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# Culture in Ibero-America: A neglected issue in behavioral and cognitive randomized control trial interventions

Juan Preciado[1] (*Hostos Community College of the City University of New York, USA*)

**ABSTRACT.** The purpose of this interpretative review study is to determine if researchers from the Ibero-American region are aware of culture and of cultural adaptations in psychological interventions and treatment. As a preliminary approach to examine these issues, the words «culture», «cultural factors», or «cultural adaptations» were searched within the text of cognitive behavioral randomized controlled trial (RCT) articles assessing clinical and health outcomes in children and adults in Ibero-American countries. International and regional databases were systematically searched for randomized controlled trials adhering to specified criteria. Results show that the word culture and cultural adaptations are absent from most descriptions of RCT studies from Ibero-America. Although the exploratory nature of this paper may limit its findings, researchers from this region might be attuning their interventions to their particular contexts without explicitly calling them culture adaptations. An explanatory concept, the Cultural Alliance Effect, is advanced to account for the inclusion of culture in the US literature and its exclusion in Ibero-America. It is recommended that efforts be undertaken by Ibero-American researchers to fully describe adaptations of intervention protocols so that their experiences can inform other scholars, particularly in developing countries.

**KEYWORDS.** Culture. Cultural adaptations. Randomized controlled trials. Cultural alliance effect. Interpretative review study.

**RESUMEN.** El propósito de este estudio de revisión interpretativo es determinar si los investigadores iberoamericanos son conscientes de la cultura y adaptaciones culturales a tratamientos y programas de intervención psicológica. Como una primera aproximación para estudiar estos aspectos, se realizaron búsquedas de las palabras

[1] Correspondence: Hostos Community College of the City University of New York. 500 Grand Concourse. Bronx, NY 10451 (USA). E-mail: jpreciado@hostos.cuny.edu

«cultura», «factores culturales» o «adaptaciones culturales» en cualquier parte del texto de artículos cognitivo-conductuales de tipo ensayo controlado aleatorio (ECA) sobre temas clínicos, y de la salud en niños y adultos de países iberoamericanos. Se realizaron búsquedas en bases de datos norteamericanas y regionales sobre ECAs que cumplieran con los criterios de inclusión. Los resultados muestran que las palabras cultura y adaptaciones culturales están ausentes en la mayor parte de las descripciones de los estudios tipo ECA de Iberoamérica. A pesar de las limitaciones de este estudio exploratorio, los investigadores ibero-americanos están probablemente ajustando sus intervenciones a los contextos particulares, sin explícitamente identificarlos como adaptaciones culturales. Se propone el concepto Efecto de Alianza Cultural para explicar porque la cultura es reconocida en la literatura Norteamericana y desatendida en la iberoamericana. Se recomienda que las adaptaciones a manuales y protocolos clínicos iberoamericanos sean ampliamente descritas para facilitar su aplicación por otros investigadores, particularmente de los países en desarrollo.

**PALABRAS CLAVE.** Cultura. Adaptaciones culturales. Ensayos controlados aleatorios. Efecto de alianza cultural. Estudio de revisión interpretativo.

The influence of culture on psychological interventions and treatment has been a subject of discussion in the mental health literature for many years (Lamkaddem, Spreeuwenberg, Deville, Foets, and Groenewegen, 2012; Ruiz, 2011). One area that has received worldwide attention is the use of tests and survey instruments to study psychological phenomena across cultures or countries (Berry *et al.,* 2002). Cross-cultural psychology has developed extensive protocols to ensure linguistic and cultural equivalency whenever survey instruments or psychological tests are used between cultures (Bartram, 2011).

In contrast, there is less information about how to proceed when importing therapeutic techniques or program interventions across cultural contexts (Jacob and Kuruvilla, 2012). Assuming the validity of psychological interventions and simply replicating them across countries and cultural contexts may be questionable, particularly in developing countries (Lund *et al.,* 2011; Patel, Chowdhary, Rahman, and Verdeli, 2011). A recurrent concern is that most therapies and treatments, which were developed and tested with white populations, are still required to demonstrate their applicability with the rest of the world, which is diverse and nonwhite (Arnett, 2008). The World Health Organization has called for interventions to be empirically validated and adapted to local communities' characteristics including culture in the developing world (World Health Organization, 2010). To get a better understanding of how culture is studied in different parts of the world, the next section will briefly examine its role on psychological interventions under two settings: multi-contextual and mono-contextual.

