CHAPTER ONE

What Is Cultural Adaptation?

> Maria was meeting with a mental health practitioner for the first time as a result of referral from her primary care provider. The concern was that Maria was so depressed that she was unable to care for herself and her kids. The practitioner opened by saying, "So we are here to talk about your depression. How have you been feeling in the past week?" Maria replied, "Good. But I don't need to be here."

Helping can seem straightforward when your client is from a similar background but may feel less so when the client is not. Although from the outside an interaction can seem to go well, internal questions ("Why was the patient so quiet?"; "Did I say something wrong?") may remain for you. I've had those experiences.

Decades ago, I participated in team meetings as a substance use counselor on a psychiatric inpatient unit in an urban city hospital. We would meet with patients from different racial and cultural groups to discuss their progress. I remember one meeting with a Puerto Rican patient and the attending, a White woman wearing pearls and high heels. The attending tried several times to engage the patient. The patient responded with little elaboration and a somewhat restricted emotional expression. Afterward, the team met to discuss the patient's treatment plan. From the outside, there didn't seem to be anything wrong. We were doing what we were supposed to do. There was a treatment plan in place. Yet I came away feeling we knew nothing about the patient, that a great deal was going on for them that we were blind to. In my experience, this

feeling, of things not said, has been more pronounced in cross-cultural encounters compared to other interviews when the patient was White (most of the team was White). In initial meetings with White patients, it seemed like there was more chatter and a greater shared understanding. These experiences triggered my curiosity, and drove me to research targeting this question: When does difference make a difference? This book is about improving the kind of care we can give by making a well-known evidence-based counseling approach—motivational interviewing (MI)—more relevant and accessible to the client. We do that by attending closely to the many facets of the patient's identity, and to their priorities—in short, by attending to and welcoming their *culture* into the consultation.

WHAT IS CULTURAL ADAPTATION?

Twenty years after my experience on that psychiatric inpatient unit, from what I have heard and seen, not much has changed in our treatment of diverse patients and clients. One thing that has changed is the increased outcry for culturally adapted treatments that reflect unique needs and priorities. Yet, there are few models that explain the how-tos, or even the whys. I think part of the reason for this impasse is the term *cultural adaptation* itself.

Cultural adaptation is a hot-button term. Everyone agrees that it is important, but few people know what it looks like in clinical practice. This lack of insight into practical application is reflected in academic studies that rarely specify what has been adapted (Bahafzallah et al., 2020; Hai et al., 2021; Ramos & Alegría, 2014). Others may feel that an intervention does not need to be adapted for diverse groups, although change to models is common and necessary to scientific advancement (Tabak et al., 2012, p. 133).

What does cultural adaptation look like in clinical practice?

The Merriam-Webster Dictionary (n.d.) defines **adaptation** as a change in an organism that makes it more fit for existence, and in science, *adaptation* refers to changing the appropriateness of the selected model to the intervention being disseminated or implemented to a new population or setting (Tabak, 2012, p. 113). In fact, practitioners in the field are continually adapting established models, yet these adaptations

A Data-Driven Model of Cultural Adaptation in CAMI (Lau, 2006)

The central tenet of the culturally adapted motivational interviewing (CAMI) framework is that data should be used to decide whether and when adaptation is warranted. One of the data-driven factors was the identification of unique risk factors for drinking among Latines.* In short, social stressors related to immigration status and to acculturation (i.e., experiences of **discrimination**/marginalization) were associated with changes in drinking behavior among Latine adults (Lee et al., 2006). The Measure of Drinking Related to Immigration and Acculturation Stress (MDRIAS; Rosales et al., 2023), based on this research, was administered to English- and Spanish-speaking participants in the randomized clinical trial (Lee et al., 2019). CAMI-trained interventionists used the measure to elicit discussion of sensitive experiences, and the association to drinking to cope, with Latine adults.

