a). Specifically, their model of coordinated strategic action advocates for using evidence [including research evidence or local evidence, such as clinician expertise (Chorpita et al. 2005)] to iteratively determine what problem should be addressed in psychotherapy and how that problem should be addressed. A pilot randomized trial found that school-based clinicians in a predominantly low-income, Latino/a context could be successfully trained to use a set of decision-support tools that applied the coordinated strategic action model to guide clinical decisions around when to make additional efforts to engage a family in psychotherapy (Becker et al. 2019). Clinicians trained in the coordinated strategic action model used more CBT-based engagement practices with families than untrained clinicians. Notably, the model of coordinated strategic action was not specifically developed to inform cultural adaptations but can be applied to incorporate culture into psychotherapy. For example, a therapist may be concerned about the personal relevance of CBT for their client, after considering the universal, group, and individual factors outlined in Hall et al.'s PROP model. According to the model of coordinated strategic action, the therapist should then use research evidence (e.g., conduct a literature search for EBTs with more personal

relevance) or local evidence (e.g., consult with their supervisor) to guide actions around how to address the lacking personal relevance. To offer ideas for increasing the PROP for youth of color, Park et al. (2022) distilled 20 strategies for incorporating culture into psychotherapy from the mental health services literature (e.g., discussing cultural context in sessions, matching clients with clinicians with similar backgrounds, using culturally tailored materials).

Finally, Hayes and colleagues (Hayes & Toarmino 1995, Hayes et al. 2011) provide guidance on incorporating culture into CBTs (including acceptance and commitment therapy) by linking cultural knowledge and functional analysis. Specifically, they assert that knowledge of cultural difference alone is insufficient for providing culturally competent psychotherapy. Rather, clinicians providing culturally competent CBTs should use their cultural knowledge to develop hypotheses about how their client came to think, feel, and act in certain ways. Following the behaviorist perspective that behaviors evolve and develop within a given context, it is imperative to understand a client's cultural worldviews, beliefs, values, and traditions. They argue for using cultural knowledge primarily as a source for hypothesis testing about the function of client behaviors, and then testing systematically in the context of treatment to confirm the relevance for the specific client (Hayes & Toarmino 1995). One advantage of this implicit approach to cultural sensitivity is that it aligns with standard functional analysis training that students in CBT-oriented graduate programs should be receiving already (Klepac et al. 2012). From this perspective, the documented benefits that ethnic minorities derive from CBTs may in part result from embedded assessment strategies that permit a more idiographic approach to cultural salience. Thus, ensuring that CBT clinicians in training are well-versed in functional analysis methodology may be an important way to promote cultural sensitivity, particularly in light of the declining emphasis on functional analysis in intervention research (Hofmann & Hayes 2019). That said, we know of no studies assessing whether functional analysis training or utilization facilitates improved CBT outcomes for ethnic minorities.

## FINAL THOUGHTS

Coordinated and concerted research, practice, and policy initiatives over the past several decades have established CBT as a “gold standard” treatment. However, evidence supporting the effectiveness and implementation of culturally sensitive CBT remains sparse. Although CBT effects appear to be robust across cultural groups, the minimal existing guidance on how to deliver culturally competent CBT represents a missed opportunity for reducing the burden of mental illness among ethnic minority groups. Additionally, the underrepresentation of ethnic minorities in the mental health services literature, the inconsistent methods used to study cultural competency, the limited empirical data on culturally competent CBT training and intervention, and the lack of a universal definition of cultural competency restrict the conclusions that can be drawn from the extant literature.

To meet the needs of all prospective clients, the same effort, time, and funding that has been granted to studying CBT must be afforded to studying culturally competent CBT. Just as a task force was constituted to define evidence-based practice (APA Pres. Task Force Evid.-Based Pract. 2006), we as a field should define cultural competency. Just as Stuart & Lilienfeld (2007) posited that the “current debate centers on how research findings should be factored into interventions, not on whether it is necessary to do so” (p. 616), it is past time to shift our attention from addressing the question of whether cultural competency training is necessary to how we can sustainably train clinicians who are culturally sensitive *and* clinically effective. Just as there has been a proliferation of RCTs testing CBT, we need to rigorously test whether proposed models for providing culturally competent mental health care deliver the expected results.

As we continue to advance this research agenda, there are many steps that can be taken simultaneously to reduce racial and ethnic disparities and promote mental health among ethnic minority

groups. Institutions can work toward recruiting, supporting, and retaining ethnic minority researchers, clinicians, and trainees to diversify the mental health workforce. Advisors, mentors, and supervisors can initiate conversations with trainees about multicultural considerations in case conceptualization and treatment planning to model the importance of cultural competency and move toward more holistic mental health care. Clinicians can also be trained to use existing, culturally sensitive assessments and interventions with growing support, such as the cultural formulation interview (Sanchez et al. 2022). Additionally, trainees can use measurement-based care (Scott & Lewis 2015) to conduct case studies applying multicultural therapy models with their clients and testing whether doing so improves client outcomes.

Psychology competencies have been operationalized as including values, knowledge, and skills (Falender et al. 2004). Remarkable advances have been made in both the field's value and knowledge of cultural competency. Our next step is translating that knowledge into skills that can benefit the diverse clients seeking our help.

## DISCLOSURE STATEMENT

The authors are not aware of any affiliations, memberships, funding, or financial holdings that might be perceived as affecting the objectivity of this review.

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## Errata

An online log of corrections to *Annual Review of Clinical Psychology* articles may be found at <http://www.annualreviews.org/errata/clinpsy>