*Multi-contextual settings*

Psychological interventions in the United States (US) are carried out in a multi-contextual setting in which many races, languages, and ethnicities interact. Although the majority of the US population is white and of European ancestry, it is estimated that

about one third of the population is minority and of non-European origin (Humes, Jones, and Ramirez, 2011). Research suggests that racial and ethnic minorities underutilize mental health services because of many factors including inability to pay and a mismatch of treatment to patients' cultural characteristics (Alegria, Atkins, Farmer, Slaton, and Stelk, 2010). To meet the mental health needs of minorities, the most influential psychological organization in the United States, the American Psychological Association (APA), has repeatedly called for considering culture when working with minorities (*i.e.,* individuals of non-European background) (American Psychological Association, 2002, 2006). APA's code of ethics states that psychologists should be aware and respect cultural differences and that ignoring them may constitute unethical behavior (American Psychological Association, 2002). The same organization issued guidelines to encourage psychologists to consider cultural factors in research and treatment of minority populations. The most recent APA guidelines provide the following comprehensive definition of culture.

> *Culture, in this context, is understood to encompass a broad array of phenomena (e.g., shared values, history, knowledge, rituals, and customs) that often results in a shared sense of identity. Racial and ethnic groups may have shared a culture, but those personal characteristics are not the only characteristics that define cultural groups (e.g., deaf culture, inner-city culture). Culture is a multifaceted construct, and cultural factors cannot be understood in isolation from social, class, and personal characteristics that make each patient unique* (American Psychological Association, 2006, p. 278).

In multicultural settings, culture is of relevance when establishing what psychological interventions work best for what group and under which conditions. Although empirically based treatments work with minorities (Gaudiano, 2010), US researchers proposed that psychological interventions be adapted to enhance their acceptability and effectiveness particularly with Hispanic minorities (*i.e.,* individuals whose ethnic origin can be traced to Latin America and Spain) (Cardemil, 2010). Culture adaptation has been defined as «the systematic modification of an evidence-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values» (Bernal, Jimenez-Chafey, and Domenech Rodriguez, 2009, p. 362).

Although there are various promising models on how to adapt culture to psychological interventions (Le, Zmuda, Perry, and Muñoz, 2010), there is no consensus on how and when to adapt treatments to culture (Benish, Quintana, and Wampold, 2011). Evidence-based treatments (EBTs), particularly cognitive behavioral ones, are still the best choice for minorities, and they should be employed and refined according to the necessities of these groups (Ollendick, Lewis, and Fraire, 2010). Under the multi-contextual lens, culture is a factor that should be taken into account when applying psychological treatments, especially with nonwhite minorities.

*Mono-contextual settings*

Mono-contextual applications occur in countries in which providers and patients share the same nationality and common language without much regard for cultural variations within each country. In these settings, psychological interventions (*e.g.,* evidence-based treatments) originally developed for mostly white Americans and in English are typically imported and delivered by providers who share the same nationality (*e.g.,* Mexican) and a common language (*e.g.,* Spanish) with the recipients. There are illustrations of mono-contextual interventions originally developed in the US, and their subsequent adaptation to the language and culture of countries in different parts of the world. In Holland, a therapeutic intervention from the US was adapted to reduce cannabis use in school-aged children (Hendriks, Van, and Blanken, 2011); and in Kenya, a cognitive behavior therapy intervention was adapted to effectively reduce alcohol use among HIV-infected individuals (Papas *et al.,* 2010).

Are cultural adaptations taking place in mono-contextual applications in Ibero-America? In Spain, an entire issue of the journal, Psichotema (http://www.psicothema.com/tabla.asp?Make=2001andTeam=1003), devoted to evidence-based treatments (EBTs), did not mention the adaptation of treatments to culture in its nine articles. Only one article briefly discussed how «ironic» it was for Spain to insist on dissemination of imported cognitive techniques, whereas Americans were advancing an indigenous psychology (Fernández Hermida and Pérez Álvarez, 2001). Likewise, the neglect of culture was observed in Latin America when discussing EBTs in local journals (Lacerda *et al.,* 2011). With few exceptions (Vera-Villarroel and Mustaca-Alba, 2006), it appears that culture has not received much attention when delivering interventions in mono-contextual settings of the Ibero-American region.