CAMI adaptations, following the Lau model, fell into two categories: (1) augmenting intervention with culturally relevant content or (2) enhancing engagement. A few examples were given. For the first category, Latine-specific norms for alcohol consumption were available. There was also discussion about the health and social consequences specific to Latine adults, such as the importance of sending money and support to family in other countries. To enhance engagement, there was discussion about "what mattered" to Latine adults as a way evoking culture and communicating acceptance of the participant. As part of the introduction to CAMI, interventions encouraged participants to take an active role in CAMI discussion, even disagreeing with the practitioner if they wanted to. This adaptation was made to minimize the potential reluctance to share openly in a relationship that seems outwardly hierarchical (interventionists seeming like "experts"). This kind of encouragement hearkens to the Latino/a cultural value of *personalismo* and *sympatía* (Añez et al., 2008) in relationships, which might manifest in Latine adults not wanting to seem outwardly disagreeable; further research is needed to validate this possibility.

*In this book the term *Latine* is used because it is gender inclusive (Cardemil et al., 2019). However, people in the community more commonly use Latino or Latina (Greenwood, 2020), so in the dialogues these terms are used accordingly.

are often not reported (though they should be[1]). As I use it in this book, the word *adaptation* means modifying a model to make it more appropriate, relevant, attractive, or feasible, to benefit the recipient.

The word *modification* also means lessening, increasing, adding, or reorganizing. I like the word **optimization** to cover these activities. *Optimization* means making the best or most effective use of, or rearranging something to improve impact and efficiency (Oxford English Dictionary, n.d.).

In that light, MI might be refitted or rearranged to meet the client where they are, in terms of their level of awareness of and their level of comfort, familiarity, or personal agreement with aspects of **MI spirit**. There are many ways to modify a treatment that preserve or enhance its underlying active ingredients (if those active ingredients are found to be helpful to the target audience). Optimization emphasizes keeping the original treatment while testing nuances in its delivery. The cultural adaptation presented in this book is about achieving the full potential for MI with diverse groups by amplifying certain aspects strategically and delivering others in slightly different ways.

All treatments developed in clinical trials have to be optimized or modified for use in a real-life setting. Clinical interventions and approaches like MI are *optimally efficacious* only when they have been shown to be implementable with fidelity by practitioners in the real world (Onken et al., 2014, p. 22). That is what this book is about. Truly patient-centered care requires incorporating patient needs and priorities (Bahafzallah et al., 2020). If you are curious about how to do this, you're probably trying to implement MI in the real world with as many people as you can.

HOW WOULD YOU DEFINE CULTURE?

Culture is another term that is taken for granted but cannot be defined easily. This is called the anthropological paradox: The hardest thing to know, in a relative or comparative sense, is one's own culture (Napier

[1]For example, Dr. Rebeca Castellanos is conducting research asking community providers how they adapt interventions for their culturally diverse clients. This raises the point that adaptation is so ubiquitous that it may not even be noticed in session. Future efforts must investigate and leverage the wisdom of therapists and care providers, which include community health workers.

et al., 2014). Because we are immersed in our own culture, it is hard to recognize how it shapes us.

Let's begin with a partial definition of culture. First, there is the **symbolic (or surface) definition of culture**, things we can all see and hear: holidays, special foods, specific customs (Resnicow et al., 2002). At a less visible level, there is the **values definition of culture** as equivalent to an individual's thoughts, beliefs, and values rooted in membership in one's racial, ethnic, religious, or social group (Office of Minority Health, 2013).

But while these definitions may be useful in some way, using only these definitions leads to an incomplete understanding of a client. First, we are assuming that this person is made up of cultural values attributed to their group. But these values may not be meaningful to them. Second, cultural values are also influenced by social context and are constantly changing. For example, the Latine emphasis on *familismo* (family as a source of support and resources) may also be a function of the fact that in the United States, family may be all people have to count on (S. R. Lopez, personal communication, 2000). Last, taking an exclusive "culture is values" approach, in my opinion, leads to a cookbook kind of clinical stance, where we assume there is a Hispanic psychology distinct from other groups (Santos et al., 2021).

