culturally embedded implies the strongest relationship such that psychotherapy is considered an integral part of the context, whereas *culturally adapted* suggests systematic changes to the protocol of an existing treatment in order to make features of the treatment relevant to the culture of the target population. More specifically, cultural adaptation is "any modification to an evidence-based treatment that involves changes in the approach to service delivery, in the nature of therapeutic relationship, or in components of the treatment itself to accommodate the cultural beliefs, attitudes, and behaviors of the target population" (Whaley & Davis, 2007, pp. 570–571). The term *culturally sensitive* is used in this review to indicate varying degrees of integration of culture in psychotherapy, which may range from culturally embedded psychotherapy to one or two specific cultural adaptations, such as changing the language or hiring bicultural staff.

Culture, Race, Ethnicity, and Disparities in Service Utilization Among Ethnic Minorities

In the last two decades, there has been an increased awareness of the influence of culture on psychopathology and psychotherapy (Leach & Aten, 2010; López & Guarnaccia, 2000). Working definitions of race, ethnicity, and culture are provided below as these concepts are often used interchangeably (Betancourt & Lopez, 1993). Race refers to similar observable physical characteristics, such as skin color, hair type and color, eye color, and facial features. It often implies biological variation as the physiognomic

all of the elements that Hwang listed. Additionally, this review utilizes Leong's Cultural Accommodations Model (CAM; Leong & Lee, 2006

Table 1
Culturally Sensitive Treatments for Depression

Study	Participants	Demographics	Treatment condition (# of sessions and duration)	Culturally sensitive elements	Dropped out	Retention	Effect size	Outcome
Chavez-Korell et al. (2012)	186	Latino elders	8–12-session individual PST and BA	1) Making the treatment feasible for a community setting to improve Latino elders' access, retention, and outcomes; 2) Adapting/translating all materials and conducting all services in Spanish; 3) Adapting materials for populations with low or no literacy; 4) Decreasing the ratio of providers and clients; and 5) Engaging in culturally sensitive and appropriate treatment activities. In particular, Latino values of *familismo, personalismo, respeto, dignidad, espiritualidad, machismo,* and *marianismo* were thoughtfully used in treatment conceptualization, planning, and intervention; Emphasis on warm and personal interactions	6 (3.3%)	180 (96.7%)	N/A	Outcome data revealed significant decrease in depression symptoms with 56.15% (73 of 130) of participants presenting with 50% or greater reduction in depressive symptoms in 6 months and 63.22% (55 of 87) of participants presenting with 50% or greater reduction in 12 months.
Chu et al. (2012)	1	Chinese American elderly	12-session individual PST	Five recurrent themes of cultural modifications were developed from stakeholder feedback, literature review, and pilot testing: 1) A need for flexibility; 2) Psychoeducation and de-stigmatizing language; 3) Managing expectations of the provider-client relationship: hierarchy, respect, case management, and providing suggestions; 4) Visual aids and measurement; and 5) Acculturative processes	N/A	N/A	N/A	Remission of clinical depression ($n = 1$)

(*table continues*)

Table 1 (*continued*)

Study	Participants	Demographics	Treatment condition (# of sessions and duration)	Culturally sensitive elements	Dropped out	Retention	Effect size	Outcome
Kanter et al. (2010)	10	Latina women in the U.S.	12-session individual BA	Inclusion of free, low-cost, and culturally sensitive activation targets (e.g., walking, attending community activities, such as local festivals and recreational groups, going to church, borrowing fitness DVDs from the library, going to the park); Incorporation of Latino-specific values and beliefs (				

Table 1 (

Table 1 (*continued*)

Study	Participants	Demographics	Treatment condition (# of sessions and duration)	Culturally sensitive elements	Dropped out	Retention	Effect size	Outcome
Miranda, Chung, et al. (2003)	267 (randomized)	African American (n = 117), Latino (n = 134) low income women	8-session CBT	Bilingual providers; Manual and materials in Spanish; Spanish-speaking staff; Psychotherapists and nurse practitioners experienced and committed to working with low-income minorities	N/A	48 (53%) received 4 or more CBT sessions	N/A	The psychotherapy intervention was not superior to community referral in decreasing depressive symptoms (p = .32) or improving role functioning (p = .58), but did result in improved social functioning (p = .06).
Naeem et al. (2011)	34 (randomized)	Pakistani adults	9-session individual CBT + antidepressant (n = 17) and control (n = 17)	Used qualitative data from clinical psychologists about their experience providing CBT to depressed patients and barriers in therapy; Collected information about symptoms, referral behavior, attribution styles, and acceptability of therapy from 9 depressed patients; Next, conducted focus groups with college students using the "name the title" technique to obtain equivalent idiomatic phrases without translating the terminology in Urdu first; Therapists focused on physical symptoms; Urdu equivalents of CBT jargon; Appropriate homework; Attendance of a family member; Folk stories and examples of the life of Prophet Muhammad and Quran used	3 (18%) attended fewer than 6	14 (82%)	d = .60	In a RCT, the authors compared a 9-session CBT + antidepressants (n = 17) and antidepressants + usual care (n = 17) and observed significant improvement in depressive, anxiety, and somatic symptoms among patients who received CBT.