The role of culture under controlled conditions has rarely been examined in countries of Latin America, Portugal, and Spain (*i.e.,* Ibero-America). Although Vera-Villaroel and Mustaca-Alba (2006) argued that there might be cultural differences in the application of treatments, they did not examine the role of culture in their review of evidence based treatments in two South American countries. This paper limits its exploration of culture to cognitive behavioral treatments and programs, because they are among the most empirically supported psychological interventions (McHugh and Barlow, 2010). The present analysis will focus on peer-reviewed, randomized controlled trials (RCTs), a recognized standard against which to measure the outcome of a therapeutic approach (Moher *et al*., 2010; Ponniah and Hollon 2008). The purpose of this review study is to determine if researchers from the Ibero-American region are aware of culture and of cultural adaptations in psychological interventions and treatment. As a preliminary approach to examine these issues, the words «culture,» «cultural factors» or «cultural adaptations» were searched within the text of cognitive behavioral randomized controlled trial (RCT) studies assessing clinical and health outcomes in children and adults in Ibero-American countries

## Method

This review study is of an interpretative nature (Fernández-Ríos and Buela-Casal, 2009). The systematic review of the literature was limited to the following.

a) Articles that appeared on peer-refereed journals and were published between January 2000 and January 2012.

b) Randomized controlled trials or controlled clinical trial studies identified as such by the authors in the title and/or method sections.

c) Any studies whose authors' descriptions included some elements of cognitive behavioral approaches including third-generation therapies as part of their interventions.

d) Studies examining clinical and health outcomes in adult and children populations.

e) Publications carried out in Spain, Portugal, and Latin American countries and published in Portuguese, Spanish, and English.

This exploratory bibliographic review excluded the following:

a) Reviews, thesis, dissertation, and meta-analytic studies.

b) Experimental studies whose authors did not identify them as RCTs or single subject designs.

c) Studies with Latin American, Spanish, or Hispanic samples carried out in the US and its territories.

d) Psycho-educational approaches or programs that did not explicitly identify behavioral or cognitive components.

*Databases examined*

The following databases were searched for articles published between January 1, 2000 to January 5, 2012: Cochrane Reports; Cumulative Nursing Index, Embase, Google Scholar, CINAHL, Lilacs, Medline, Medpub, Psycho info, PubMed, Redlayc, Scielo, Scopus, and Web of Science. The reference list of some of the selected articles also was searched for additional RCTs.

*Search terms used*

The following terms and their equivalents in Spanish and Portuguese were inserted across all databases. Topic=(Randomized controlled trials OR Randomized clinical trials OR Controlled trials, randomized OR Randomized controlled trial OR Clinical trials, randomized OR Controlled trial, randomized OR Trials, randomized clinical OR Trials, randomized controlled OR Trial, randomized controlled OR Controlled clinical trials, randomized) AND Topic=(behavior therapy (behavior modification OR cognitive behavior therapy OR Functional Analytic Psychotherapy OR Dialectical Behavior Therapy OR Acceptance and Commitment Therapy) AND Topic = Spain, OR Portugal, OR Latin America (Argentina, Or Brazil, OR Chile, Or Colombia, OR Mexico, OR Peru, OR, Venezuela) OR Central America.

A librarian, with experience searching clinical trials, checked the search strategy and confirmed its results on two occasions at random. Articles that satisfied the inclusion criteria were then read to see if the words «culture», cultural factors» or «cultural

adaptations» appear on any part of the text (except references). A second reader, a psychologist familiar with cultural factors, was asked to check the contents of a small sample of RCTs to ensure accuracy.

## Results

The total number of RCTs that met the inclusion criteria was 101. Of these, 55 were from Spain, 6 from Portugal, and 40 from Latin America. Of the 101 RCTs examined, only 19 included the words «culture» or «cultural factors» in their texts (see Table 1). And 9 of the 19 studies described cultural adaptations of their interventions (see Table 1). And 5 of the 9 were from the same author.

**TABLE 1.** Randomized controlled trial studies that included culture in the text.

| Study | Country | Culture/ Cultural factors | Cultural adaptation |
|---|---|---|---|
| Althabe *et al.* (2008) | Argentina and Uruguay | Yes | No |
| Carraça *et al.* (2011) | Portugal | Yes | No |
| Claudino *et al.* (2007) | Brazil | Yes | No |
| Gallegos *et al.* (2008) | Mexico | Yes | Yes |
| Garcia-Rodriguez *et al.* (2009) | Spain | Yes | No |
| Lara *et al.* (2003a) | Mexico | Yes | Yes |
| Lara *et al.* (2003b) | Mexico | Yes | Yes |
| Lara *et al.* (2003c) | Mexico | Yes | Yes |
| Lara, Navarro *et al.* (2010) | Mexico | Yes | Yes |
| Lara, Navarro, Navarrete *et al.* (2010) | Mexico | Yes | Yes |
| Miguez and Becoña (2008) | Spain | Yes | No |
| Otero *et al.* (2006) | Brazil | Yes | No |
| Reinares *et al.* (2008) | Spain | Yes | No |
| Sanchez Hervás *et al.* (2008) | Spain | Yes | Yes |
| Secades-Villa *et al.* (2008) | Spain | Yes | No |
| Silva *et al.* (2010) | Portugal | Yes | No |
| Simão *et al.* (2008) | Brazil | Yes | No |
| Valencia *et al.* (2010) | Mexico | Yes | Yes |
| Zimmer *et al.* (2007) | Brazil | Yes | Yes |