Culture Is What Matters to the Client

However, culture can best be understood when you view the client in their social context and not through a lens of group difference. This is because culture is dynamic. It changes in response to what is happening to the person in their social world. Notably, taking a broader perspective of the client in their social world helps us to see them as a whole person, which is crucial to communicating acceptance, a major component of the CAMI approach (which I will explain later). This socially based definition of culture is grounded in the everyday lives of people (Lakes, 2006). Accordingly, if you want to identify cultural influences, you must identify *what matters* to your clients in their everyday lives, then examine how they organize their lives around that priority (Kleinman, 1995). Asking someone *what matters* to them is like asking, "What is at stake for you? What is most important to you? How do you organize your life around that?" It is possible to detect culture when it is reflected or outlined in the context of the social world—in terms of what we prioritize and how we choose to live. Let's see what this looks like in a case example.

Case Example

Gabriela is a single mother from Colombia who lives with a teenage daughter in the United States. Since losing her job in an office a year earlier, she has increased her drinking with friends at home. In the following excerpt, she describes her feelings about being unemployed, draws comparisons to her own childhood and her mother and the expectations her upbringing created for her, and expresses her feelings about her drinking when her daughter is watching.

Culture is dynamic and changes in response to the social world.

GABRIELA: I have never been drinking as much as I did after I lost my job. Before, I just drank occasionally. But, when my daughter is around, I still don't drink. This is because kids do what they see.

PRACTITIONER: So being a mom is important to you.

GABRIELA: But once my daughter saw me drinking. I had told her that I only drink when my friends come over and she asked me, then how come you are drinking when they are not here? And that made me feel terrible. I thought, Why was I drinking? Why can't I wait? I was already a few drinks in.

PRACTITIONER: That really got you to the core.

GABRIELA: I really care about what she thinks. She was always proud of me for working. But now what I do is drink.

PRACTITIONER: Sounds like you think that affects her.

GABRIELA: I think it does. I hate to tell my daughter that I can't give her things. I used to give her incentives to study in school and now I can't. That makes me want to drink.

PRACTITIONER: So you feel down when you can't give your daughter the things she wants when she is trying the best she can. And to take your mind off that feeling you have a drink.

GABRIELA: My mom [in Colombia] used to tell us: "I couldn't give you all everything I wanted but I gave you all my love." She gave us things by cooking for us. I had a great mom. That actually pushed me to do more because she was always good.

PRACTITIONER: You want to give your daughter things the way your mom did, though she didn't have a lot, but you feel you are not doing that now. What do you make of that?

GABRIELA: Now that you're asking me, it's not worth . . . I need to stop. I really need to stop.

LISTENING FOR *WHAT MATTERS* AS A WAY OF UNDERSTANDING CULTURAL INFLUENCES

Here are some questions I would ask trainees as a way of helping them to identify *what matters* to Gabriela:

1. *What is Gabriela's social world like? How would you describe it?* Possible responses to consider: Gabriela is isolated from her family of origin. She earns money to support herself and her teenage daughter. Her girlfriends seem to be her main social network. She has close ties to her family of origin in another country.

2. *What is most at stake for her? What is most important? What affects her most? How does she organize her life around this priority?* Possible responses to consider: For Gabriela, *what matters* most is being a role model and provider for her daughter as a way of expressing love and care. Being a role model for Gabriela means not drinking in front of her daughter. She is upset when her daughter catches her drinking—as if she is disappointing her daughter in some way. Being a provider means giving not only material things but also love and care. She talks about her own mother who had limited means but provided love, and that was inspirational to Gabriela. To her, being a provider also means giving her daughter something, the way her mother gave her food and love.

I would ask the following questions to encourage thoughts about how Gabriela's responses and choices reflect cultural influences on her:

3. *How, if at all, does what is most at stake to Gabriela reflect a cultural process?* Possible responses to consider: Gabriela makes a comparison to her mother in her country of origin and describes different norms for being a mother (staying at home) and for drinking, which may reflect traditional gender roles for women. Gabriela talks often about the importance of the mother's role as caretaker—in her country of origin and in the United States.