(*table continues*)

Table 1 (*continued*)

Table 1 (

Table 1 (*continued*)

Study	Participants	Demographics	Treatment condition (# of sessions and duration)	Culturally sensitive elements	Dropped out	Retention	Effect size	Outcome
Rossello et al. (2008)	112 (randomized)	Puerto Rican adolescents in Puerto Rico	12-session individual CBT (n = 23), group CBT (n = 29), individual IPT (n = 31), or group IPT (n = 29)	Based on ecological validity and cultural sensitivity model (Bernal et al., 1995); Same as Rossello & Bernal (1999); Adapted group manuals using the cultural adaptation model	1 (4.3%; individual CBT), 1 (3.4%; group CBT), 3 (9.6%; individual IPT), and 1 (3.4%; group IPT)	95.7% (CBT individual); 96.6% (CBT group); 90.4% (IPT individual); 96.6% (IPT group)	Individual vs. Group was d = .18, individual therapy better by 54% than group therapy; CBT vs. IPT d = .43, patients in CBT 67% better than IPT	Both IPT and CBT in their individual and group format performed well. However, CBT (combined group and individual) resulted in significantly greater decreases in depressive symptoms, changes in self-concept, and reduction in internalizing and externalizing behaviors in comparison to IPT (combined group and individual).
Stacciarini (2008)	16	Puerto Rican women in the U.S.	Community-based group intervention (development)	Focus groups yielded the following categories: family and community values, mainland/non-mainland cultural variances, communication style, religion, education and occupational variances, health beliefs, Puerto Rican traditions, emotions, and coping skills.	N/A	N/A	N/A	N/A

Table 1 (*continued*)

Study	Participants	Demographics	Treatment condition (# of sessions and duration)	Culturally sensitive elements	Dropped out	Retention	Effect size	Outcome
Wong (2008)	96 (randomized)	Chinese adults in Hong Kong, 22% male	10-week group CBT vs. waitlist control	Translation of all terminology to colloquial expressions, modification of dysfunctional rules in relation to family and interpersonal relationships, active involvement of group leaders, and the delivery of mini-lectures about the exercises and worksheets to increase structure and problem-focused approach.	0 (0%; experimental), 8 (20%; control)	100%	C-BDI d = .76, COPE d = 57, DAS d = .88, and negative emotions d = .59 between the experimental and control group	The participants in the experimental group showed a significant decrease in the severity of depression symptoms, negative emotions, and dysfunctional beliefs and better coping skills in comparison with the control group.
Yeung et al. (2010)	100 (randomized)	Chinese American adults	Usual care or care management (1 in-person meeting, 7 calls over 24 weeks)	CSCT involves a culturally sensitive psychiatric interview, which consists of a standard psychiatric interview and a cultural component that uses Kleinman's questions to explore patients' illness beliefs; Information about depression introduced in ways compatible with patients' beliefs	N/A	N/A	N/A	The two conditions did not differ significantly. Yeung et al. concluded that the CSCT improved the recognition and treatment engagement of depressed Chinese Americans.

Note. ACDC = Adolescent Coping with Depression Course; BA = behavioral activation; CBT = cognitive behavioral therapy; CSCT = culturally sensitive collaborative treatment; DCM = depression care manager; IPT = interpersonal therapy; MDD = major depressive disorder; PCP = primary care patients; PST = problem-solving therapy; QII = quality improvement intervention.

Seven of the adapted treatments were offered in a group format. Only one of the studies (Kohn et al., 2002) indicated that the group was closed after the start of the group, although it appeared that other group treatments worked similarly (Dai et al., 1999; Rossello et al., 2008) but it was not clear if the closed group format would be preserved in a nonresearch setting. Depending on the format of

Based on this review, there are two likely directions for the future of CSTs: researchers will continue to adapt existing treatments by changing the process and content based on theory and previous research or they will rely more on using frameworks and community focus groups that will inform them of what to include in the treatment. Both directions seem promising as long as the adaptations are made based on sound reasoning and evidence. The utilization of focus groups to inform and guide the adaptation process may be particularly helpful when treating specific populations that have not received much attention in previous research. No matter which direction researchers choose, it is important to document every cultural adaptation and the logic behind it. Similarly, Cardemil (2010) argued that researchers need to investigate the social validity/acceptability, the efficacy, and the mechanisms of action associated with the cultural adaptations as well as changes in symptoms and levels of engagement among participants.

Other recommendations focus on the types of demographic groups that need to be targeted in the future. First, this review did

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