## Discussion

This is a first attempt to determine if researchers from the Ibero-American region are aware of culture and reporting cultural adaptations in psychological interventions and treatment, and thus, our findings should be seen as exploratory. The results show that most RCTs of the Ibero-American region do not mention culture or cultural adaptations in their texts. These findings seem to hold true for Latin America, Portugal, and Spain. Despite the apparent neglect of culture, there is no evidence to question the validity and acceptability of cognitive behavioral interventions, which were mostly developed and tested in their original versions in the US.

A possible explanation for the lack of inclusion of culture is that cognitive-behavioral techniques require no cultural adaptation when replicating them in Ibero-American countries. However, it is interesting to note that authors from the developing world, outside Ibero-America, have identified their cognitive behavioral interventions as cultural adaptations because they are being delivered by providers and researchers who mirror the language and culture of their local populations. For example, a cognitive behavior therapy-based intervention to alleviate depression symptoms for mothers in rural Pakistan was reported as a cultural adaptation, because it was delivered by Pakistani providers to patients in the local language (Rahman, Malik, Sikander, Roberts, and Creed, 2008).

An alternative explanation is that a lack of awareness of cultural factors may be partially responsible for the omission of said variable in RCT studies carried out in Ibero-America. A descriptive concept, the Cultural Alliance Effect, is proposed to explain why US researchers are more likely to identify cultural elements in their cognitive behavioral interventions, and to include the variable culture as an explanatory concept in their writings than their Ibero-American counterparts. It is speculated that four factors might contribute to the Cultural Alliance Effect.

First, as stated elsewhere, the US can be seen as a multi-contextual society in which a variety of languages and cultures coexist and are recognized. Psychological interventions are expected to match the cultural characteristics of minority patients (Sue, 2010). Such awareness of cultural factors by US minority researchers may account for the explicit inclusion of the word culture in their publications. Alternatively, interventions in Ibero-American countries are delivered by researchers who are presumed to have the same language and culture of the participants. The notion of any cultural factor mediating a therapeutic relation remains far removed in this type of setting, and it is unlikely to surface in the discussions of RCT studies in the Ibero-American literature.

Second, the ethics code of the American Psychological Association encourages psychologists to take culture into account in their research and practices (American Psychological Association, 2002). In contrast, some ethic codes of the Ibero-American region might not explicitly call for the adaptation of treatment and programs to culture. A quick overview of the six ethics codes (Argentina, Colombia, Chile, Peru, Spain and Venezuela) available from the website of the Federation of Ibero-American Psychology (http://www.fiapsi.org) shows that only the Spanish code deals with cultural differences and the inclusion of culture in services and programs. It should be noted that Spain adheres to an international European ethics code adhered to by associations across European countries.

Third, having therapists who speak the same language and share the same culture with their patients constitutes a cultural adaptation for ethno linguistic minorities in the US (Bernal *et al.,* 2009). This is probably the most common cultural adaptation to treatments and programs reported in the multi-contextual US literature (Ollendick *et al.,* 2010). Conversely, in the Ibero-America milieu, culture is not considered in an intervention because it is being applied in a mono-cultural context in which therapists and patients share the same nationality and a common language. In this context, modifications to protocols and manuals to accommodate literacy levels or learning styles may be seen

as part of the standard process of delivering an intervention rather than a cultural adaptation per se.

Fourth, US researchers might see a need to test the cultural appropriateness of behavioral and cognitive approaches with minorities, particularly Hispanics, because there are a few systematic applications with these populations as compared to the white majority. In contrast, some behavioral and cognitive therapeutic approaches have been taught in academic circles for many years, and their applications with selected populations were published since the mid-seventies in both Latin America (Ardila, 1982) and Spain (Zych and Quevedo-Blasco, 2011). As such, researchers from this region might see no reason to test for cultural appropriateness.

These four factors comprising the *Cultural Alliance Effect* may explain the explicit omission of culture in the RCT literature of Ibero-America, and its inclusion in the multi-contextual US. Although Ibero-American researchers may not label their applications as cultural adaptations, they still engage in minimal cultural adaptations by the mere fact that they are delivering their RCT interventions in Spanish and Portuguese to populations who share a similar culture and linguistic background. Cognitive behavioral RCT Studies from countries outside Ibero-America identified their interventions as cultural adaptations, because they are being delivered by providers and researchers who share the same language and culture of the recipients (Patel and Kirkwood, 2008).