4. *How might her social circumstances and structures interact with her*

cultural values? Possible responses to consider: This example shows how culture shows up in, and is a product of, our social contexts and challenges. By investigating and paying attention to *what matters* to Gabriela, we can see that she prioritizes holding her role as a mother and all that it means for her in the United States and in her past upbringing even in her social context that is different: the absence of an extended family, increased opportunities, and relaxed social norms around drinking.

As this work with Gabriela illustrates, in listening for *what matters* you can see how culture can be made evident. This example also shows how cultural values are intertwined with social context and can be illuminated when we ask more broadly about people's lives. For example, this exploration reveals that being a provider seems to be *what matters* to Gabriela. Being a provider, however, is closely tied to a traditional gender role definition of being a mother, which can include abstinence from alcohol. In trying to hide her drinking from her daughter, it appears that for Gabriela, the role of mother that remains faithful in some way to the traditional definition is important to her. Being a mother also means providing care, if not actual financial support. That Gabriela is drinking in front of her daughter and is no longer providing what she wants to provide causes internal conflict. In sum, the way we live our lives, centered on our most important priorities, reflects value(s) that may be culturally influenced—we enact our culture, every day.

Everyone Has a Culture

This book is about listening for and responding to what matters in the client, but it makes sense for you, the MI practitioner, to consider and identify what matters to you as well. Let's take the example of a busy working mother who is Chinese, who insists on cooking home-made meals for her children. She gets up before going to work and prepares these meals so her children have something to eat when they return from school. Why? It could be that what matters to her is showing that she cares about her children through cooking—as a concrete and culturally sanctioned way to express caring and love. She is prioritizing what matters—making a meal over taking extra time for herself or for work—to be present in some way when her children return from school. Or take the example of a White Jewish woman who spends her time making sure her children get to lessons in preparation for bar/bat mitzvahs and educational advancement. Here,

arguably, what matters to this mother is providing means and opportunities for growth and development that may be culturally grounded. In both examples it is possible to detect social and cultural influences. Of course, this analysis is a brief snapshot and therefore incomplete, but you get the idea.

PAUSE AND CONSIDER

Think about what was most important to you on a recent day. Then ask yourself: Why was that important? What was the expectation you were taught to fulfill? And where did that expectation come from? In doing this self-reflection, try to connect the dots for yourself, detecting the cultural and social influences on your behavior and choices.

LANGUAGE AND THE IMPORTANCE OF CULTURAL IDIOMS

Language is a carrier of culture, so when people deliver treatments in another language, they may be adapting them partially. I say partially because even if you speak the language you need to understand the cultural underpinnings of the meanings of the words spoken and how meanings might differ in one context versus another. Translation is considered a partial adaptation because translation does not always tap into underlying beliefs, values, or the experience of a unique culture (Resnicow et al., 2018). This idea is reinforced by the American Council on the Teaching of Foreign Languages, which defines distinguished speakers as individuals who are culturally competent *in addition* to being fluent. I learned from Spanish-speaking practitioners that important idioms and metaphors in Spanish convey great meaning to their clients; two examples are "*aguantagua mucho*" (hold on a lot), and "*poner de su parte*" (to do one's bit or share).

On the MINT (Motivational Interviewing Network of Trainers) listserv, MI practitioner Rik Bes offered a rich example of how important idioms and metaphors evoke cultural preferences and priorities. He observed that in Arab countries, the language is more flowery and interlaced with beautiful verbal images. He was talking to a patient in his clinic in Doha (Qatar), and his patient responded that his life was a

sandstorm, so he felt completely disoriented, frightened, and lonely. Rik explained that sandstorms in the Arab deserts are indeed overwhelming and can be so unexpected that you do not know what happened. Here, the patient replied to the question "How are you doing?" with a metaphor: a sandstorm. This patient had recently been through much, including losing his house, and was "riding out the storm" in the clinic. When Rik saw him a year later, he remembered the metaphor-answer, so asked, "How are the weather conditions?" This indirect question led to a big smile from the patient and a long answer, helping build an immediate connection (R. Bes, personal communication, August 22, 2023).