Many of the RCTs reviewed stated that their interventions were based on someone else's work, usually a US researcher, and yet did not describe how the Ibero-American version differed from the original study. Possibly, some of these interventions are being delivered at a lower cost in the Ibero-American context, and could potentially be disseminated in developing countries with limited resources. Thus, efforts should be made to describe in more detail the intervention protocols to facilitate their replication.

The diversity within each Latin American country is not reflected in published RCT studies, which mostly describe populations that are readily available, educated, and of above average income (Rojas, Real, Garcia-Silverman, and Medina Mora, 2011). Said populations may not represent indigenous and afro-American groups of Latin America who may hold traditional beliefs (Rey-Natera and Sainz, 2007). The work by Lara and her team illustrates how cultural factors can be incorporated into cognitive behavioral interventions to prevent depression in low-income women in Mexico (Lara, Navarro, Navarrete *et al.,* 2010). Her team has carefully described samples, manualized interventions, and employed RCT methodology to assess outcomes. A significant feature of Lara's work is how her team counteracted the CAE via international collaborations with researchers working with Hispanic minorities in the US. Through mutual collaborations and exchanges, both the US and the Mexican teams found cultural commonalities and differences of US Hispanics and Mexican populations (Lara, Le, Letechipia, and Hochhausen, 2009). The racial and ethnic diversity of Latin America may require additional resources and international partnerships to uncover cultural factors, which may remain elusive if they continue to be studied under a mono-contextual lens.

As the population of Ibero-American countries becomes more diverse, cultural themes are beginning to emerge in research studies. For example, the impact of culture and gender differences on HIV risk behaviors was recently examined in samples of

native Spaniards and Latin American youths in Spain (Bermúdez, Castro, Gude, Buela-Casal, 2010; Bermúdez *et al.,* 2012). Also, it should be noted that some psychological interventions have been so extensively developed in Ibero-America that they may now be considered local interventions. Some noted examples include the following: cognitive narrative psychotherapy (Gongalves, 1995) and Acceptance and Commitment Therapy protocols (Luciano, 2001).

*Limitations*

The exploration of culture was restricted to articles assumed to have a high degree of experimental control, namely, those identified by the authors themselves as RCTs. Nonetheless, one could argue that the identified studies were not truly RCTs, because the present review did not verify adherence to CONSORT, or any other quality control criteria of RCTs (Moher *et al.,* 2010). Given that this review includes all published RCTs, it is unlikely that their quality had any effect on the explicit inclusion or exclusion of culture.

It should be acknowledged that there are experimental studies, not identified as RCTs by the authors, which have described cultural adaptations of cognitive behavioral interventions in Ibero-America (see Macià Antón, Olivares Olivares, and Amorós Boix, 2012). Thus, the applicability of the present findings may be limited, because experimental studies whose titles or methods did not include the term «randomized clinical trials» were not included. Future studies should look at how culture is incorporated in non-RCT studies including single subject designs. Based on the present findings, it is expected that the explicit exclusion of culture would persist even when examining it through other methodological lenses.

Findings of this review do not represent the entire gamut of psychological interventions due to the exclusion of research using non-behavioral approaches such as psychodynamic and systemic therapies. Although non-behavioral approaches are employed by many practitioners in Ibero-America, cognitive and behavioral techniques were selected, because they are the most empirically supported psychological interventions (McHugh and Barlow, 2010).

This paper was limited to the most recently published literature as searched through US, international, and Latin American databases. Like other systematic reviews of the literature, the possibility exists that some RCTs were missed, particularly those in Portuguese, or in journals not indexed in widely known international and regional databases (Medina-Urra and Barria Pailaquilén, 2002). Nonetheless, the explicit omission of culture was so pervasive that missing RCTs would not alter the results.

In conclusion, this exploratory paper suggests that Ibero-American researchers have neglected the discussion of culture in their replication and dissemination of cognitive behavioral interventions under controlled conditions due to the proposed Cultural Alliance Effect. Although the exploratory nature of this paper may limit its findings, researchers from this region might be modifying their interventions to their particular contexts without explicitly calling them culture adaptations. However, the diversity of Ibero-American countries may demand further exploration of cultural issues with indigenous and marginalized populations.

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Note: References for randomized controlled trial studies without the words culture, cultural factors, or cultural adaptations are available from the author upon request.

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