Rik used MI to reflect on the meaning of the analogy: He referred to his client's state of mind by asking about the weather. He also shared with the MINT listserv that his way of communicating as a Dutch person (which was very direct, a way of showing respect and value for someone else because one is being transparent) was different from the ways of communication in other parts of the world, which are more indirect and metaphorical, and that he always kept this in mind.

Delivering MI in a Different Language

In the clinical trial that tested CAMI against standard MI, about 30% of the patients wanted to receive CAMI in Spanish, and one of my therapists was a fluent Spanish speaker. Yet we found that clients still responded positively to the other CAMI practitioners' efforts to speak Spanish. The gold standard is undoubtably delivery by therapists fluent in the client's language, yet these findings also suggest that trying to speak the language, even imperfectly, has some beneficial effects and can improve how people respond to MI.

WHOM IS THIS BOOK FOR?

The word *diverse* refers to so many different identities (e.g., able-bodied status, gender, sexual orientation) that I am unable to address in this book. That is because the work behind this book has focused on helping socially disadvantaged Latine men and women who use alcohol and drugs heavily.

I propose that this book can be used as a tool to bridge differences. It is meant to be a resource when you are in doubt about how to talk

to someone and wonder how to best connect. If this isn't clear already, in this model of CAMI, I prefer to *allow the client to define what culture means to them*—your work is to listen for that and to **elicit** when needed—while not making any presumptions. Thus, this is not a book about how to do MI differently with one cultural group versus another: I feel that approach would lead us to stereotyping and narrowing our views of our clients. I seek to do the opposite: broaden focus, take a broader perspective of clients, while understanding that culture is deeply entwined and unable to be separated from the social context, with all of its stressors and pressures.

An idea running through CAMI is that what is cultural is also what is social. CAMI emphasizes the social of the biopsychosocial model.[2] This dual lens (culture as social) is necessary because we are equally shaped by both and they are inseparable. One's culture is invisible and difficult to define to another person. In CAMI, culture is operationalized broadly as *what matters* to a person, their everyday priorities. In eliciting and listening for what the person prioritizes and how they arrange their lives to achieve their priorities, it becomes possible to discern major cultural and social influences on people's choices and behaviors while avoiding making any presumptions about what their cultural values are.

In CAMI, culture is *what matters* to a person.

HOW IS THIS BOOK ORGANIZED?

The first part of this book focuses on the ideas underlying how to deliver MI in a way that is culturally attuned. In Chapter 2 I lead you through an examination of MI spirit and MI tasks and how you as the practitioner can optimize both to forge a connection with your client. In Chapter 3 I explain why acknowledging and discussing issues related to discrimination and stigma with your client is important. Chapters 4 through 7 focus on describing how CAMI is used to optimize MI methods. Chapters 8 and 9 conclude with a summary of the ideas presented in the book and suggestions for further investigation and training

[2]Social, psychological, and biological factors are interconnected factors that work together to impact health.

PUTTING IT ALL TOGETHER

This book is about trying to help our clients more effectively across differences. I show how you can take an efficacious evidence-based treatment like MI and *improve its fit* for anyone. The goal is to improve your ability to serve your clients, to make it worthwhile and valuable to have them see you. You don't have to be trained in MI to read this book because I provide an overview of MI as a basis for explaining the culturally adapted approach, CAMI. This approach to optimizing MI is deeply rooted in MI spirit (**partnership**, **acceptance**, **compassion**, and **empowerment**) and in MI methods. CAMI doubles down on the humanistic foundation of MI. There is an explicit framing of the individual that is positive and strengths based. In the end, this book is intended for those of you who, like me, have left the room wondering if a clinical discussion could have gone differently, or feeling that something was missing, misunderstood, or uncomfortable. This book is for those who dare to go beyond their scope of practice and ask: How can I best connect with someone who is of a different background? I hope you continue reading with curiosity, feeling encouraged, and with desire to learn this approach.